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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

February 2025

Cycle 7

Medical Inspection Report

Salinas Valley State Prison

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Introduction

Pursuant to California Penal Code section 6126 et seq., the Office of the Inspector General (the OIG) is responsible for periodically reviewing and reporting on the delivery of the ongoing medical care provided to incarcerated 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.

[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 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. The penal code provides 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 Salinas Valley State Prison, 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 January 2023 to June 2023.[4]

[4] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between May 2022 and February 2023, and transfer reviews between October 2022 and April 2023.

Summary: Ratings and Scores

We completed the Cycle 7 inspection of SVSP in November 2023. OIG inspectors monitored the institution's delivery of medical care that occurred between January 2023 and June 2023.

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

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

The OIG clinicians (a team of physicians and nurse consultants) reviewed 48 unique cases, which contained 1,123 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 November 2023 to verify their initial findings. The OIG physicians rated the quality of care for 20 comprehensive case reviews. Of these 20 cases, our physicians rated 18 ***adequate*** and two ***inadequate***.

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 369 patient records and 1,147 data points and used the data to answer 93 policy questions. In addition, we observed SVSP's processes during an on-site inspection in August 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 SVSP.

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

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

		Ratings: Proficient / Adequate / Inadequate		*Scoring Ranges*: 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	=	86.7%	86.1%	=
2	Diagnostic Services	Adequate	=	60.0%	57.6%	=
3	Emergency Services	Adequate	↑	N/A	N/A	N/A
4	Health Information Management	Adequate	=	89.3%	88.9%	=
5	Health Care Environment†	N/A	N/A	55.7%	61.9%	=
6	Transfers	Adequate	=	73.6%	66.1%	=
7	Medication Management	Adequate	=	62.5%	67.8%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	69.3%	69.7%	=
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	=	67.9%	70.0%	=
14	Specialty Services	Adequate	↑	73.2%	68.2%	=
15	Administrative Operations†	N/A	N/A	68.8%	82.6%	↓

* 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 found no adverse event at SVSP 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 SVSP. Of these 10 indicators, OIG clinicians rated 10 ***adequate***. The OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 18 were ***adequate***, and two were ***inadequate***. In the 1,123 events reviewed, we found 239 deficiencies, 46 of which OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at SVSP:

- Compared to Cycle 6, providers improved their medical record review, decision-making, follow through with treatment plans, and continuity of care.
- SVSP delivered excellent provider and nurse access.

Our clinicians found the following weaknesses at SVSP:

- SVSP needed improvement with specialty access, which has been ongoing from Cycle 6.
- SVSP needed improvement in timely completing diagnostic studies.

Compliance Testing Results

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

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

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

- Staff performed well in scanning initial health care screening forms, community hospital discharge reports, specialty service reports, and requests for health care services into patients' electronic medical records within required time frames.
- Nurses processed sick call request forms, performed face-to-face evaluations, and completed nurse-to-provider referrals within required time frames.
- Providers evaluated patients returning from outside community hospitals or specialty service appointments within required time frames. Moreover, patients were referred within required time frames to their providers upon arrival at the institution.

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

- SVSP's clinical areas had multiple expired medical supplies.
- Health care staff did not consistently follow hand hygiene precautions before or after patient encounters.
- Nursing staff did not regularly inspect emergency response bags.
- Staff often did not maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients admitted to a specialized medical housing unit. In addition, SVSP had poor medication continuity for patients who transferred into the institution, transferred within the institution, or had a temporary layover at SVSP.
- SVSP did not consistently provide routine and STAT laboratory services within specified time frames.
- Providers often did not communicate results of diagnostic services timely. Most patient letters communicating these results were missing the date of the diagnostic service, the date of the results, and whether the results were within normal limits.

Institution-Specific Metrics

Located five miles north of Soledad, on a 300-acre site in Monterey County, Salinas Valley State Prison (SVSP) has been designed to house Level 1, Level 3 and Level 4 patients. The institution ran clinics in which staff members handled nonurgent requests for medical care. Patients requiring urgent or emergent care were seen in the institution's triage and treatment area (TTA). SVSP also had a licensed correctional treatment center (CTC) for providing inpatient care. SVSP has been designated by California Correctional Health Care Services (CCHCS) as a *basic care institution*. Basic care facilities are typically located in rural areas, away from tertiary care centers and specialty care providers whose services would likely be used frequently by patients at higher medical risk.

As of July 18, 2024, the department reports on its public tracker that 78 percent of SVSP's incarcerated population is fully vaccinated for COVID-19 while 65 percent of SVSP's staff is fully vaccinated for COVID-19.[7]

In August 2023, the Health Care Services Master Registry showed SVSP had a total population of 2,910. A breakdown of the medical risk level of the SVSP population as determined by the department is set forth in Table 2 below.[8]

Table 2. SVSP Master Registry Data as of August 2023

Medical Risk Level	Number of Patients	Percentage*
High 1	224	7.7%
High 2	338	11.6%
Medium	1,467	50.4%
Low	881	30.3%
Total	**2,910**	**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 08-14-2023

[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 CCHCS, as identified in Table 3 below, SVSP had 3.0 vacant executive leadership positions, 8.0 primary care provider vacancies, 5.5 nursing supervisor vacancies, and 179.8 nursing staff vacancies.

Table 3. SVSP Health Care Staffing Resources as of August 2023

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	6.0	13.0	41.5	339.1	399.6
Filled by Civil Service	5.0	5.0	36.0	159.3	205.3
Vacant	3.0	8.0	5.5	179.8	196.3
Percentage Filled by Civil Service	83.3%	38.5%	86.7%	47.0%	51.4%
Filled by Telemedicine	0	2.0	0	0	2.0
Percentage Filled by Telemedicine	0	15.4%	0	0	0.5%
Filled by Registry	0	4.0	0	110.0	114.0
Percentage Filled by Registry	0	30.8%	0	32.4%	28.5%
Total Filled Positions	5.0	11.0	36.0	269.3	321.3
Total Percentage Filled	**83.3%**	**84.6%**	**86.7%**	**79.4%**	**80.4%**
Appointments in Last 12 Months	0	2.0	0	21.0	23.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave ‡	0	0	3.0	20.0	23.0
Adjusted Total: Filled Positions	**5.0**	**11.0**	**33.0**	**249.3**	**298.3**
Adjusted Total: Percentage Filled	**83.3%**	**84.6%**	**79.5%**	**73.5%**	**74.6%**

* 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 August 14, 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 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 SVSP's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. Currently, only two HEDIS measures are available for review: poor HbA1c control, which measures the percentage of diabetic patients who have poor blood sugar control, and colorectal cancer screening rates for patients ages 45 to 75. For poor HBA1c control, SVSP's results compared favorably with those found in State health plans for this measure. We list the applicable HEDIS measures in Table 4.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—SVSP'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 these data for informational purposes. SVSP had a 33 percent influenza immunization rate for adults 18 to 64 years old and a 50 percent influenza immunization rate for adults 65 years of age and older.[9] The pneumococcal vaccination rate was 90 percent.[10]

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

[10] 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.

Cancer Screening

When compared with statewide Medi-Cal programs, SVSP's colorectal cancer screening rate of 68 percent was equal to or slightly lower than Kaiser Northern California (Medi-Cal) and Kaiser Southern California (Medi-Cal), respectively

Table 4. SVSP Results Compared With State HEDIS Scores

HEDIS Measure	SVSP Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	91%	–	–	–
Poor HbA1c Control (> 9.0%) ‡,§	**14%**	36%	31%	22%
HbA1c Control (< 8.0%) ‡	79%	–	–	–
Blood Pressure Control (< 140/90) ‡	88%	–	–	–
Eye Examinations	57%	–	–	–
Influenza – Adults (18–64)	33%	–	–	–
Influenza – Adults (65+)	50%	–	–	–
Pneumococcal – Adults (65+)	90%	–	–	–
Colorectal Cancer Screening	68%	37%	68%	**70%**

Notes and Sources

* Unless otherwise stated, data were collected in August 2023 by reviewing medical records from a sample of SVSP'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 *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2022–June 30, 2023 (published March–April 2024); https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Managed-Care-Technical-Report-Volume-1.pdf.

‡ For this indicator, the entire applicable SVSP 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 SVSP's performance, we offer the following recommendations to the department:

Diagnostic Services

- The department should develop strategies to ensure providers generate letters communicating test results to their patients and the letters include all elements as required by CCHCS policy.

- Medical leadership should determine the root cause(s) of challenges to timely collecting, receiving, and notifying providers of STAT laboratory results and implement remedial measures as appropriate.

Emergency Services

- Nursing leadership should determine the root cause(s) of challenges preventing staff from completing thorough assessments and accurate documentation after an emergent event and should implement remedial measures as indicated.

- Executive leadership should determine the root cause(s) of challenges to completing thorough reviews of urgent and emergent events in which patients transfer to the community hospital and should implement remedial measures as indicated.

Health Care Environment

- Medical and nursing leadership should analyze the root cause(s) for staff not following all required universal hand hygiene precautions and should implement remedial measures as appropriate.

- Executive leadership should analyze the root cause(s) for staff not following equipment and medical supply management protocols and should implement remedial measures as appropriate.

- Nursing leadership should determine the root cause(s) for staff not ensuring the EMRBs are regularly inventoried and sealed or not properly completing the monthly logs and should implement remedial measures as appropriate.

Transfers

- Nursing leadership should identify the root cause(s) for R&R nurses not completing the initial health screening, including answering all questions and documenting an explanation for each "yes" answer, not documenting a complete set of vital signs as part of the patient's initial health screening assessment, and not completing the initial health screening form prior to a patient being placed in housing. Nursing leadership should implement remedial measures as appropriate.

- Nursing leadership should identify the challenges to ensuring newly arrived patients receive medications without interruption and implement remedial measures as appropriate.

Medication Management

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

- Nursing leadership should determine the root cause(s) for nursing staff not documenting patient refusals and no shows in the medical administration record, as described in CCHCS policy and procedures, and leadership should implement remedial measures as appropriate.

Preventive Services

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

- Nursing leadership should analyze the challenges to ensuring nursing staff perform the annual TB screening during the patient's birth month and should implement remedial measures as appropriate.

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

Nursing Performance

- Nursing leadership should analyze the challenges to nurses performing thorough assessments during face-to-face patient evaluations and should implement remedial measures as indicated.

Specialty Services

- Medical leadership should determine the root cause(s) of challenges to the timely provision of specialty appointments, including preapproved specialty appointments for transfer-in patients, and should implement remedial measures as appropriate.

- The department should consider developing and implementing measures to ensure the institution timely receives the specialty reports and providers timely review these reports.

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	***Proficient* (86.7%)**

SVSP's performance improved in case review compared to its performance in Cycle 6. SVSP facilitated excellent access to providers and nurses, follow-up appointments after specialty appointments, and follow-up appointments after hospital discharge. However, SVSP needed improvement with access to specialty services. The OIG rated the case review component of this indicator ***adequate***.

SVSP's performance in compliance testing continued to improve in Cycle 7. Providers showed good performance in timely evaluating newly transferred patients, patients after their return from specialist appointments and hospitalizations, and patients with chronic care conditions. Nurses timely reviewed all patient sick call requests and frequently completed face-to-face triage. However, SVSP did not maintain a good process to ensure housing units adequately stored requests for health care services forms. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***proficient***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 522 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events that may have required the institution to generate appointments. We identified 26 deficiencies relating to **Access to Care**, six of which were significant.[11] Of the 20 minor deficiencies, 12 involved delays in obtaining diagnostic studies. Four of the six significant deficiencies were due to specialty appointment scheduling delays.

Access to Care Providers

Access to clinic providers is an integral part of patient care in health care delivery. Case review found SVSP performed excellently in access to care providers. We reviewed 135 outpatient provider events and found no deficiencies with the timeliness of outpatient provider appointments ordered by the provider or referred by nurses.

[11] Access to care deficiencies occurred in cases 8, 15–19, 21, 23–25, and 47. Significant deficiencies occurred in cases 16, 18, 23, and 24.

In contrast, compliance testing showed intermittent access to chronic care follow-up appointments (MIT 1.001, 72.0%); however, nursing-to-provider sick call referrals frequently occurred (MIT 1.005, 91.7%).

Access to Specialized Medical Housing Providers

SVSP provided very good access to CTC providers. OIG clinicians reviewed 49 CTC provider encounters and only found two access deficiencies, which occurred in the same case:

- In case 23, the CTC provider did not evaluate the patient within policy time frames.

Access to Clinic Nurses

SVSP performed excellently with access to nurse sick calls and provider-to-nurse referrals. Compliance testing showed nurses always reviewed patients' requests for service the same day they were received (MIT 1.003, 100%), and nurse appointments often occurred within one business day after review of a sick call request (MIT 1.004, 93.3%). Our clinicians assessed 148 nursing events in the outpatient and CTC setting, as well as seven nursing sick call requests in five cases. We found no deficiencies with access to nurses.

Access to Specialty Services

SVSP's performance was mixed with referrals to specialty services. Compliance testing showed room for improvement with completion rates for high-priority (MIT 14.001, 66.7%) and medium-priority (MIT 14.004, 66.7%) appointments, but SVSP had a very good completion rate for routine-priority appointments (MIT 14.007, 86.7%). Specialist follow-up appointment completion also varied with high-priority (MIT 14.003, 90.0%), medium-priority (14.006, 71.4%), and routine-priority (MIT 14.009, 60.0%) appointments. Case review clinicians found most specialty appointments occurred within requested time frames; however, we identified eight deficiencies due to delays. The following are two examples:

- In case 23, the patient had a lung nodule suspicious for cancer. The provider ordered a high-priority request for a lung specialist. However, staff scheduled the appointment more than one month later, which was a delay of over twenty days.

- In case 24, the patient had kidney stones that were not resolving with conservative treatment. The provider ordered a urology telemedicine appointment to occur within 24 days, but staff scheduled the appointment more than six weeks late.

Follow-Up After Specialty Services

Compliance testing revealed provider appointments after specialty services frequently occurred within the required time frame (MIT 1.008, 83.3%). The OIG clinicians reviewed 81 off-site or telemedicine specialty consultations or procedures and found only three

deficiencies in which the provider appointment after specialty services was not scheduled. The following are examples:

- In case 18, the patient had a high-priority oncology specialist consultation for leukemia but did not have a follow-up appointment with the provider afterward. The provider eventually saw the patient about two months later for a chronic care appointment.

- In case 21, on two separate occasions, staff did not order a provider follow-up appointment within five days after a high-priority off-site procedure or specialist consultation.

Follow-Up After Hospitalization

SVSP performed excellently and always ensured providers evaluated patients after hospitalizations. Case review did not find any deficiencies in this area.

Follow-Up After Urgent or Emergent Care (TTA)

Providers always evaluated their patients following a triage and treatment area (TTA) event as requested. OIG clinicians reviewed 48 TTA events and identified no delays in provider follow-up appointments.

Follow-Up After Transferring Into SVSP

Access to care for patients who had recently transferred into the institution was satisfactory. Compliance testing showed acceptable access to intake appointments for newly arrived patients (MIT 1.002, 84.0%). 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

Our case review clinicians spoke with SVSP's executive leadership, medical and nursing leadership, and schedulers regarding the institution's access to care. They explained diagnostic services were delayed due to an interim process in which patients who refused laboratory tests were given additional opportunities to complete the tests. This is discussed further in the **Diagnostics Services** indicator. They also explained how specialty consultations had occurred late due to the insufficient availability of specialty services and appointments in the surrounding region for the medical complexity of their patients. Specifically, despite its designation as a "basic" institution, SVSP has a diverse and substantial population of patients requiring medical oversight, including the psychiatric inpatient and other outpatient mental health care programs, a large disabled population, a large transgender population, a large addiction treatment program, and an extraordinarily high percentage of high risk patients.[12] Due to the impact of these factors,

[12] Institutions designated as "basic" are generally expected to have a high risk medical population of approximately 5%. At nearly 20%, SVSP's high risk population is essentially four times the expected ratio. However, this institution is still assigned a medical staffing package consistent with its *basic* designation.

even with telemedicine specialty services, SVSP experienced difficulty scheduling specialty consultations within desired time frames.

Compliance On-Site Inspection and Discussion

Four of six housing units randomly tested at the time of inspection had access to the Health Care Services Request Form (CDCR 7362) (MIT 1.101, 66.7%). In two housing units, custody officers did not have a system in place for restocking CDCR 7362. The custody officers reported reliance on medical staff to replenish the CDCR 7362 in the housing units.

Compliance Score 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)	21	4	0	84.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	30	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004)	28	2	0	93.3%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005)	11	1	18	91.7%
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)	2	0	28	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007)	22	3	0	88.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	34	8	3	81.0%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	4	2	0	66.7%
				Overall percentage (MIT 1): **86.7%**

* 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

	Scored Answer			
Compliance Questions	**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)	5	2	0	71.4%
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)	10	5	0	66.7%
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	1	5	90.0%
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)	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	2	8	71.4%
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)	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	3	2	10	60.0%

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. In addition, in Cycle 7, we examined the institution's performance in timely completing and reviewing immediate (STAT) laboratory tests.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (60.0%)**

Case review found SVSP performed acceptably with diagnostic services, similar to Cycle 6. We found more test completion delays of one to two days in comparison to the last cycle. Providers almost always endorsed test results timely; however, they often did not generate complete patient test result notification letters. Although the number of these letter deficiencies were high, they did not significantly increase the risk of harm to the patients. Overall, the OIG rated the case review component of this indicator ***adequate***.

SVSP's overall compliance testing scores needed improvement for this indicator. Staff performed exceptionally in timely completing radiology tests, frequently retrieved pathology reports timely, and often timely reviewed radiology and laboratory results. However, staff only sometimes completed routine-priority laboratory tests within the required time frames, and never completed STAT tests within the required time frames. Providers almost always promptly endorsed diagnostic results but inconsistently generated patient test result letters with all required elements. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 161 diagnostic events and found 40 deficiencies, two of which were significant.[13] Of the 40 deficiencies, 12 related to delays in obtaining labs and 27 related to incomplete patient notification letters.

Test Completion

Compliance testing showed mixed performance in test completion. Completion of X-rays was perfect (MIT 2.001, 100%) and completion of laboratory tests was satisfactory (MIT 2.004, 80.0%); however, completion of STAT laboratory tests was very poor (MIT 2.007, zero).

[13] Diagnostic deficiencies occurred in cases 2, 8, 13–15, 17–19, and 23–25. Significant diagnostics deficiencies occurred in cases 13 and 24.

With case review, SVSP's test completion performance was acceptable. Case review clinicians found 11 deficiencies related to completion delays in routine diagnostics and one delay with a STAT laboratory test. Most of the delays in test completion were not significant and did not increase the risk of harm.

- In case 24, the provider ordered a STAT urine test to be completed on the same day. However, this specimen was collected two days later.

Health Information Management

In compliance testing, providers always reviewed X-rays timely (MIT 2.002, 100%) and often reviewed laboratory tests timely (MIT 2.005, 90.0%). Providers always endorsed STAT laboratory tests (MIT 2.009, 100%); however, patient notification of STAT laboratory test results never occurred timely (MIT 2.008, zero). With pathology tests, staff often retrieved the results (MIT 2.010, 80.0%) and providers often reviewed the results timely (MIT 2.011, 80.0%); however, providers rarely sent proper patient notification letters (MIT 2.012, 10.0%).

With case review, SVSP staff retrieved laboratory and diagnostic results promptly and sent them to providers for review. Case review clinicians identified one deficiency in which providers did not timely endorse the result, and 25 deficiencies where patient notification letters were either incomplete or not generated. The clinicians reviewed these deficiencies in the context of the type of diagnostic test and the severity of not reporting the results to the patient. These deficiencies did not require any changes to treatment plans and had minimal impact or risk of harm to the patient.

Clinician On-Site Inspection

The case review clinicians discussed deficiencies with laboratory supervisors. The supervisors stated the delays in test completion were due to a temporary policy in which, if patients refused a diagnostic study, the laboratory staff would return the next day and offer to perform the diagnostic study again. This gave the patients an opportunity to have the diagnostic study performed without having to go through the refusal process and obtain a new order. Because patients at SVSP refused frequently, diagnostics were delayed, and the laboratory staff felt overwhelmed. Leadership stated this was no longer the policy at SVSP.

Compliance Score 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)	10	0	0	100%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	7	3	0	70.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	6	4	0	60.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	9	1	0	90.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	3	7	0	30.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	0	6	0	0
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	0	6	0	0
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	6	0	0	100%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	8	2	0	80.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	1	9	0	10.0%
				Overall percentage (MIT 2): **60.0%**

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

Recommendations

- The department should develop strategies to ensure providers generate letters communicating test results to their patients and the letters include all elements as required by CCHCS policy.

- Medical leadership should determine the root cause(s) of challenges to timely collecting, receiving, and notifying providers of STAT laboratory results and implement remedial measures as appropriate.

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, cardiopulmonary resuscitation (CPR) quality, triage and treatment area (TTA) care, provider performance, and nursing performance. Our clinicians also evaluated the Emergency Medical Response Review Committee's (EMRRC) performance in identifying problems with its emergency services. The OIG assessed emergency services 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***

SVSP performed satisfactorily in emergency services. Compared to Cycle 6, SVSP staff improved in initiating CPR, notifying emergency medical services (EMS), and administering oxygen. Nurses and providers performed adequate evaluations for patients and delivered appropriate interventions. The EMRRC generally identified deficiencies with emergency services and training needs; however, the clinicians found opportunities for improvement in identifying deficiencies regarding reassessment and documentation. Considering all factors, the OIG rated this indicator ***adequate.***

Case Review Results

Our clinicians reviewed 65 urgent or emergent events and found 53 emergency care deficiencies.[14] Of these 53 deficiencies, four were significant.[15] Of the 53 deficiencies, 32 deficiencies were contained in two cases for patients who had multiple complaints of chest pain.

Emergency Medical Response

Generally, SVSP provided good emergency care. Our clinicians reviewed five cases in which patients required CPR.[16] Custody staff initiated CPR without delay, administered Narcan, and notified emergency medical services (EMS) and the TTA staff. Health care staff almost always responded to medical emergencies throughout the institution without delay. We identified one deficiency of delayed response. Additionally, our clinicians identified opportunities for improvement in documentation of time lines and the flow

[14] Of the 65 urgent or emergent events, 41 events occurred in cases 1 and 2.

[15] Deficiencies occurred in cases 1–8, 19–22, and 47. Significant deficiencies occurred in cases 1, 2, 20, and 22.

[16] CPR events occurred in cases 3–5, 7, and 9.

rate of oxygen administered to patients. We identified five deficiencies related to these areas, none of which were significant. [17]

Provider Performance

SVSP providers performed excellently in urgent and emergent situations as well as with after-hours care. They made appropriate triage decisions and diagnoses. Of the 65 TTA events, we reviewed 60 TTA events in which providers were present or consulted and found no provider deficiencies.

Nursing Performance

Medical first responders and TTA nurses mostly performed good assessments, intervened, and notified providers as needed. Our clinicians identified opportunities for improvement in the areas of nursing assessment and intervention. The following are examples:

- In cases 1, 2, and 8, staff evaluated patients in the TTA for urgent symptoms. However, the TTA nurses did not perform reassessments or reassess vital signs prior to the patient's release to the housing unit.

- In case 1, the patient received urgent care for chest pain. The nurse assessed the patient and received orders to transfer the patient emergently to a higher level of care by ambulance. However, the nurse delayed contacting EMS for 34 minutes due to miscommunication.

- In case 20, the TTA nurse responded to a patient with pale, cool skin after a witnessed fall. Upon arrival at the patient's location, the TTA nurse assessed the patient with increased respirations; however, the nurse did not promptly take a complete set of vital signs or perform an objective assessment to determine if immediate intervention and 9-1-1 activation was required. Instead, the TTA nurse transferred the patient to the TTA for further assessment and observation. While the patient was observed in the TTA, the nurse assessed the patient with critically low blood pressure and a rapid respiratory rate. The patient required immediate fluid resuscitation to provide life saving measures; however, the nurse did not make multiple intravenous (IV) attempts or initiate intraosseous (IO) access after the initial IV was unsuccessful.[18]

Nursing Documentation

Nurses in the TTA usually performed thorough documentation for emergent events. Although documentation was lacking for time line of events and medication administration, these deficiencies did not affect overall patient care. [19]

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[17] CPR event deficiencies occurred in cases 3–5, and 7.

[18] Interosseous access involves inserting a catheter into bone to provide immediate medication or fluids.

[19] Deficiencies occurred in case 1–3, 6, 7, 21, and 22.

Emergency Medical Response Review Committee

The EMRRC is required to audit all unscheduled transports to a higher level of care to evaluate staff performance, documentation, and policy adherence as well as to identify training issues. Our clinicians reviewed 28 events and identified 10 deficiencies.[20] SVSP's EMRRC met monthly, usually identified deficiencies, and provided staff training. However, we identified a trend in which the committee did not always identify deficiencies regarding reassessment and documentation.

Compliance testing showed the institution rarely performed reviews within required time frames (MIT 15.003, 8.3%). Compliance inspectors found additional errors including incomplete checklists and missing entries, and the chief medical executive (CME) and chief nurse executive (CNE) or designees did not perform a clinical review.

Clinician On-Site Inspection

Our clinicians toured the TTA during our on-site inspection. The TTA had two bays: one was used for emergent or urgent patients; the other was shared by the off-site return nurse and specialty clinics.

TTA nursing staff reported nursing staff respond to medical alarms in the outpatient environment. Nursing staff in CTC and PIP respond to medical emergencies in the inpatient setting and notify TTA nursing staff if additional medical help is needed.[21]

SVSP staff reported the institution participated in a pilot program where patients received two doses of intranasal Narcan for emergency use on two yards. In addition, when custody responded to a medical alarm and found a patient unresponsive from a suspected overdose, the custody sergeant would administer Narcan doses until the arrival of healthcare staff.

[20] Deficiencies occurred in cases 1, 2, 4, 7, and 19.

[21] PIP is the Psychiatric Inpatient Program.

Recommendations

- Nursing leadership should determine the root cause(s) of challenges preventing staff from completing thorough assessments and accurate documentation after an emergent event and should implement remedial measures as indicated.

- Executive leadership should determine the root cause(s) of challenges to completing thorough reviews of urgent and emergent events in which patients transfer to the community hospital and should implement remedial measures as indicated.

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*** **(89.3%)**

Case review found SVSP's performance for this indicator was similar to Cycle 6. Staff often timely retrieved and scanned hospital discharge records, diagnostic results, and urgent and emergent reports. However, we found room for improvement with specialty report retrieval and in obtaining provider endorsements timely. About half the deficiencies we identified resulted from incomplete or missing patient notification letters. The OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed SVSP performed excellently in this indicator. Staff always timely scanned patients' requests for medical care and retrieved hospital discharge documents. They also showed good performance in scanning specialty reports and ensuring medical records were labeled and filed in the appropriate patient files. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***proficient***.

Case Review and Compliance Testing Results

We reviewed 1,123 events and found 48 deficiencies related to health information management. Of these 48 deficiencies, four were significant.[22] The significant deficiencies with health information management related to delays, not retrieving specialty reports, and not scanning one wound culture result into the EHRS.[23]

Hospital Discharge Reports

Case review clinicians reviewed 61 off-site emergency discharge department and hospital encounters. SVSP staff generally retrieved hospital records, scanned them into the EHRS,

[22] HIM deficiencies occurred in cases 1, 2, 10, 13–15, 17, 18, 20, 21, 23–25, 32, 34–37, and 47. Significant HIM deficiencies occurred in cases 10, 13, 14, and 15.

[23] EHRS is the Electronic Health Records System. The department's electronic health record system is used for storing the patient's medical history and health care staff communication.

and reviewed them properly. We identified two delays with provider endorsement of records, one hospital record that was incorrectly scanned, and the deficiency below.

- In case 13, the patient was hospitalized with soft tissue infection of his left leg. SVSP staff did not retrieve or scan the wound culture results.

Staff always scanned hospital reports into the EHRS (MIT 4.003, 100%) and frequently retrieved and scanned hospital discharge records (MIT 4.005, 88.0%).

Specialty Reports

Although improved from last cycle, SVSP still had some difficulty with managing specialty reports. We found four deficiencies with retrieving and scanning reports as well as three endorsement delays. The following are examples:

- In case 10, the otolaryngologist evaluated the patient, but the staff retrieved this specialist's report 12 days later.
- In case 14, the podiatrist evaluated the patient, but staff did not retrieve and scan the specialist's report into the EHRS.
- In case 15, the gastroenterologist evaluated the patient, but the staff did not retrieve and scan this specialist's report into the EHRS until notified by the OIG.

Diagnostic Reports

SVSP staff's handling of diagnostic reports was good. We reviewed 160 diagnostic events and identified 26 deficiencies related to health information management (HIM) and handling of diagnostic reports: two deficiencies related to late provider endorsements and 24 related to incomplete patient notification letters. All these deficiencies were minor and did not significantly increase the risk of harm to the patient.

Compliance performance was mixed for diagnostic reports. Staff did not timely complete STAT laboratory testing (MIT 2.007, zero) and did not notify providers of STAT results (MIT 2.008, zero). Providers rarely generated pathology notification letters (MIT 2.012, 10.0%); however, providers often reviewed and endorsed pathology results (MIT 2.011, 80.0%).

Urgent and Emergent Records

OIG clinicians reviewed 149 emergency care events and found SVSP nurses and providers recorded these events well. The providers also recorded their emergency care sufficiently, including off-site telephone encounters, and we did not identify any deficiencies with providers in the emergent setting. However, we identified problems with the electrocardiogram (EKG) machines not being calibrated to reflect the accurate time. The **Emergency Services** indicator provides additional details.

Scanning Performance

Case review found SVSP performed well with scanning and labeling of records. We did not identify any deficiencies with the scanning accuracy of the records we reviewed. Last cycle, SVSP had deficiencies with missing refusal forms, but this was not an issue in

Cycle 7. Compliance testing showed borderline performance with scanning documents (MIT 4.004, 75.0%).

Clinician On-Site Inspection

We discussed health information management processes with SVSP supervisors. They described how medical records staff coordinate with off-site specialty nurses to obtain off-site specialty reports. They verbalized some specialists do not complete their consultations reports timely.

Compliance Score 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	10	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	25	5	15	83.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	20	0	5	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	18	6	0	75.0%
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)	22	3	0	88.0%
			Overall percentage (MIT 4): **89.3%**	

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

Table 9. Other Tests Related to Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	10	0	0	100%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	9	1	0	90.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	0	6	0	0
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	8	2	0	80.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	1	9	0	10.0%
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)	14	1	0	93.3%
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)	8	6	1	57.1%
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)	8	5	2	61.5%

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

Recommendations

The OIG offers no recommendations for this indicator.

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.

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 compliance rating.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (55.7%)**

In this cycle, multiple aspects of SVSP's health care environment were poor: medical supplies storage areas inside of the clinics contained expired medical supplies; several areas of the examination rooms were unsanitary; emergency medical response bag (EMRB) logs were missing staff verification or inventory was not performed; several clinics did not meet the requirements for essential core medical equipment and supplies; and staff did not regularly sanitize their hands before or after examining patients. Based on the overall compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Patient Waiting Areas

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

Photo 1. Patient waiting area (photographed on 8-30-23).

Photo 2. Patient individual waiting modules (photographed on 8-31-23).

Clinic Environment

All nine 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, 100%).

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. In addition, we observed the clinical staff kept the examination room door open and discussed the plan of care for a patient by the doorway with a different patient inside the examination room, which hindered auditory privacy.

Photo 3. Expired medical supply dated February 2021 (photographed on 8-29-23).

Clinic Supplies

Only three of the nine clinics followed adequate medical supply storage and management protocols (MIT 5.107, 33.3%). We found one or more of the following deficiencies in six clinics: expired medical supplies (see Photo 3, right and Photo 4, next page); unorganized, compromised, unlabeled, or inaccurately labeled medical supplies (see Photo 5, next page); cleaning materials stored with medical supplies; and staff members' personal food stored long term in the medical supply storage cart.

Photo 4. Expired medical supply dated May 5, 2022 (photographed on 8-29-23).

Photo 5. Inaccurately labeled and disorganized medical supplies (photographed 8-30-23).

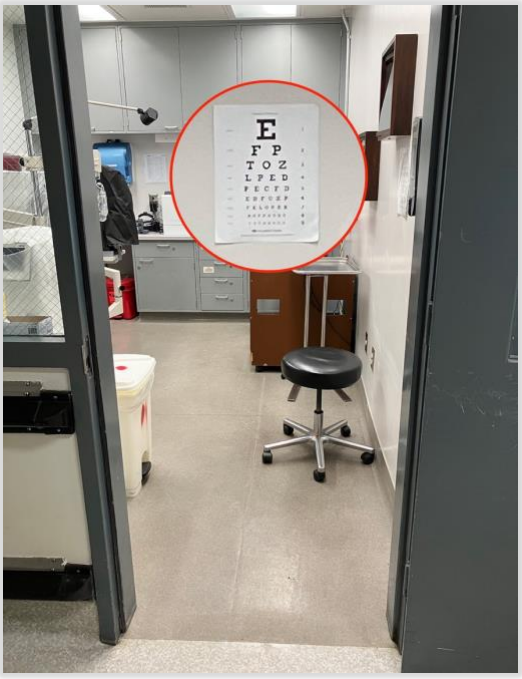

Photo 6. Snellen reading chart did not have a corresponding distance line marked on the floor or wall, and the chart used was a printout (photographed on 8-30-23).

Only two of the nine clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 22.2%). Seven clinics lacked medical supplies or had nonfunctional equipment. The missing items included examination table paper, an oto-ophthalmoscope, and tips for the otoscope. The staff had not properly calibrated an automated vital signs machine and a nebulization unit. Several clinics contained nonfunctional oto-ophthalmoscopes or nonfunctional overhead lights. We found the Snellen reading chart did not have a corresponding distance line marked on the floor or wall and the chart utilized was a printout (see Photo 6, left). In addition, staff had not completed the AED or defibrillator performance test log documentation within the last 30 days. Furthermore, the clinic daily glucometer quality control logs were either inaccurate or incomplete.

We examined emergency medical response bags (EMRBs) to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Four of the seven applicable EMRBs passed our test (MIT 5.111, 57.1%). In three EMRBs we found one or more of the following deficiencies: staff did not ensure the EMRB's compartments were sealed and intact or staff had not inventoried the EMRBs when the seal tags were replaced.

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). The warehouse manager did not maintain a temperature log for medical supplies with manufacturer temperature guidelines stored in the medical warehouse. Although intravenous (IV) solutions stored were within the recommended temperature at the time of our inspection, we found several solutions had accumulated condensation (see Photo 7, right).

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 with the existing system.

Photo 7. IV solution accumulated condensation (photographed on 8-29-23).

Infection Control and Sanitation

Photo 8. Insect in the clinic's medication room (photographed on 8-30-23).

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. In addition, in one of the two clinics, we found an insect in the clinic's medication room (see Photo 8, right).

Staff in seven of nine clinics (MIT 5.102, 77.8%) properly sterilized or disinfected medical equipment. In two clinics, we found one or more of the following deficiencies: staff did not date stamp the packaging of sterilized medical equipment; staff did not have a good understanding of the sterilization cleaning protocols and the institution's local operating procedures; and the previously sterilized reusable invasive medical equipment label did not correctly change color to verify successful sterilization.

We found operating sinks and hand hygiene supplies in the examination rooms in five of nine clinics (MIT 5.103, 55.6%). In four clinics, the patient restroom lacked antiseptic soap or disposable hand towels.

We observed patient encounters in seven clinics. In all seven clinics, clinicians did not wash their hands before or after examining their patients, before applying gloves, after performing blood draws, after performing blood draw services, or during re-gloving while performing wound care services (MIT 5.104, zero).

Health care staff in all clinics followed proper protocols to mitigate exposure to bloodborne pathogens and contaminated waste (MIT 5.105, 100%).

In addition to the above findings, our compliance inspectors observed the following notable findings in the clinic during their on-site inspection:

- We found an expired chemical testing strip used to make sure chemicals intended for disinfection were within the correct concentration levels (see Photo 9, next page).

- The clinic at D-2 had a non-functional patient restroom. We promptly notified the staff of this concern, and assigned custody staff immediately submitted a work order and had it approved by the yard's sergeant.

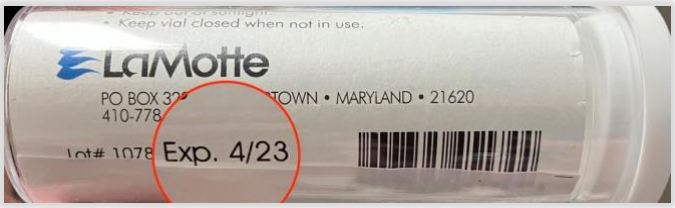

Photo 9. Expired chemical test strip dated April 2023 (photographed on 8-31-23).

Physical Infrastructure

At the time of our medical inspection, the institution's administrative team reported no ongoing health care facility improvement program construction projects. The institution's health care management and plant operations manager reported all clinical area infrastructures were in good working order (MIT 5.999).

Compliance Score Results

Table 10. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	7	2	1	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)	7	2	1	77.8%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	5	4	1	55.6%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	0	7	3	0
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	9	0	1	100%
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)	3	6	1	33.3%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	2	7	1	22.2%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	9	0	1	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	8	1	1	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)	4	3	3	57.1%
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): **55.7%**

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

Recommendations

- Medical and nursing leadership should analyze the root cause(s) for staff not following all required universal hand hygiene precautions and should implement remedial measures as appropriate.

- Executive leadership should analyze the root cause(s) for staff not following equipment and medical supply management protocols and should implement remedial measures as appropriate.

- Nursing leadership should determine the root cause(s) for staff not ensuring the EMRBs are regularly inventoried and sealed or not properly completing the monthly logs and should implement remedial measures as appropriate.

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	***Inadequate* (73.6%)**

In case review, SVSP performed satisfactorily in the transfer process. Compared to Cycle 6, nurses improved in nursing assessment for patients returning from the community hospital or emergency rooms. For patients transferring in and out of the institution, case review found nursing assessments were good; however, nurses did not perform COVID-19 point-of-care testing prior to patients transferring out of SVSP. Providers evaluated patients timely for newly arrived patients. In contrast, SVSP did not perform well in the transfer-out process. We identified opportunities for improvement in transfer screenings, COVID-19 screenings, and medication continuity. Factoring all the information, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed mixed results for the transfers indicator. SVSP scored low in completing initial health screening forms and ensuring medication continuity for newly transferred patients. In contrast, the institution performed very well in completing the assessment and disposition sections of the screening process. The institution also showed good performance in ensuring transfer packets for departing patients included the required documents and medications. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 73 events in 21 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 17 deficiencies, six of which were significant.[24]

Transfers In

The transfer-in process was very good. Compliance testing showed receiving and release (R&R) nurses always completed the assessment and disposition section of the forms (MIT 6.002, 100%); however, the nurses frequently did not thoroughly complete the screening (MIT 6.001, 56.0%). This included nursing staff completing the initial health screening form after the patient was transferred to the housing unit, not documenting an explanation to questions answered with a "yes," or not documenting patients' weight. Our clinicians reviewed three transfer-in cases and found nurses performed very well completing assessments and ordering the initial provider appointments within required time frames. We identified one minor deficiency in nursing documentation.

Compliance testing showed SVSP performed well with ensuring newly arrived patients saw a provider within the required time frames (MIT 1.002, 84.0%). Our clinicians did not identify any deficiencies with the timeliness of provider appointments for newly arrived patients.

Case review and compliance testing had mixed results for medication continuity for transfer-in patients (MIT 6.003, 55.0%). Our case review clinicians did not identify any concerns with medication continuity. Analysis of the compliance data showed patients received keep-on-person (KOP) medications up to one day late, medication was not delivered to the patient by the ordered administration date, and nurses did not always document completely.

Case review and compliance testing had mixed results for timely scheduling specialty appointments. Compliance testing showed SVSP performed poorly in scheduling pre-approved specialty appointments for patients who transferred into the institution (MIT 14.010, 35.0%). Analysis of the compliance scores show SVSP did not schedule patients for specialty appointments timely; the appointments occurred between one and 141 days late. Our case review clinicians did not identify any concerns with specialty appointments.

Transfers Out

The transfer-out process needed improvement. Our clinicians reviewed three cases and found five deficiencies, three of which were significant.[25] In two cases, the R&R nurses did not perform a COVID-19 point-of-care test to rule out COVID-19. Compliance testing showed R&R nurses ensured five of six patients transferring out of the institution had the required medications, transfer documents, and assigned durable medical equipment (DME) (MIT 6.101, 83.3%). For one patient, the transfer packet included a

[24] Deficiencies occurred in cases 1, 8, 13, 15, 20, 21, 24, 26, 29-31, and 47. Significant deficiencies occurred in cases 13, 20, 21, 29, and 31.

[25] Transfer-out deficiencies occurred in case 29, 30, and 31. Significant deficiencies occurred in cases 29 and 31.

medication with an expired pharmacy label. Our clinicians identified one deficiency regarding a lapse in medication continuity for patients transferring out of the institution:

- In case 31, the patient transferred out of the institution without medications prescribed for hypertension and gastric reflux disease.

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, successful health information transfer is necessary for good quality care. Any transfer lapse can result in serious consequences for these patients.

For hospital returns, SVSP's performance resulted in different findings for case review and compliance testing. OIG clinicians reviewed 63 events in 15 cases in which patients returned from a hospitalization or emergency room evaluation and identified 11 deficiencies, three of which were significant.[26] Of the significant deficiencies identified, none related to nursing performance as the nurses performed excellent assessments.

In contrast, SVSP performed poorly in medication continuity for patients who returned to the institution after discharge from the hospital (MIT 7.003, 36.0%). Our clinicians also identified one minor deficiency related to medication continuity.[27]

Compliance testing showed SVSP performed well in timely provider follow-up appointments (MIT 1.007, 88.0%), staff always scanned hospital discharge documents into the patient's electronic health record (MIT 4.003, 100%), and providers often reviewed the hospital discharge report timely (MIT 4.005, 88.0%). Our clinicians found most documents scans were timely. We found four deficiencies, which are addressed in the **Health Information Management** indicator.[28]

SVSP provider performance with hospital returns will be discussed further in the **Provider Performance** indicator. Case review clinicians found three deficiencies where the provider did not follow hospital recommendations and medications.

Clinician On-Site Inspection

During the on-site inspection, our clinicians interviewed the R&R nurse, who was familiar with the transfer process and did not report any issues with supplies, equipment, or pharmacy. The R&R nurse reported SVSP receives 60 to 70 new arrivals per week. When patients arrive at the institution, the R&R nurse must wait until the care team panels are assigned in EHRS before documenting on the initial screening form. When patients transferred to the institution or returned from a hospitalization, the nurses reconciled medication orders and the providers reconciled remaining orders and DME.

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[26] Deficiencies occurred in cases 1, 8, 13, 15, 20, 21, 24, and 47. Significant deficiencies occurred in cases 13, 20 and 21.

[27] Deficiencies occurred in case 20.

[28] Deficiencies occurred in cases 1, 13, 20, and 47. A significant deficiency occurred in case 13.

Compliance Score Results

Table 11. Transfers

	Scored Answer			
Compliance Questions	**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)	14	11	0	56.0%
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)	25	0	0	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)	11	9	5	55.0%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	5	1	2	83.3%
				Overall percentage (MIT 6): **73.6%**

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

Table 12. Other Tests Related to Transfers

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	21	4	0	84.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007)	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)	20	0	5	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)	22	3	0	88.0%
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)	9	16	0	36.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	14	11	0	56.0%
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)	4	6	0	40.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	7	13	0	35.0%

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

Recommendations

- Nursing leadership should identify the root cause(s) for R&R nurses not completing the initial health screening, including answering all questions and documenting an explanation for each "yes" answer, not documenting a complete set of vital signs as part of the patient's initial health screening assessment, and not completing the initial health screening form prior to a patient being placed in housing. Nursing leadership should implement remedial measures as appropriate.

- Nursing leadership should identify the challenges to ensuring newly arrived patients receive medications without interruption and implement remedial measures as appropriate.

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. In 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	***Inadequate* (62.5%)**

Case reviewers found SVSP performed sufficiently in medication management. Staff adequately ensured patients received their medications timely during the transfer-in and transfer-out processes as well as for new medication prescriptions, chronic care medications, and hospital discharge medications. While SVSP improved overall in specialized medical housing (SMH) continuity of medications as compared to Cycle 6, our clinicians still identified a trend in SMH medication lapses. Considering all factors, the OIG rated the case review component of this indicator ***adequate.***

Compliance testing showed SVSP needed improvement with this indicator. SVSP scored low in providing patients with chronic care medications, newly prescribed medications as ordered, community hospital discharge medications, and medications for patients temporarily housed at the institution. SVSP also scored low in medication continuity for patients transferring within the institution. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 125 events in 27 cases related to medications and found 20 medication deficiencies, four of which were significant.[29]

New Medication Prescriptions

For new medication availability, compliance testing showed the institution's performance needed improvement. Compliance testing revealed SVSP intermittently made available, administered, or delivered medications within the required time frame (MIT 7.002, 52.0%). In contrast our case review clinicians found staff almost always administered newly prescribed medications timely. Our clinicians found three

[29] Deficiencies occurred in cases 8, 10, 12, 16, 18, 20–23, 31, and 48. Significant deficiencies occurred in cases 10, 16, and 31.

deficiencies for newly prescribed medications, one of which was significant.[30] The following is an example:

- In case 16, the provider ordered a dosage increase for medication to treat the patient's hypertension. The patient received the new blood pressure medication one month late and, on that day, received two 30-day supplies of the medication.

Chronic Medication Continuity

Compliance testing showed patients' chronic care medications were only occasionally available within the required time frames (MIT 7.001, 25.0%). Our clinicians found nine cases with lapses in chronic care medication continuity.[31] Below is an example:

- In case 2, the patient received KOP nitroglycerin medication twice within a seven-day period. In addition, the patient did not receive an automatic refill of the scheduled medication to treat to a prostate condition in February 2023.

Hospital Discharge Medications

Compliance testing showed patients returning from hospitals or emergency rooms sporadically received their medications within the required time frames (MIT 7.003, 36.0%). Analysis of the compliance data showed nursing staff either did not administer medications or did not document the patient's reason for the refusal or for not presenting to the medication line. In contrast, our case review clinicians found staff almost always administered medications timely. We found one deficiency involving a lapse in continuity of chronic care medication, which was not significant. Please refer to the **Transfers** indicator for additional details.

Specialized Medical Housing Medications

Case review and compliance testing had mixed results. Compliance testing showed SVSP needed improvement managing medications in the SMH (MIT 13.003, 14.3%). Although patients received their medications as ordered, the low score was due to the pharmacy not filling and dispensing the medication timely, and to nursing staff not documenting reasons for refusal. Case reviewers identified six deficiencies, none of which were significant.[32]

Transfer Medications

Case review showed better results for transfer medications compared with the findings from compliance testing. Compliance testing showed SVSP needed improvement in medication continuity for patients arriving to the institution (MIT 6.003, 55.0%) and with medication continuity when patients transferred from yard to yard (MIT 7.005, 56.0%).

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[30] Deficiencies occurred in cases 16, and 18. A significant deficiency occurred in case 16.

[31] Patients did not receive timely chronic care medications in cases 8, 10, 12, 16, 18, 20, 21, 29, and 48. Significant deficiencies occurred in cases 10 and 16, and 22.

[32] Deficiencies occurred in cases 8, 23, and 48.

Our case review clinicians did not identify any deficiencies related to medication continuity for patients who transferred into the institution.

Compliance testing showed SVSP frequently ensured patients who transferred out of the institution received a five-day supply of medications (MIT 6.101, 83.3%). Our clinicians identified only one significant deficiency that we further discuss in the **Transfers** indicator.

In compliance testing, patients who were temporarily housed at the facility occasionally received their medications without interruption (MIT 7.006, 40.0%). Our clinicians did not review any cases where patients were temporarily housed at SVSP.

Medication Administration

SVSP performed very well in ensuring continuity of tuberculosis (TB) medications (MIT 9.001, 100%). However, the institution poorly monitored patients on TB medications (MIT 9.002, 50.0%). Our clinicians did not have any case review samples with events related to TB medications.

Clinician On-Site Inspection

Our clinicians attended various huddles where medical staff discussed expired medications, medication noncompliance, and out-of-compliant TB medication. In one huddle, the provider addressed the expiring medications.

We interviewed several medication nurses, and found they were familiar with medication-related processes such as KOP medications, patient refusals, and the transfer process. Licensed vocational nursing (LVN) staff reported patients have four days to pick up KOP medication. If the patient does not pick up the medication on the fourth day, the medication nurse will document on the medication administration record (MAR) the patient was a "no show/no barrier." For patients who were not at the institution during the scheduled medication administration time due to off-site appointments or hospitalizations, the nurses would document in the MAR "out to medical" and document in the comments "no show/no barrier."

Nurses reported the institution's involvement in a pilot program in two yards for KOP Narcan where each patient has access to two doses of Narcan and can request refills as needed.

Medication nurses reported they believed nursing morale was fair; they could communicate concerns to their supervisors and had a good rapport with custody staff.

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in all of nine applicable clinic and medication line locations (MIT 7.101, 100%).

SVSP appropriately stored and secured nonnarcotic medications in four of 11 applicable clinic and medication line locations (MIT 7.102, 36.4%). In five locations, nurses did not maintain unissued medication in its original labeled packaging. In the remaining two locations, treatment cart logs were missing daily security check entries.

Staff kept medications protected from physical, chemical, and temperature contamination in six of the 11 applicable clinic and medication line locations (MIT 7.103, 54.6%). In five locations, we found one or more of the following deficiencies: staff did not consistently record the room temperature; staff did not store internal and external medications separately; staff stored medications with disinfectants; and the medication refrigerator was unsanitary.

Staff successfully stored valid, unexpired medications in 10 of the 11 applicable medication line locations (MIT 7.104, 90.9%). In one location, nurses did not label multi-use medications as required by CCHCS policy.

Nurses exercised proper hand hygiene and contamination control protocols in three of seven applicable locations (MIT 7.105, 42.9%). In four locations, some nurses neglected to wash or sanitize their hands before each subsequent regloving or change gloves when the gloves were compromised.

Staff in all of seven applicable medication preparation and administration areas showed appropriate administrative controls and protocols when preparing medications for patients (MIT 7.106, 100%).

In contrast, staff in only two of seven applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 28.6%). In five locations, we observed one or more of the following deficiencies: medication nurses did not distribute medications to patients within the required time frame; medication nurses did not consistently observe patients while they swallowed direct observation therapy medications; and during insulin administration, we observed some medication nurses did not properly disinfect the vial's port prior to withdrawing medication.

Pharmacy Protocols

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

The pharmacist-in-charge (PIC) did not thoroughly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC or nurse present at the time of the medication area inspection did not correctly complete the medication area inspection checklists (CDCR form 7477). This error resulted in a score of zero for this test (MIT 7.111, zero).

We examined seven pharmacy-related 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 SVSP, 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. Of 20 applicable patients interviewed, 13 indicated they had access to their rescue medications. Two patients stated they did not receive their medication upon transfer to the unit or institution. Two patients reported they ran out of their medication but did not ask for a refill. Two patients reported they did not have their prescribed rescue medication. The remaining patient's medication was expired at the time of our inspection. We promptly notified the CEO of this concern, and health care management obtained new refusal documentation for one patient and immediately issued replacement rescue inhalers to the other patients (MIT 7.999).

Compliance Score 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)	4	12	9	25.0%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	13	12	0	52.0%
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)	9	16	0	36.0%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004)	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	14	11	0	56.0%
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)	4	6	0	40.0%
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)	9	0	3	100%
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	7	1	36.4%
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)	6	5	1	54.6%
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)	10	1	1	90.9%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	3	4	5	42.9%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	7	0	5	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	2	5	5	28.6%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	7	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): **62.5%**

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

Table 14. Other Tests Related to Medication Management

	Scored Answer			
Compliance Questions	**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)	11	9	5	55.0%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	5	1	2	83.3%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	8	0	0	100%
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	4	0	50.0%
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)	1	6	0	14.3%

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

Recommendations

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

- Nursing leadership should determine the root cause(s) for nursing staff not documenting patient refusals and no shows in the medical administration record, as described in CCHCS policy and procedures, and leadership should implement remedial measures 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* (69.3%)**

SVSP had a mixed performance in preventive services. Staff performed well in administering TB medications, offering patients an influenza vaccine for the most recent influenza season, and offering colorectal cancer screening for patients from ages 45 through 75. However, SVSP did not always administer TB medications, monitor patients taking prescribed TB medications or offer required immunizations to chronic care patients. Based on the overall compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Score 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)	8	0	0	100%
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	4	0	50.0%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	14	11	0	56.0%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	23	2	0	92.0%
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)	3	14	8	17.7%
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): **69.3%**

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

Recommendations

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

- Nursing leadership should analyze the challenges to ensuring nursing staff perform the annual TB screening during the patient's birth month and should implement remedial measures as appropriate.

- Medical leadership should analyze the challenges related to the timely provision of preventive vaccines to chronic care patients and should 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 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***

SVSP nurses provided sufficient nursing care. Nurses generally performed good assessments and interventions; however, the clinicians identified opportunities for improvement with nursing assessment in the outpatient clinics, specialized medical housing, and emergency services. Considering all factors, the OIG rated this indicator ***adequate.***

Case Review Results

We reviewed 294 nursing encounters in 45 cases.[33] Of the nursing encounters we reviewed, 83 occurred in the outpatient setting and 48 were sick call requests. We identified 82 nursing performance deficiencies, 14 of which were significant.[34]

Outpatient Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interviews) and objective (observation and examination) elements. A comprehensive assessment allows nurses to gather essential information about their patients and to develop appropriate interventions.

[33] Nursing encounters occurred in cases 1–9, 11, 13, and 15–48.

[34] Deficiencies occurred in cases 1–8, 15–17, 19–22, 24–26, 29–32, 35, 36, 38, 39, and 45–48. Significant deficiencies occurred in cases 1, 15, 16, 20, 21, 25, 29, and 31.

Our clinicians identified 31 outpatient nursing performance deficiencies, 10 of which were significant.[35] Nurses generally provided appropriate nursing assessments and interventions. However, our clinicians identified opportunities for improvement in sick call triage. The following are examples of outpatient deficiencies:

- In case 15, the nurse triaged the patient's sick call complaints for severe headaches, fatigue, dizziness, and abdominal pain. However, the nurse did not evaluate the patient the same day for urgent symptoms. Instead, the nurse scheduled the patient to be seen the next business day.

- In case 16, the nurse evaluated the patient for symptoms of chest congestion, coughing up mucus, and a scratchy throat. The nurse did not inquire if the patient had a productive cough and did not assess the sputum color, amount, or consistency. Secondly, the patient presented with an abnormally elevated blood pressure, but the nurse did not recheck the patient's blood pressure prior to discharging the patient to the housing unit or notifying the provider of the abnormal reading. Lastly, the nurse did not perform a COVID-19 point-of-care test for the patient with acute respiratory symptoms.

- In case 21, the nurse triaged the patient's sick call as non-symptomatic for complaint of dramatic weight loss and a request to be placed back on a nutritional liquid supplement. The nurse scheduled an LVN follow-up appointment in 14 days; however, the nurse should have triaged this sick call as symptomatic and scheduled the patient for a RN face-to-face assessment the following 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. Nursing staff generally documented care appropriately.

Case Management

OIG clinicians reviewed four events in two cases in which patients were evaluated by a care manager.[36] We did not identify deficiencies in chronic care management.

Wound Care

Our clinicians reviewed six events in four cases in which nurses provided wound care. Nurses performed appropriate assessments and wound care. Our clinicians did not identify any deficiencies.

[35] Deficiencies occurred in cases 1, 2, 15–17, 20–22, 24, 25, 32, 35, 36, 38, 39, and 45–46. Significant deficiencies occurred in cases 1, 15, 16, 20, 21, and 25.

[36] The RN care manager assessed patients in cases 1, 16, and 24.

Emergency Services

We reviewed 65 urgent or emergent events. Nurses responded promptly to emergent events. However, their assessments, interventions, and documentation showed room for improvement, which we detail further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 63 events involving patients returning from off-site hospitals or emergency rooms. The nurses performed excellent nursing assessments. Our clinicians did not identify any nursing deficiencies. Please refer to the **Transfers** indicator for further details.

Transfers

We reviewed six cases involving the transfer-in and transfer-out processes. Nurses performed appropriately for the transfer-in process. However, we identified opportunities for improvement in assessments and interventions for the transfer-out process. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

We reviewed five cases with a total of 66 nursing events, including five events in which nurses provided emergency care.[37] Nurses performed appropriate assessments. For more specific details, please refer to the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed 27 events in 11 cases in which patients returned from off-site specialty appointments.[38] Our clinicians identified two nursing performance deficiencies, neither of which was significant.[39] Nurses frequently performed appropriate assessments and interventions. Please refer to the **Specialty Services** indicator for additional details.

Medication Management

OIG clinicians examined 125 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

During the clinician on-site inspection, we interviewed SVSP nursing leadership and nursing staff. We interviewed nursing staff in the outpatient clinics, medication areas, TTA, R&R, CTC and the PIP. At the time of our inspection, the institution did not have any backlog with nursing appointments.

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[37] Nurses provided urgent or emergent care in the Specialized Medical Housing in cases 8, 19, and 47.

[38] Nursing performed assessments for patients returning from off-site specialty appointments in cases 1, 2, 8, 11, 16, 17, 19, 21, 22, 24, and 25.

[39] Deficiencies occurred in cases 8 and 17.

The CNE reported nursing leadership had hired two Directors of Nursing. The CNE expressed gratitude for the support SVSP received from the regional nurse consultant from CCHCS. The regional consultant performed audits of the sick call process and worked closely with nursing leadership to improve nursing triage of sick calls, assessments, interventions, and documentation.

Our clinicians also attended SVSP's nursing subcommittee. Nursing leadership discussed the sick call process, corrective action plans in place, and barriers to patient care. Nursing leadership addressed our findings, acknowledged opportunities for quality improvement, and immediately implemented corrective action based on OIG findings.

Recommendations

- Nursing leadership should analyze the challenges to nurses performing thorough assessments during face-to-face patient evaluations 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***

SVSP providers delivered generally acceptable care, which is an improvement from Cycle 6. Providers improved their reviews of records and improved on following through with stated treatment plans. However, we found opportunities for continued improvement with assessments, decision making, review of records, and chronic care management. The OIG clinicians did not find any continuity of care issues in the cases we reviewed this cycle. Some of the improvement can be attributed to increasing the number of available providers to deliver care. Considering all aspects, the OIG rated this indicator ***adequate***.

Case Review Results

Providers delivered satisfactory care during the review period. OIG clinicians reviewed 198 medical provider encounters and identified 36 deficiencies, 15 of which were significant.[40] In addition, our clinicians examined the quality of care in 20 comprehensive case reviews. Of these 20 cases, we found 18 ***adequate*** and two ***inadequate***.

In our case reviews, we found SVSP patients often required many mental health services, refused appointments and services, behaved aggressively, and were noncompliant with medical care. We considered the providers' performance in this context.

Assessment and Decision-Making

Providers, overall, conducted acceptable evaluations and made sound decisions. Provider evaluation and decision-making are the most important aspects of provider care. Determining diagnoses and treatments is nearly impossible without obtaining a proper history of the patients' complaints or medical conditions. Equally important for providers is examining specific areas of the body with relevance to suspected medical issues. This

[40] Provider deficiencies occurred in case 8, 10–12, 14–17, 20–25, and 47. Significant deficiencies occurred in cases 11, 16, 20–24, and 47.

allows providers to determine possible diagnoses and treatment plans. The providers performed satisfactorily in this area. However, we found opportunities for improvement.

- In case 8, the CTC provider reviewed laboratory test results indicating low white blood cells and low sodium levels but did not evaluate for possible causes.

- In case 21, on more than one occasion, the provider evaluated the patient, who had chronic obstructive lung disease with low oxygen levels. The provider did not obtain vital signs or thoroughly review the patient's medical record to be aware the patient was still on prednisone, a medication used for chronic obstructive lung disease.

- In case 23, instead of evaluating the patient in person, the provider only performed a chart review for this CTC patient, who had a CTC rounding event due. The patient required an assessment for his uncontrolled diabetes and recurrent diarrhea.

- In case 24, the provider evaluated the patient, who complained of dizziness, palpitations, and chest pressure with activity; however, the provider did not order a Holter monitor or cardiac stress test to evaluate the cause of the symptoms.

Review of Records

Providers generally reviewed medical records carefully with some exceptions. Case review clinicians found five deficiencies with record reviews. The following are examples:

- In case 14, the provider evaluated the patient for follow-up and documented elevated blood pressure. The provider did not review the medication administration record to be aware the patient had not picked up his lisinopril, a blood pressure medication, that month.

- In case 16, the provider evaluated a patient for passing out and considered arrhythmia as a possible cause but did not order an electrocardiogram, a simple office test to evaluate electrical activity of the heart.

- In case 20, the patient returned from the hospital with diabetic ketoacidosis with low blood pressure.[41] However, the provider did not review records carefully to reconcile laboratory orders or hospital recommendations to repeat the echocardiogram or follow up with a cardiologist.[42]

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

[42] An echocardiogram is a procedure using an ultrasound to examine and image the heart.

Emergency Care

Providers appropriately managed patients in the TTA with urgent and emergent conditions. They triaged patients and sent them out to the hospital when necessary. We did not find any provider performance deficiencies with emergency care.

Chronic Care

Providers needed to improve their handling of hypertension and diabetes. We found five deficiencies related to elevated blood pressure in five cases.[43] Sometimes the providers ignored the vital signs; in other instances, they did not follow up with the patient after making medication adjustments. The diabetes care deficiencies pertained to lack of review of blood sugar records, lack of review of laboratory test intervals, and lack of therapeutic adjustments.[44] The following are examples of deficiencies related to diabetes and blood pressure management:

- In case 11, the provider did not review the diabetic patient's elevated blood sugar to be aware the patient was three times the normal range in the week prior to the appointment and did not discuss the patient's repeated refusals of his diabetes medication.
- In case 20, the provider had an encounter with the patient, who was diagnosed with diabetic ketoacidosis. The provider did not order the diabetes monitoring test (hemoglobin A1c).
- In case 22, the patient started a blood pressure medication due to elevated blood pressure. At the provider follow-up appointment, the provider did not manage the patient's blood pressure. He did not document a blood pressure reading and did not order a follow-up appointment to determine whether the medication needed further adjustments.
- In case 23, the provider evaluated the patient for diabetes several times but did not adjust the patient's therapy to improve compliance and diabetes control.

Specialty Services

SVSP appropriately referred patients for specialty care, when needed. Case review clinicians reviewed 79 specialty encounters and found only three instances where providers did not follow recommendations. We discuss providers' specialty services performance further in the **Specialty Services** indicator. The following is an example:

- In case 11, the provider evaluated the patient and recommended follow-up with a podiatry consultation. The patient was diagnosed with "diabetic foot," but the provider did not review the patient's recent elevated blood sugar levels and did not discuss the patient's recurrent refusals of diabetic medications.

[43] Blood pressure deficiencies occurred in cases 12, 14, 16, and 22.

[44] Deficiencies involving diabetic care occurred in cases 11, 20, and 23.

Patient Notification Letters

Providers did not always send patient notification letters to patients. When they did, the letters did not always contain the four elements required by policy. Case review clinicians found 24 deficiencies in this area.[45]

Provider Continuity

SVSP offered good provider continuity, which was a marked improvement when compared with last cycle. Case review clinicians did not find any deficiencies from lack of provider continuity.

Clinician On-Site Inspection

We spoke with providers and medical leadership about the provider performance deficiencies. The providers voiced the rationale for their decisions. They had good working relationships with nursing staff and custody officers. Medical leadership was approachable and able to assist with their issues.

Medical leadership stated they had more staffing than they previously had during Cycle 6. They voiced concern about SVSP being staffed as a "basic" institution but having a substantial and diverse population of patients requiring significant medical care as would be more expected of an "intermediate" institution. They expressed appreciation for having more full-time providers available, noting they performed better and experienced fewer continuity issues.

[45] These deficiencies occurred in cases 2, 14, 15, 17, 18, 24, and 25.

Recommendations

The OIG offers no recommendations for this indicator.

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, SVSP's specialized medical housing consisted of a correctional treatment center (CTC) and psychiatric inpatient program (PIP).

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (67.9%)**

Overall, SVSP delivered fair medical care in the CTC. Nursing staff performed thorough admission assessments. Our clinicians found the nurses evaluated patients every shift but needed improvement on assessments and documentation during rounding. We found providers delivered sufficient care. Taking all factors into consideration, the OIG rated the case review component of this indicator ***adequate.***

Compliance testing showed mixed performance in this indicator. Although staff sometimes completed timely admission assessments and history with physical examinations, staff needed improvement in medication administration. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 49 provider events and 66 nursing events in five cases.[46] 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 40 deficiencies, eight of which were significant.[47]

Provider Performance

Case review clinicians reviewed 49 specialized medical housing (SMH) events; each event may have encompassed care lasting up to a month at a time. We identified 15 provider deficiencies in three cases; most of the deficiencies were in case 23. The provider did not accurately document diabetes management changes on multiple

[46] Specialized medical housing events occurred in cases 8, 19, 23, 47, and 48.

[47] Deficiencies occurred in cases 8, 19, 23, 47 and 48. Significant deficiencies occurred in cases 19, 23, and 47.

occasions. The provider also did not round on the patient appropriately. While the care in case 23 was poor, overall provider care in the CTC was acceptable. Our clinicians did not identify any deficiencies with the timeliness of provider admission history and physicals; however, compliance testing revealed providers intermittently completed timely admission history and physicals (MIT 13.002, 71.4%).

- In case 23, the patient had uncontrolled diabetes throughout the review period. The provider did not adjust the patient's diabetes regimen at times.

- In case 47, the patient reported to the CTC nurse about complaints of chest pain. The CTC nurse contacted the CTC provider, and the provider evaluated the patient about 30 minutes later. The provider only commented on shoulder pain from a fall and did not document any discussion on the patient's chest pain.

Nursing Performance

In the inpatient setting, nurses identifying changes in patients' conditions is crucial. Changes in a patient's condition may require immediate assessments, urgent evaluations, immediate contact with the provider, or EMS activation.

Our clinicians evaluated urgent or emergent care in the CTC and PIP, transfers to the community emergency department for further evaluation, hospital return assessments, and nursing care continuity. We reviewed six events in three cases where patients transferred to a higher level of care for evaluation. We identified three deficiencies, none of which were significant.[48]

SMH nurses provided adequate care. They performed rounds each shift, ensured patient safety, and provided good emergency care. Compliance testing concluded patients admitted to the CTC and PIP often received timely initial health assessments (MIT 13.001, 85.7%). Our clinicians found nurses frequently performed complete initial assessments; however, we identified nursing deficiencies in assessments and documentation.

In both CTC and PIP, nurses intermittently did not perform complete patient assessments. We also found, when nurses identified abnormal findings, they sometimes did not reassess their patients thoroughly or provide needed interventions. The following are examples:

- In case 19, the patient was readmitted to the PIP in March 2023, after a hospitalization for head injury and schizophrenia. Nurses frequently did not perform neurological assessments. In addition, nurses documented elevated pulse but did not reassess the patient's pulse or notify the provider of the abnormal findings.

- In case 48, the bedridden patient was readmitted to the CTC in March 2023, after discharging from the hospital with a blood infection and pneumonia. The patient had multiple contractures and had tube feedings for nutrition. The CTC nurses frequently did not perform thorough assessments to

[48]Deficiencies occurred in cases 8 and 19.

monitor for risk of choking or monitor the patient's weight for adequate intake, and the nurses did not perform appropriate pre- and post-assessments for tube feedings.

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

Medication Administration

Compliance testing showed newly admitted patients to the CTC only sporadically received their medications within the required time frames (MIT 13.003, 14.3%). Analysis of the compliance data showed the pharmacy did not dispense or deliver medication timely, staff did not administer medications from the licensed correctional clinic (LCC) by the provider's ordering date and time, and nursing staff did not document the reason for refusal in the patient's medication record. In contrast, our clinicians did not identify a lapse of medication continuity for newly admitted patients to the CTC or the PIP. However, our clinicians found lapses in medication continuity for patients during their stay in the CTC and PIP.[49] The following are examples:

- In case 8, the patient with a history of thyroid disease missed four days of thyroid medication in January 2023.
- In case 23, the diabetic patient did not receive one dose of insulin and one pill of diabetic medication in June 2023.

Clinician On-Site Inspection

Our clinicians toured the CTC, observed the CTC huddle, and interviewed nursing and supervisory staff. At the time of our on-site inspection, the CTC had 12 medical beds occupied. The CTC had 24-hour nursing staff. We interviewed the supervising registered nurse (SRN), who reported performing monthly audits and annual reviews. Providers were available on-site from 7 a.m. to 3 p.m. After hours, the nurses contacted the on-call provider and obtained verbal orders for medications. The providers reconciled the remaining orders when they arrived at the institution the next business day.

[49] Deficiencies occurred in cases 8, 23, and 48.

Compliance Score 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)	6	1	0	85.7%
Was a written history and physical examination completed within the required time frame? (13.002)	5	2	0	71.4%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	1	6	0	14.3%
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): **67.9%**

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
Adequate	***Inadequate* (73.2%)**

In case review, SVSP provided acceptable specialty services for their patients. Both provider performance and nursing performance related to specialty care were very good. The institution managed specialty health information acceptably. Compared with Cycle 6, SVSP improved with access to specialty services and information management. The OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed mixed performance in this indicator. Providers generated appropriate referrals, and staff timely scheduled follow-up specialty appointments. However, access to specialists ranged from excellent to poor, depending on the appointment priority. Preapproved specialty referrals for newly arrived patients occasionally occurred within the recommended time frames. In addition, retrieval of specialty reports and prompt provider endorsements both needed improvements. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 154 events related to specialty services; 81 were specialty consultations and procedures. We found 21 deficiencies in this category, seven of which were significant.[50]

Despite its remote location, SVSP has a large proportion of patients who are medically complex and require more specialty care. Due to these circumstances, access to specialists was affected. We considered SVSP's specialty service performance in this context.

Access to Specialty Services

SVSP provided suboptimal access to specialists. Compliance testing showed variable access depending on the priority. Specialty referrals for routine-priority appointments were very good (MIT 14.007, 86.7%), while referrals for medium- and high-priority

[50] Specialty deficiencies occurred in cases 8, 10, 11, 14,–18, 21, 23–25, and case 47. Significant deficiencies occurred in cases 10, 14–16, 18, 23, and 24.

appointments needed improvement (MIT 14.004, 66.7% and MIT 14.001, 66.7%). Continuity of specialty services after transfer was poor (MIT 14.010, 35.0%).

Case reviewers found SVSP had room for improvement in access to specialty services. Our clinicians identified eight deficiencies related to delays in access to specialists or follow-up appointments with the SVSP providers after specialty appointments, three of which were significant. The following are examples:

- In case 23, the provider requested a high-priority pulmonology appointment for a nodule suspicious for cancer. This appointment occurred one month late.

- In case 24, the provider ordered a urology appointment for kidney stones to occur by a specified date. This appointment was delayed by six weeks.

Provider Performance

SVSP providers ordered specialty consultations within proper time frames. Compliance testing showed providers and nurses generally evaluated patients within five days of a specialty consultation (MIT 1.008, 81.0%). The providers also followed up with patients after high-priority referrals most of the time. Case reviewers found only one deficiency, in case 18, where the provider did not evaluate the patient after a high-priority oncology encounter. Providers generally followed specialists' recommendations; however, we found two instances where they did not. The following is an example:

- In case 10, the provider reviewed the specialist's recommendation to keep the cholesterol level below 70 but did not follow this recommendation.

Nursing Performance

SVSP nursing performance with specialty services was very good. Nurses evaluated patients returning from off-site appointments and messaged providers for the necessary medication and specialty orders. We found one instance where the nurse messaged the primary provider instead of the on-call provider, which resulted in a delay in obtaining the specialist's recommended medication.

Health Information Management

SVSP had some difficulty managing health information of specialty reports. Case reviewers found three deficiencies with endorsements, two deficiencies with retrieving reports, and two deficiencies with scanning specialty reports into the EHRS. Compliance testing showed mixed performances. Please see the **Health Information Management** indicator for further details.

Clinician On-Site Inspection

We discussed specialty services in SVSP with supervisors in nursing, medical, and specialty services. The supervisors conveyed, because the institution has so many missions (differing incarcerated populations) affecting healthcare and lack sufficient proximate specialists to serve the high number and variety of health care needs, SVSP has experienced difficulty obtaining specialty consultations within the required time frames.

Leadership similarly reported the many missions and lack of specialists caused delays in scheduling of specialty consultations.

Specialty supervisors also explained, once a request for service (RFS) was approved, the institution prioritized telemedicine consultations unless otherwise documented in the RFS.[51] This was how the institution tried to expand the available specialty pool for patients at SVSP. They also stated the TTA RN processed patients when they returned from off-site specialty appointments. If the patients needed new medication orders, the TTA RN would message the on-call provider to obtain the necessary orders. The RN directed follow-up orders or other further RFSs to the primary providers responsible for the patient. The nurses who support the specialists on site at the institution reviewed the telemedicine specialty recommendations. The on-site nurses were responsible for messaging the provider for all necessary orders.

[51] The request for service (RFS) is a referral order for a specialty consultation.

Compliance Score Results

Table 17. Specialized 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)	10	5	0	66.7%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	14	1	0	93.3%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	9	1	5	90.0%
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)	10	5	0	66.7%
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)	8	6	1	57.1%
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	2	8	71.4%
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)	13	2	0	86.7%
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)	8	5	2	61.5%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	3	2	10	60.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	7	13	0	35.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	20	0	0	100%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	18	2	0	90.0%
			Overall percentage (MIT 14): **73.2%**	

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

Table 18. Other Tests Related to Specialized Services

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	34	8	3	81.0%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	25	5	15	83.3%

* 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.

Recommendations

- Medical leadership should determine the root cause(s) of challenges to the timely provision of specialty appointments, including preapproved specialty appointments for transfer-in patients, and should implement remedial measures as appropriate.

- The department should consider developing and implementing measures to ensure the institution timely receives the specialty reports and providers timely review these reports.

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 compliance rating.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (68.8%)**

SVSP's performance was mixed in this indicator. While SVSP scored well in some applicable tests, performance needed improvement in several areas. The EMMRC did not always complete the required checklists and review the cases within required time frames. The institution conducted medical emergency response drills with incomplete documentation of required emergency response drill forms. Physician managers did not always complete annual performance appraisals timely. The nurse educator did not ensure a newly hired nurse received the required onboarding training timely. These findings are set forth in the table on the next page. Based on the overall compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Scores

Nonscored Results

At SVSP, the OIG did not find any applicable adverse sentinel events required root cause analysis during our inspection period. (MIT 15.001). We obtained CCHCS Mortality Case Review reporting data. Ten patient deaths occurred during our review period. The OIG inspectors found no evidence the regional and institutional physician and nurse executives received, accepted, or rejected the preliminary mortality reports timely. The reports were also overdue at the time of OIG's inspection (MIT 15.998).

Compliance Score 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)	5	1	0	83.3%
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)	4	0	0	100%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the 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)	8	2	0	80.0%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	9	1	0	90.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	2	4	1	33.3%
Did the providers maintain valid state medical licenses? (15.106)	15	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)	0	1	0	0
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): **68.8%**

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

Recommendations

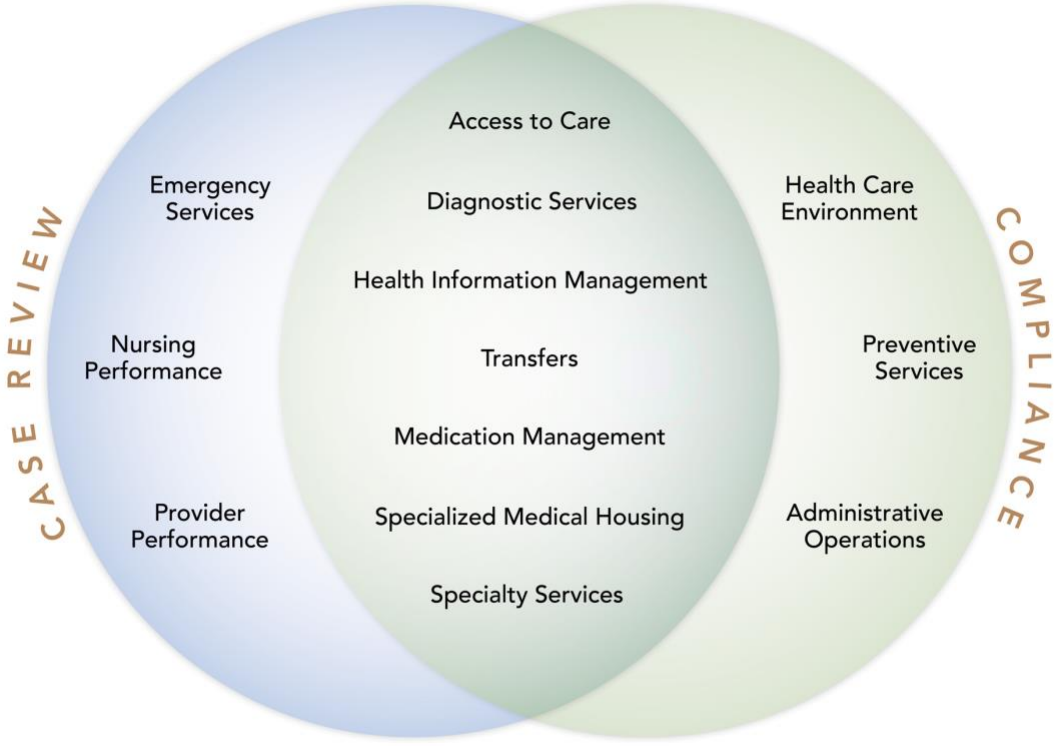
The OIG offers no recommendations for this indicator.

Appendix A: Methodology

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

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

Figure A–1. Inspection Indicator Review Distribution for SVSP



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

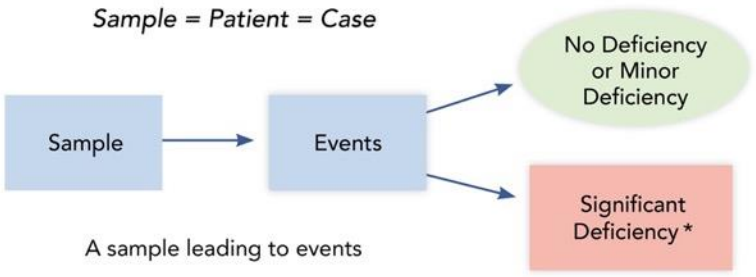
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

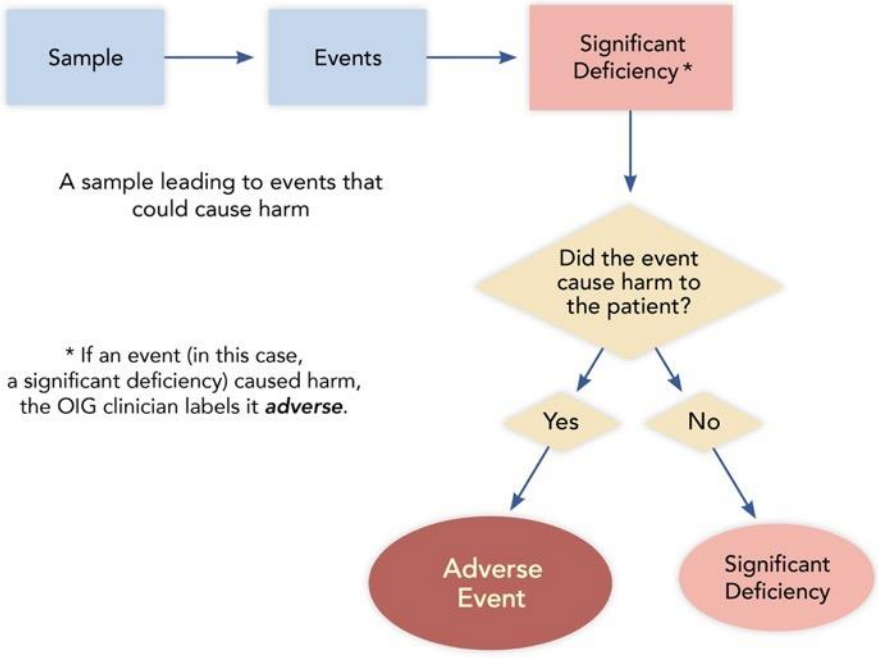
Figure A–2. Case Review Testing

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***.



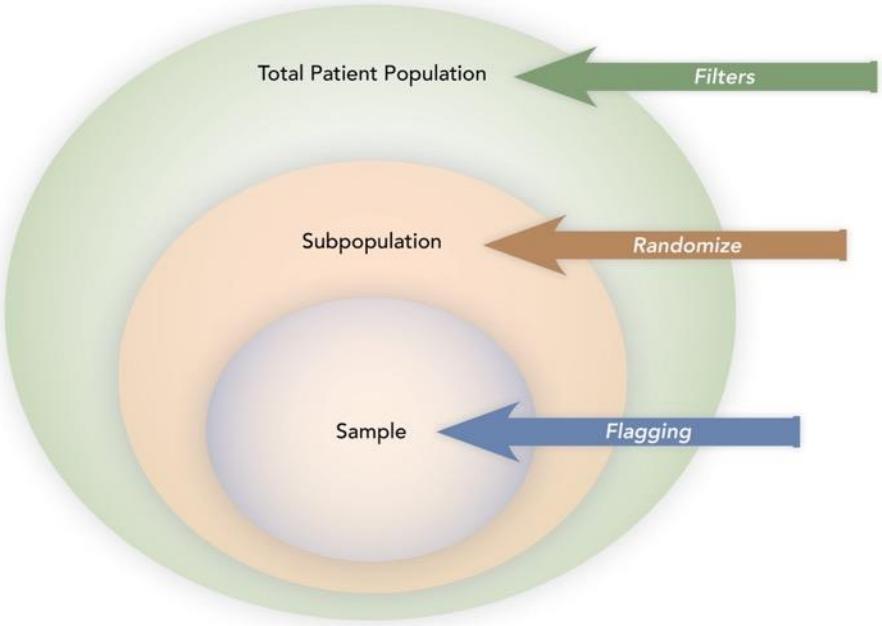
Source: The Office of the Inspector General medical inspection analysis.

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. SVSP Case Review Sample Sets

Sample Set	Total
Anticoagulation	1
CTC/OHU	2
Death Review/Sentinel Events	2
Diabetes	4
Emergency Services – CPR	5
Emergency Services – Non-CPR	2
High Risk	4
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	15
Specialty Services	3
	48

Table B–2. SVSP Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	6
Anticoagulation	5
Arthritis/Degenerative Joint Disease	3
Asthma	14
Cancer	4
Cardiovascular Disease	4
Chronic Kidney Disease	1
Chronic Pain	10
Cirrhosis/ End Stage Liver Disease	2
COPD	2
COVID-19	1
Deep Venous Thrombosis/ Pulmonary Embolism	2
Diabetes	10
GERD	15
HIV	1
Hepatitis C	12
Hyperlipidemia	13
Hypertension	24
Mental Health	21
Migraine	1
Seizure Disorder	9
Sleep Apnea	1
Substance Abuse	21
Thyroid Disease	3
	185

Table B–3. SVSP Case Review Events by Program

Diagnosis	Total
Diagnostic Services	160
Emergency Care	148
Hospitalization	69
Intrasystem Transfers In	5
Intrasystem Transfers Out	5
Outpatient Care	420
Specialized Medical Housing	162
Specialty Services	154
	1,123

Table B–4. SVSP Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	20
MD Reviews Focused	2
RN Reviews Detailed	10
RN Reviews Focused	26
Total Reviews	58
Total Unique Cases	48
Overlapping Reviews (MD & RN)	10

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Appendix C: Compliance Sampling Methodology

Salinas Valley State Prison

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	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, BMP, or CMPs only • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	6	Quest	• Appt. date (90 days–9 months) • Order name (CBC, BMP, or CMPs only • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology-related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	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	10	OIG inspector on-site review	• Identify and inspect all on-site clinical areas
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	6	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	7	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	20	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	8	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, radiology, follow-up wound care / addiction medication, narcotic treatment program, and transgender 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, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Specialty Services (continued)				
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, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize
MIT 14.010	Specialty Services Arrivals	20	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	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	10	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations (continued)				
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	6	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	15	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff • Providers (ACLS) • Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications
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	10	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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February 3, 2025

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 draft Medical Inspection Report for Salinas Valley State Prison conducted by the Office of the Inspector General from January 2023 to June 2023. Thank you for preparing the report. While CCHCS disagrees with the findings for the compliance portion of the OIG Inspection for Salinas Valley State Prison, we understand that the OIG is forming a workgroup to revise the Medical Inspection Tool to reduce or eliminate subjectivity and complex, compound questions that make it difficult for CCHCS to determine areas of policy non-compliance. CCHCS looks forward to participating in such efforts and urges the OIG to begin the process as soon as possible.

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

Sincerely,

DocuSigned by:
DeAnna Gouldy
3B7F6B95AC0A4D1...

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

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Jeff Macomber, Secretary, CDCR
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
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Cycle 7

Medical Inspection Report

for

Salinas Valley State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

STATE *of* CALIFORNIA
February 2025

OIG