Roy W. Wesley, Inspector General

Bryan B. Beyer, Chief Deputy Inspector General

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

July 2020

Cycle 6
Medical Inspection Report

California State Prison
Los Angeles County

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Introduction

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

In Cycle 6, the OIG continues to apply the same assessment methodologies used in Cycle 5, including clinical case review and compliance testing. These methods provide an accurate assessment of how the institution's health care systems function regarding patients with the highest medical risk who tend to access services at the highest rate. This information helps to assess the performance of the institution in providing sustainable, adequate care.[2]

We continue to review institutional care using 15 indicators, as in prior cycles. Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the *medical inspection tool* (MIT).[3] We determine a total compliance score for each applicable indicator and consider the MIT scores in the overall conclusion of the institution's performance. In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff.

In reviewing the cases, our clinicians examine whether providers used sound medical judgment in the course of caring for a patient. In the event we find errors, we determine whether such errors were clinically significant or led to a significantly increased risk of harm to the patient.[4] At the same time, our clinicians examine whether the institution's medical system mitigated the error. The OIG rates the indicators as ***proficient***, ***adequate***, or ***inadequate***.

1. 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.
2. 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.
3. The department regularly updates its policies. The OIG updates our policy-compliance testing to reflect the department's updates and changes.
4. If we learn of a patient needing immediate care, we notify the institution's chief executive officer.

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

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

We completed our sixth inspection of LAC, and this report presents our assessment of the health care provided at that institution during the inspection period between September 2018 and April 2019.[5]

LAC houses more than 3,400 patients and is located in the city of Lancaster. The institution has been designated as an *intermediate care prison*, which responds to nonurgent requests for medical services and provides an enhanced outpatient program. The institution conducts patient screenings in its receiving and release (R&R) clinical area, treats patients who require urgent or immediate care in its triage and treatment area (TTA), and treats patients who require inpatient care in its correctional treatment center (CTC).

5. Samples are obtained per the case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews that occurred between April 2018 and April 2019, and registered nurse (RN) sick calls that occurred between November 2018 and July 2019.

Summary

We completed the Cycle 6 inspection of LAC in August 2019. OIG inspectors monitored the institution's delivery of medical care that occurred between September 2018 and April 2019.

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

Table 1. LAC Summary Table

Ratings

Proficient *Adequate* *Inadequate*

Health Care Indicators	Cycle 6 Ratings: Case Review	Cycle 6 Ratings: Compliance	Cycle 6 Ratings: Overall	Change Since Cycle 5*
Access to Care				↑↑
Diagnostic Services				↑
Emergency Services		N/A		↓
Health Information Management				↑
Health Care Environment	N/A			=
Transfers				↓
Medication Management				=
Prenatal and Postpartum Care	N/A	N/A	N/A	N/A
Preventive Services	N/A			=
Nursing Performance		N/A		=
Provider Performance		N/A		=
Reception Center	N/A	N/A	N/A	N/A
Specialized Medical Housing				=
Specialty Services				↑
Administrative Operations†	N/A			=

* The symbols in this column correspond to changes that occurred in indicator ratings between the medical inspections conducted during Cycle 5 and Cycle 6. The equals sign means there was no change in the rating. The single arrow means the rating rose or fell one level, and the double arrow means the rating rose or fell two levels (green, from *inadequate* to *proficient*; pink, from *proficient* to *inadequate*).

† **Administrative Operations** is a secondary indicator and is not considered when rating the institution's overall medical quality.

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

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 391 patient records and 1,134 data points and observed LAC's processes during an on-site inspection in June 2019. They used the data to answer 87 policy questions. Table 2 below lists LAC's average scores from Cycles 4, 5, and 6.

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 68 cases, which contained 1,194 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in August 2019 to verify their initial findings. The OIG physicians rated the quality of care for 25 comprehensive case reviews.

Table 2. LAC Policy Compliance Scores

Scoring Ranges

100%–85% | 84%–75% | 74%–0

Medical Inspection Tool (MIT)	Policy Compliance Category	Average Score		
		Cycle 4	Cycle 5	Cycle 6
1	Access to Care	72%	73%	90%
2	Diagnostic Services	73%	59%	59%
4	Health Information Management	65%	70%	83%
5	Health Care Environment	67%	71%	44%
6	Transfers	74%	75%	55%
7	Medication Management	70%	72%	28%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	73%	66%	68%
12	Reception Center	N/A	N/A	N/A
13	Specialized Medical Housing	78%	85%	84%
14	Specialty Services	77%	70%	75%
15	Administrative Operations	78%*	63%	68%

* In Cycle 4, there were two secondary (administrative) indicators, and this score reflects the average of those two scores. In Cycle 5 and moving forward, the two indicators were merged into one, with only one score as the result.

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

Of these 25 cases, our clinicians rated four ***proficient***, 17 ***adequate***, and four ***inadequate***. Our clinicians found no adverse events during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 13 health care indicators.[6] Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our clinicians acknowledged institutional structures that catch and resolve mistakes that may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable for this institution in Table 1, the LAC Summary Table.

In April 2019, the Health Care Services Master Registry showed that LAC had a total population of 3,215. A breakdown of the medical risk level of the LAC population as determined by the department is set forth in Table 3 below.

Table 3. LAC Master Registry Data as of April 2019

Medical Risk Level	Number of Patients	Percentage
High 1	283	8.8%
High 2	563	17.5%
Medium	1,344	41.8%
Low	1,025	31.9%
Total	**3,215**	100.0%

Source: Cycle 6 medical inspection preinspection questionnaire staffing matrix received on May 28, 2019, from California State Prison, Los Angeles County.

6. The indicators for **Reception Center** and **Prenatal Care** do not apply to LAC.

Based on staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, LAC had no vacant nurse supervisor positions, but approximately two vacant nurse positions. At the time of the OIG's inspection, one nursing supervisor and three nursing staff were on extended leave from the institution.

Table 4. LAC Health Care Staffing Resources as of April 2019

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	6	11	16	177.4	210.4
Filled by Civil Service	5	10	16	175.3	206.3
Vacant	1	1	0	2.1	4.1
Percentage Filled by Civil Service	100%	100%	100%	99%	98%
Filled by Telemedicine	N/A	0	N/A	N/A	0
Percentage Filled by Telemedicine	N/A	0	N/A	N/A	0
Filled by Registry	N/A	0	N/A	2.1	2.1
Percentage Filled by Registry	N/A	0	N/A	0	0
Total Filled Positions	5	10	16	177.4	208.4
Total Percentage Filled	83.3%	90.9%	100%	100%	96.1%
Appointments in Last 12 Months	1	1	2	19	23
Redirected Staff	N/A	0	0	0	0
Staff on Extended Leave‡	N/A	0	1	3	4
Adjusted Total: Filled Positions	**5**	**10**	**15**	**174.4**	**204.4**

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes Senior Psychiatric Technician and Psychiatric Technician.

‡ In Authorized Positions.

Note: The OIG does not independently validate staffing data received from the department.

Source: Cycle 6 medical inspection preinspection questionnaire staffing matrix received on June 10, 2020, from California State Prison, Los Angeles County.

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.[7]

Our inspectors did not find any adverse events at LAC during the Cycle 6 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to LAC. Of these 10 indicators, OIG clinicians rated one ***proficient***, six ***adequate***, and three ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, four were ***proficient***, 17 were ***adequate***, and four were ***inadequate***. In the 1,194 events reviewed, there were 270 deficiencies, 38 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at LAC:

- Since we completed our review during Cycle 5, LAC improved its backlog of provider appointments. The institution provided excellent access to care in most clinical areas, especially in provider appointments.
- The providers delivered good patient care. The providers in the outpatient setting made sound medical judgments and maintained good continuity of care for patients.
- The providers expressed satisfaction with their managers, the nursing staff, and the ancillary services.
- The physician managers collaborated with the clinicians and were committed to quality improvement. They conducted a productive population health management review.
- Since we completed our review during Cycle 5, LAC improved in ensuring specialty appointment access and retrieving specialty reports timely.

7. For a further discussion of an adverse event, see Table A–1.

- Since we completed our review during Cycle 5, LAC improved with completing diagnostic tests, especially the blood thinning monitoring test.

Our clinicians found LAC could improve in the following areas:

- The institution should retrieve and scan pathology reports within the required time frame.
- LAC nursing leadership should evaluate its clinical reviews of the emergent events and remind supervisory staff to continue training their staff.
- LAC should ensure that chronic care and transfer-in patients receive their medications within the required time frame.
- LAC should improve the timeliness of medication administration for patients returning from the hospital, as ordered by providers.

Compliance Testing Results

Our compliance inspectors assessed 10 of the 13 indicators applicable to LAC. Of these 10 indicators, our compliance inspectors rated one ***proficient***, three ***adequate***, and six ***inadequate***. In the **Health Care Environment**, **Preventive Services**, and **Administrative Operations** indicators, we tested policy compliance only, because how the institution performed in these indicators usually does not significantly affect the institution's overall quality of patient care.

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

- Nursing staff received and reviewed sick call request forms and performed face-to-face evaluations within the required time frames. Furthermore, LAC housing units maintained adequate supplies of sick call forms and designated lock boxes.
- Patients with chronic conditions and those returning from hospital admission received timely follow-up appointments.

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

- Patients did not timely receive their chronic care medications and newly ordered medications. There was poor medication continuity for patients returning from a community hospital, transferring in from other facilities, transferring within the facility, as well as for layover patients.
- The institution did not provide high-priority specialty services within the specified time frames.
- Several clinics stored expired medical supplies. In addition, nursing staff did not regularly inspect or inventory crash carts and emergency response bags.
- Health care staff did not consistently follow universal hand hygiene precautions.

- The LAC pharmacy demonstrated poor practices in organizing, cleaning, and securing controlled substances.
- LAC poorly monitored patients who were taking tuberculosis (TB) medications.

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 6. Likewise, Kaiser (commercial plan) no longer publishes HEDIS scores, but the OIG obtained Kaiser Medi-Cal HEDIS scores through the California Department of Health Care Services' *Medi-Cal Managed Care Technical Report* to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered LAC's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. LAC's results compared favorably with those found in State health plans for diabetic care measures. We list the five HEDIS measures in Table 5.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs (California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)), LAC performed better in three of the five diabetic measures. The institution scored lower than Kaiser Southern California (Medi-Cal) in HbA1c Control (< 8.0%) and lower than Kaiser Southern California (Medi-Cal) in eye examinations.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include these data for informational purposes. LAC had a 49 percent immunization rate for adults 18 to 64 years old, and a 69 percent immunization rate for adults 65 years of age and older. The pneumococcal vaccination rate was 81 percent.

Table 5. LAC Results Compared With State HEDIS Scores

HEDIS Measure	LAC Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	**100%**	87%	95%	95%
Poor HbA1c Control (>9.0%)‡,§	**18%**	35%	24%	19%
HbA1c Control (<8.0%)‡	65%	54%	63%	**71%**
Blood Pressure Control (<140/90)‡	**86%**	66%	76%	85%
Eye Examinations	81%	61%	75%	**84%**
Influenza–Adults (18–64)	**49%**	–	–	–
Influenza–Adults (65+)	**69%**	–	–	–
Pneumococcal–Adults (65+)	**81%**	–	–	–
Colorectal Cancer Screening	**88%**	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in April 2019 by reviewing medical records from a sample of LAC's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication titled, *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2017–June 30, 2018 (published April 2019).

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

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

Recommendations

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

- Medical leadership should remind providers to consistently communicate diagnostic tests to their patients within appropriate time frames.
- Nursing leadership should remind first medical responders to perform thorough evaluations.
- The Emergency Medical Response Review Committee (EMRRC) should more thoroughly review emergency response events to improve identification of deficiencies.
- Medical staff should consistently and accurately document time lines for emergency events. This could be achieved by the standard use of either a computer clock or an atomic clock.
- Medical staff should be reminded to follow appropriate infection control in clinical health care areas and with medical equipment.
- Medical staff should be reminded to follow protocols for managing and storing bulk medical supplies.
- Medical staff should be reminded to clean, sanitize, and disinfect clinical health care areas appropriately.
- Medical staff should also be reminded to follow universal hand hygiene precautions. Implementing random spot checks may help with compliance.
- Nursing leadership should remind nursing staff to perform a complete assessment for patients returning from the hospital.
- Medical and pharmacy leadership should ensure that chronic care, transfer-in, and hospital-discharge patients receive medications timely. Hospital medications should be timely reconciled.
- Medical and pharmacy leadership should ensure proper storage of all medications.

- Nursing leadership should remind nurses to fully document and address all tuberculosis (TB) symptoms in their monitoring assessments.
- Nursing leadership should remind nursing staff to provide complete patient assessments in outpatient clinics.
- Nursing leadership should remind nursing staff to completely document wound care.
- The chief physician and surgeon should remind providers to thoroughly reconcile medications for patients returning from hospitalizations.
- Medical leadership should evaluate processes to ensure completion of high-priority specialty referrals and timely retrieval of high-priority specialty reports.
- Medical leadership should ensure timely completion of preapproved specialty services for transfer-in patients.
- Medical leadership should remind the specialty nurses to provide pertinent medical records for the specialists to review at specialty appointments.
- The EMRRC should ensure the checklist form in the incident package is fully completed.

Access to Care

In this indicator, OIG inspectors evaluated the institution's ability to provide patients with timely clinical appointments. Our inspectors reviewed the scheduling and appointment timeliness for newly arrived patients, sick calls, and nurse follow-ups. 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.

Overall Rating
Proficient

Case Review Rating
Proficient

Compliance Score
Proficient
(90%)

Results Overview

LAC provided excellent access to care in most clinical areas. The OIG clinicians found that most clinic provider, CTC provider, nurse, and specialty appointments were completed timely. The compliance testing was also consistent with the clinical review as the overall access to care score was 90 percent. The OIG rated this indicator ***proficient***.

Case Review Results

OIG clinicians reviewed 745 provider, nursing, specialty, and hospital events that required the institution to generate appointments. We identified 14 deficiencies relating to this indicator, only two of which were significant.[8]

Access to Clinic Providers

Access to clinic providers is an integral part of patient care in health care delivery, and LAC performed well with access to providers in both case review and compliance testing. Compliance testing found that most samples of chronic care follow-up occurred on time (MIT 1.001, 80%), and most nurse-to-provider sick call referrals occurred as requested (MIT 1.005, 86%). The OIG clinicians reviewed 181 clinic provider appointments and identified only two minor delays, which were not clinically significant.[9]

Access to Specialized Medical Housing Providers

LAC performed well with access in the CTC. When staff admitted the patient to the CTC, the providers examined the patients timely. The providers evaluated and documented their progress notes within the appropriate time frames. Compliance testing found that the providers performed all CTC admission history and physical examinations timely (MIT 13.002, 100%), and most provider follow-up appointments occurred within the appropriate time frames (MIT 13.003, 78%). The OIG clinicians assessed 27 CTC provider encounters and did not identify any missed or late appointments.

8. Cases 28 and 68 had significant deficiencies.
9. Minor deficiencies occurred in cases 2 and 19.

Access to Clinic Nurses

LAC performed well with access for nursing sick calls and provider-to-nurse referrals. Compliance testing found that nursing sick call requests were addressed timely (MIT 1.003, 100%), and nurses evaluated the vast majority of their patients with symptoms within the required one business day (MIT 1.004, 97%). The OIG clinicians identified only one minor delay related to clinic nurse access.[10]

LAC also performed well with provider-to-nurse referrals. The OIG clinicians identified only one minor deficiency related to nursing staff, who did not complete all blood pressure checks as requested by the provider.[11]

Access to Specialty Services

LAC performed adequately with specialty access. The compliance testing found that less than half of our samples of high-priority specialty appointments occurred timely (MIT 14.001, 40%); whereas all routine-priority specialty appointments occurred as requested (MIT 14.007, 100%). Compared with compliance testing, the OIG clinicians reviewed a larger sample of specialty events, 142 high- and routine-priority specialty appointments-related cases, in contrast to the compliance testing. We identified only four minor delays.[12] One significant error occurred in the following case:

- In case 68, the patient had a coronary artery bypass grafting, and the provider requested that the cardiothoracic specialist follow up in two weeks. However, the appointment did not occur, and the patient was transferred to another institution three weeks later.
- The specialists often requested follow-up appointments, and LAC also performed well in specialty follow-up appointments. The compliance testing found that all high-priority specialty follow-up appointments occurred timely (MIT 14.003, 100%), and all routine-priority specialty follow-up appointments occurred as requested (MIT 14.009, 100%).

Follow-Up After Specialty Service

LAC performed well in ensuring that patients saw their providers after specialty appointments. The compliance testing showed that most provider appointments after specialty services occurred timely (MIT 1.008, 76%). The OIG clinicians reviewed 116 specialty appointments and identified one significant deficiency related to a delayed provider follow-up appointment after specialty service.

10. A minor deficiency occurred in case 57.
11. A minor deficiency occurred in case 21.
12. Minor deficiencies occurred twice in case 25 and once in cases 13 and 27.

In case 28, the patient was seen by a surgeon for an urgent rectal cancer consultation, and the surgeon recommended surgical resection. The patient's follow-up appointment with his provider occurred 10 days beyond the required time frame.

Follow-Up After Hospitalization

LAC performed well in ensuring patients saw their providers after hospitalizations. The compliance testing showed that in all samples, provider appointments occurred timely after a hospitalization (MIT 1.007, 100%). The OIG clinicians reviewed 25 hospital returns and identified only three minor delays, which were not clinically significant.[13]

Follow-Up After Urgent or Emergent Care (TTA or SEMS)

LAC providers saw their patients timely after a triage and treatment area (TTA) event. The OIG clinicians assessed 34 TTA events and did not find any missed or delayed provider appointments.

Follow-Up After Transferring Into the Institution

LAC generally performed well with ensuring provider access for patients who recently transferred into the institution. The compliance testing showed that most patients saw a provider timely after arrival (MIT 1.002, 79%). The OIG clinicians evaluated five transfer-in events and identified one minor delay.[14]

Clinician On-Site Inspection

The OIG clinicians attended three organized morning huddles. The staff discussed all patients returning from hospitalization or specialty services from the prior day and addressed urgent recommendations. The staff also discussed newly arrived patients from another institution. The office technician reported that provider appointments were met, especially for patients with urgent needs.

LAC had four main clinics: A, B, C, and D, and each clinic had an office technician. At the time of our on-site inspection, the office technicians informed the OIG clinicians there was no provider backlog in the four clinics. Each clinic had two providers to complete the appointments timely. The providers reported seeing 10 to 12 patients per day, and the nurses reported seeing about 12 patients per day.

Recommendations

We have no specific recommendations for this indicator.

13. Minor deficiencies occurred in cases 3, 23, and 67.
14. A minor deficiency occurred in case 33.

Compliance Testing Results

Table 6. Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001) *	20	5	0	80%
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) *	19	5	1	79%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	35	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) *	34	1	0	97%
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) *	6	1	28	86%
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) *	0	0	35	N/A
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	25	0	0	100%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	22	7	1	76%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	6	0	0	100%
				Overall percentage (MIT 1): 90%

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

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

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

Table 7. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003) *	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	N/A	N/A	N/A	N/A
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	10	0	0	100%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	7	2	1	78%
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	6	9	0	40%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	12	0	3	100%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004) *	N/A	N/A	N/A	N/A
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	N/A	N/A	N/A	N/A
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) *	15	0	0	100%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	4	0	11	100%

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

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

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

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Inadequate **(59%)**

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's ability to timely complete radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly. In addition, in Cycle 6, we examined the institution's ability to timely complete and review stat (immediate) laboratory tests.

Results Overview

LAC performed well in completing and retrieving diagnostic tests. The OIG identified a missing pathology report as clinically significant, and the institution had implemented a process for tracking and retrieving all pathology reports. LAC processed a large volume of diagnostic tests, and errors were rare. The OIG rated this indicator ***adequate***.

Case Review Results

The OIG clinicians reviewed 226 diagnostic events and identified 16 deficiencies, 14 of which were considered minor and had no clinical significance. Of those 16 deficiencies, five were related to delayed diagnostic test completion, and 11 were related to health information management.

Test Completion

Compliance testing showed that LAC completed all radiology tests timely (MIT 2.001, 100%). The OIG clinicians reviewed 36 radiology tests and also did not identify any missed or delayed tests; and all seven electrocardiograms (EKG) were also completed timely.

The compliance testing showed that less than half the laboratory tests were completed timely (MIT 2.004, 40%). However, the OIG case clinicians reviewed a much larger number of 183 laboratory tests and identified only five delays, four of which were minor.[15] One delay was significant as described below:

- In case 19, the provider started the patient on an angiotensin-converting enzyme (ACE) inhibitor, a blood pressure medication, which required close monitoring of the patient's potassium level and a kidney function test. The provider requested appropriate laboratory tests were to be done in seven days; however, the test was completed 12 days late.

15. Minor delays occurred in cases 1, 13, 14, and 29.

Health Information Management

LAC performed well in retrieving and endorsing diagnostic reports. Compliance testing showed that the providers endorsed all radiology reports timely (MIT 2.002, 100%) and generally endorsed laboratory reports timely (MIT 2.005, 80%). The OIG clinicians identified only one minor delay in retrieving a laboratory report and eight minor delays in endorsing laboratory reports.[16, 17] Four of the eight endorsing delays were related to blood thinning test results (the INR,[18] a blood test that monitors how well the body clots blood), as the providers did not endorse these INR results timely. However, at the Coumadin clinic, the clinical pharmacist reviewed the INR results within one to two days.

LAC generally retrieved and reviewed pathology reports timely. Compliance testing found that LAC retrieved pathology reports 70 percent of the time (MIT 2.010), and the provider endorsed pathology reports 100 percent of the time (MIT 2.011). However, the providers did not send result letters to the patients within the required time frames (MIT 2.012, 0%). The OIG clinicians found that two out of three pathology reports were retrieved, and the providers timely endorsed these reports and discussed the result with their patients during the subsequent provider encounters. We considered that the one missing pathology report was clinically significant:

- In case 28, the patient had a gastric biopsy, and the institution did not retrieve the pathology report.

Clinician On-Site Inspection

In the Cycle 5 inspection, LAC performed poorly in completing time-sensitive laboratory tests. Since then, LAC assigned a designated phlebotomist to each of the four main clinics to ensure that all laboratory tests, especially time-sensitive tests, are completed timely. This additional staffing significantly improved institutional performance.

We found LAC did not often retrieve final pathology reports timely. However, by the time we completed our on-site inspection, LAC had already self-identified the problem and implemented corrective action by dedicating a licensed vocational nurse for tracking and retrieving all pathology reports.

Recommendations

Medical leadership should remind providers to consistently communicate diagnostic tests to their patients within appropriate time frames.

16. A minor delay occurred in case 29.
17. Minor delays occurred three times in case 12, twice in case 15, and once in cases 13, 23, and 30.
18. INR is the abbreviation for the *international normalized ratio* test.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	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)	4	6	0	40%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	4	6	0	40%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	8	2	0	80%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	0	10	0	0
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	N/A	N/A	N/A	N/A
Laboratory: Did the nursing staff notify the health care provider within one (1) hour from receiving the STAT laboratory results? (2.008) *	N/A	N/A	N/A	N/A
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	7	3	0	70%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	9	0	1	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	9	1	0
				Overall percentage (MIT 2): 59%

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

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

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, TTA care, provider performance, and nursing performance. Our clinicians also evaluated the Emergency Medical Response Review Committee's (EMRRC) ability to identify problems with its emergency services. The OIG assessed the institution's emergency services through case review only; we did not perform compliance testing for this indicator.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
(N/A)

Results Overview

LAC providers delivered adequate emergency care. Whereas the nurses' performance displayed numerous deficiencies, the first medical responders did not always perform sufficient evaluations or initiate critical interventions. Furthermore, the supervising registered nurses did not recognize deficiencies in their clinical review of the emergent events. Nursing emergency services is an area LAC should target for quality improvement. After considering all factors, the OIG rated this indicator ***inadequate***.

Case Review Results

The OIG clinicians reviewed 42 urgent and emergent events and found 30 deficiencies, seven of which were significant.[19]

Emergency Medical Response

LAC staff responded promptly to emergencies throughout the institution. They initiated CPR, activated emergency medical services, and notified TTA staff in a timely manner.

Provider Performance

LAC providers performed well in urgent and emergent situations. They generally made appropriate triage decisions when the patients presented emergently to the TTA. The providers were available for consultation with the TTA nursing staff. The OIG clinicians identified only one minor deficiency related to provider performance.[20]

19. Significant events occurred three times in case 1, twice in case 10, and once in cases 3 and 19.
20. A minor deficiency occurred in case 24.

Nursing Performance

LAC nurses performed poorly during emergency events. The OIG clinicians identified a pattern of incomplete nursing assessment and delays in initiating critical interventions. The following are examples:

- In case 1, the patient had a low oxygen saturation level. The first medical responder notified the TTA, but did not administer oxygen. The patient received oxygen 10 minutes later when the TTA nurse arrived. Although the patient had no adverse issues, this was below the nursing standard of care.
- In case 10, the unresponsive patient who was suspected of a narcotic overdose, had shallow respirations. The first medical responder did not initiate oxygen or obtain an oxygen saturation level, pulse, and respiratory rate. The patient received oxygen four minutes later when the TTA nurse arrived. This was below the nursing standard of care.
- In case 19, the diabetic patient complained of dizziness and weakness. He also had an elevated pulse. The nurse did not obtain a blood sugar level or obtain orthostatic vital signs.[21] This placed the patient at risk of delayed diagnosis and treatment of possible low blood sugar.

Nursing Documentation

LAC nurses did not document their emergent events well. There were time-line discrepancies related to the sequence of events, and pertinent information was missing. We identified opportunities for improvement in 12 of the 18 cases reviewed. The following are examples of poor documentation:

- In case 1, the first medical responder did not document a note for the emergent event.
- In case 5, there was a 30-minute discrepancy as the nurse incorrectly documented the time the patient was found without a pulse. In addition, the nurse administered a medication to the patient, but did not document it on the medication administration record.

In cases 2, 6, 10, and 67, the nurses documented inaccurate time lines for the emergent events.

Emergency Medical Response Review Committee

The EMRRC met monthly to review emergency response cases. Although the nursing supervisors reviewed all the emergent cases, in six cases, they did not identify the deficiencies that the OIG clinicians identified. There

21. "Obtaining orthostatic vital signs" refers to checking the patient's pulse and blood pressure in three different positions: supine, sitting, and standing.

were two significant deficiencies in which the nursing supervisors missed identifying significant nursing errors.[22]

Clinician On-Site Inspection

The TTA had four beds, an automated external defibrillator, and a well-stocked emergency crash cart. Three RNs and a provider staffed the unit during working hours, and a provider was available for phone consultation after-hours. The nurses reported that their supervisors were supportive and assisted when needed. The OIG clinicians discussed some of the case review findings with nurse managers who planned to implement training to improve LAC's emergency services.

Recommendations

Nursing leadership should remind first medical responders to perform thorough evaluations.

The EMRRC should more thoroughly review emergency response events to improve identification of deficiencies.

Medical staff should consistently and accurately document time lines for emergency events. This could be achieved by the standard use of either a computer clock or an atomic clock.

22. Significant events occurred in cases 1 and 10.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(83%)

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.

Results Overview

The OIG found that most hospital-discharge records, diagnostic results, and specialty reports were retrieved and scanned timely. There was a missing pathology report which the OIG considered as significant, but the institution had already implemented a tracking and retrieving solution. LAC scored well with both compliance testing and case review. The OIG rated this indicator ***adequate***.

Case Review Results

The OIG clinicians reviewed 1,194 events and found 24 deficiencies related to health information management. Only four of the 24 deficiencies were significant.[23]

Hospital-Discharge Reports

LAC performed well in retrieving and scanning hospital records. The compliance testing showed that LAC staff timely retrieved and scanned most hospital-discharge records (MIT 4.003, 85%), and most of those discharge records included the physician discharge summary (MIT 4.005, 96%). The OIG clinicians reviewed 25 hospital events and identified only one missing physician discharge summary. The OIG clinicians considered this missing document significant:

- In case 1, the patient returned from hospitalization where he had a lung biopsy. Although the hospital documents were available, the medical record staff did not retrieve the formal hospital-discharge summary, which included the follow-up plan for the lung biopsy. LAC did not obtain the pathology report until three months later, and only after the OIG clinicians informed the institution of the missing document.

Specialty Reports

LAC performed adequately in retrieving and in reviewing the specialty reports. While compliance testing showed that high-priority specialty

23. Significant deficiencies occurred in cases 1, 25, 27, and 28.

reports were not always promptly retrieved and reviewed (MIT 14.002, 47%), most routine-priority specialty reports were retrieved and reviewed in a timely manner (MIT 14.008, 87%). The OIG clinicians reviewed 142 specialty events and identified 10 deficiencies related to health information management, most of which were not clinically significant. Only two were considered significant, and these significant deficiencies are discussed in the **Specialty Services** indicator.

Diagnostic Reports

LAC performed well in retrieving and endorsing diagnostic reports. Compliance testing showed that the providers endorsed all radiology reports timely (MIT 2.002, 100%) and generally endorsed laboratory reports timely (MIT 2.005, 80%). The OIG clinicians reviewed 226 diagnostic events and identified only one minor delay in retrieving a laboratory report and eight minor delays in endorsing a laboratory report.

LAC generally retrieved and reviewed pathology reports timely. Compliance testing found that LAC retrieved most pathology reports timely (MIT 2.010, 70%), and the provider endorsed all pathology reports timely (MIT 2.011, 100%). The OIG clinicians found that two out of three pathology report were retrieved. The providers timely endorsed these reports and discussed the results with their patients during the subsequent provider encounters. The OIG clinicians considered the one missing pathology report clinically significant. This missing pathology report is discussed in the **Diagnostic Services** indicator.

Urgent and Emergent Records

OIG clinicians reviewed 34 emergency care events and found that LAC nurses recorded these events sufficiently. The providers also recorded their emergency care sufficiently, including the off-site telephone encounters. The OIG clinicians identified six minor deficiencies related to a lack of nursing documentation. The **Emergency Services** indicator provides additional details.

Scanning Performance

LAC performed adequately with the scanning process. The compliance testing found that the majority of records were properly scanned and labeled (MIT 4.004, 62%). The OIG clinicians identified only four deficiencies related to mislabeled medical documents.[24] These errors were not clinically significant.

Clinician On-Site Inspection

LAC designated specialty office technicians to track and retrieve specialty reports. They stated that a few specialists did not provide dictated consultation reports; however, these specialists often provided

24. Deficiencies were found in cases 19, 21, 23, and 58.

a handwritten report with recommendations on the same day of the consultation. Some specialists communicated directly with the specialty nurses or providers to discuss their recommendations. With the introduction of the electronic medical record, the laboratory vendor Quest Diagnostics placed laboratory reports directly into the medical record, thus missing laboratory reports were rare. LAC leadership acknowledged the missing pathology report and had designated a licensed vocational nurse to retrieve all pathology reports. The medical record supervisor also continued training medical record staff to improve scanning performance.

Recommendations

Recommendations for **health information management** are addressed in the **Diagnostic Services** indicator above.

Compliance Testing Results

Table 9. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	0	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	14	6	10	70%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	17	3	5	85%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	15	8	0	65%
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) *	24	1	0	96%
				Overall percentage (MIT 4): 83%

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

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

Table 10. Other Tests Related to Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Laboratory: Did the nursing staff notify the health care provider within one (1) hour from receiving the STAT laboratory results? (2.008) *	N/A	N/A	N/A	N/A
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	9	0	1	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	9	1	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	7	8	0	47%
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) *	N/A	N/A	N/A	N/A
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) *	13	2	0	87%

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

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

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(45%)

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' ability to maintain auditory and visual privacy for clinical encounters. Compliance inspectors asked the institution's health care administrators to comment on their facility's infrastructure and its ability to support health care operations. The OIG rated this indicator solely on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians typically do not rate this indicator.

Compliance Testing Results

Outdoor Waiting Areas

With the new health care facility improvement program construction of LAC clinics, there were no waiting areas that required patients to wait outdoors.

Photo 1. Indoor waiting area (photographed on 6/11/19).

Indoor Waiting Areas

Inside the medical clinics, patients had enough seating capacity while waiting for their appointments (see **Photo 1**). Depending on the population, patients were either placed in a cohesive holding module with a posted person capacity maximum or held in individual modules awaiting their medical appointments. These holding areas had temperature control, running water, toilets, and hand sanitation items. Custody and medical staff reported that patient waiting areas mostly held a maximum of 15 patients at a time.

Clinic Environment

All 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 11 clinics we observed, four contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 36%). The remaining seven clinics had one or more of the following deficiencies: examination rooms lacked visual privacy; rooms were unnecessarily cluttered and lacked adequate space (fewer than 100 square feet); and rooms had unsecured confidential medical records.

In addition to the above findings, our compliance inspectors observed the following in the clinics during their on-site inspection. Patient examination rooms were not cleaned after each patient encounter. In one instance, a urinal used by the previous patient was left near the bedside when another patient was in the room. Overflowing trash, used gloves, and soiled patient clothing still remained in examination rooms during the next patient encounter. In addition, health care staff were observed leaving unused intravenous needles in patient rooms.

Clinic Supplies

Two of the 11 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 18%). We found one or more of the following deficiencies in all nine clinics: expired medical supplies (see **Photo 2** and **Photo 3**), unidentified medical supplies, cleaning materials stored with medical supplies, staff members' personal items and food stored with medical supplies, and medical supplies stored directly on the floor.

Photo 2. Expired medical supplies dated November 2009 (photographed on 6/11/19).

Three of the 11 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 27%). The remaining eight clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing items included a nebulizer, a Snellen eye chart, an examination table, and an oto-ophthalmoscope. The staff had not properly calibrated a thermometer. The Snellen eye chart was placed at an improper distance, and there was a nonfunctioning oto-ophthalmoscope and expired lubricating jelly. LAC staff did not properly log the results of the defibrillator performance test or the automated external defibrillator checklist within the last 30 days.

Photo 3. Expired medical supplies dated July 2018 (photographed on 6/10/19).

We examined emergency medical response bags (EMRBs) to determine if they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only one of the nine

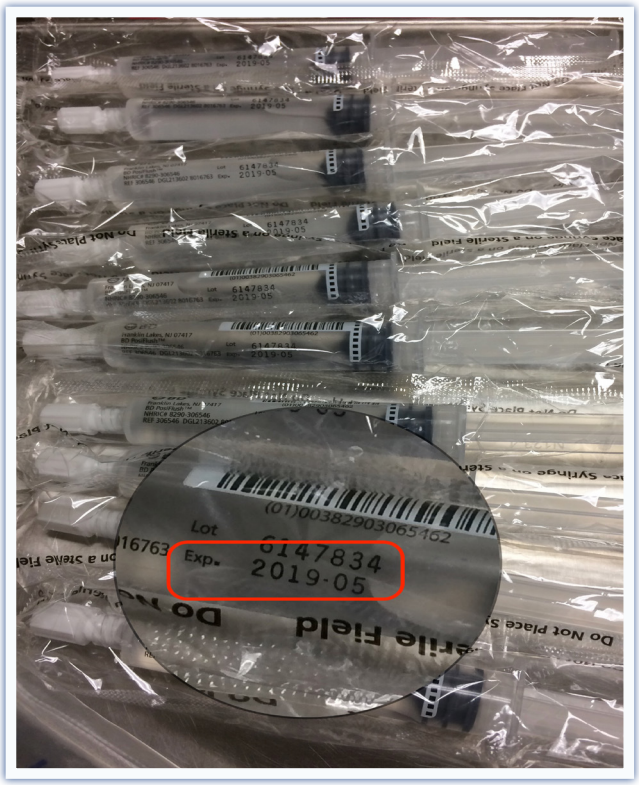


Photo 4. Expired crash cart medical supplies dated May 2019 (photographed 6/10/19).

In addition to the above findings, our compliance inspectors observed the following in the clinics during their on-site inspection: During clinic inspections, LAC had excessive amounts of expired medical supplies found in the mass casualty bags stored in all yards. Some of these supplies had expiration dates between one and nearly three *decades* ago. Nursing staff including supervisors reported that it was not normal practice to regularly check the mass casualty bag item contents. We observed that an inventory logbook was checked off every shift for these bags.

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, 0%). The warehouse did not store liquid solutions within the manufacturers'

EMRBs passed our test (MIT 5.111, 11%). We found one or more of the following deficiencies with eight EMRBs: staff failed to ensure the EMRBs' compartments were sealed and intact, staff had not inventoried the EMRBs in the previous 30 days, and the supervisor did not provide documents to verify that staff inspected the bags and inventoried them monthly. The crash carts in the TTA contained multiple expired medical supplies, which did not meet the minimum inventory level, nor was there documentation that reasonable substitutions were made (see **Photo 4** and **Photo 5**). The TTA staff did not use the crash cart inventory report (CDCR 7574).

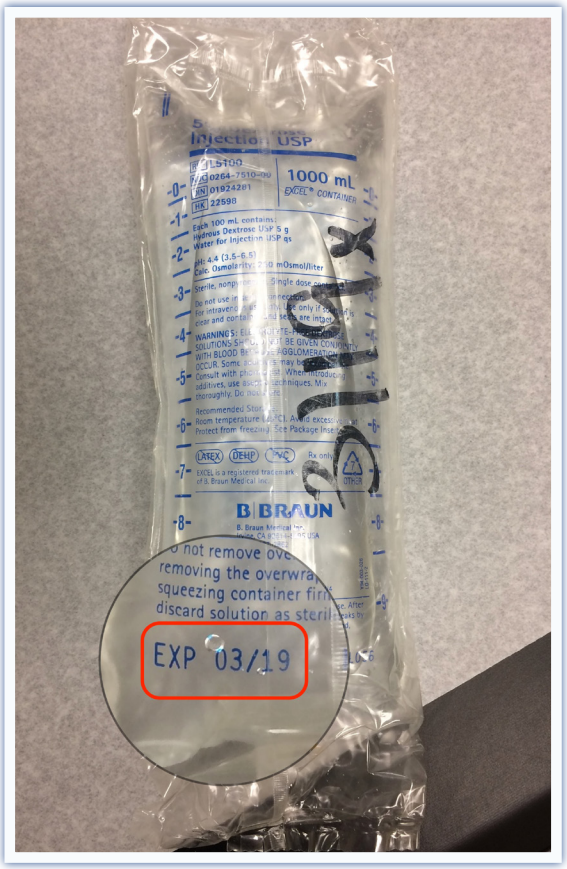


Photo 5. Expired crash cart medical supplies dated March 2019 (photographed 6/10/19).

recommended temperature guidelines. We found several solutions displaying evidence of accumulated condensation (see **Photo 6**).

According to the CEO, the institution had recently restructured the process of maintaining medical supplies and of using a certain level of replacement. Medical warehouse management reported an effective process to replenish medical clinic supplies and maintain open communication with medical staff for medical supply needs. In addition, medical warehouse management reported working closely with the main warehouse to ensure that medical supplies were received timely and stored in an organized manner.

Photo 6. Liquid solutions with accumulated condensation (photographed 06/12/19).

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected five of 11 clinics (MIT 5.101, 45%). In six clinics, we found one or more of the following deficiencies: cleaning logs were not maintained, examination room cabinets had accumulated dirt and grime, and a clinic's restroom vent had accumulated dust.

Staff in five of 11 clinics (MIT 5.102, 45%) properly sterilized or disinfected medical equipment. In six clinics, we found one or more of the following deficiencies: staff did not mention disinfecting the examination table as part of their daily start-up protocol and did not change the examination table paper between patient encounters. In addition, staff did not date stamp and initial the packaging of sterilized medical equipment and did not regularly log sterilized reusable medical equipment. We also found compromised seals on the sterilized reusable medical equipment.

We found operating sinks and hand hygiene supplies in the examination rooms in nine of 11 clinics (MIT 5.103, 82%). The patient restrooms in two clinics lacked either antiseptic soap or disposable hand towels.

We observed patient encounters in nine clinics. In six clinics, clinicians did not wash their hands before or after examining their patients, before applying gloves, before performing blood draws, or after performing wound assessments (MIT 5.104, 33%). Health care staff in 11 clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 100%).

Photo 7. Recently completed health care facility improvement program room unable to accommodate an ADA patient (view 1, photographed 6/10/19).

Physical Infrastructure

At the time of the compliance inspection, LAC did not have any ongoing health care facility improvement program projects. However, health care executives expressed their concerns with the recently completed Americans With Disabilities Act (ADA) room in the CTC.

The executives reported that the measurement of the dedicated ADA room was not ADA compliant (see **Photo 7** and **Photo 8**). As a result, any patient needing ADA accommodations would be required to transfer to another institution (MIT 5.999).

Photo 8. Recently completed health care facility improvement program room unable to accommodate an ADA patient (view 2, photographed 6/10/19).

Recommendations

Medical staff should be reminded to follow appropriate infection control in clinical health care areas and with medical equipment.

Medical staff should be reminded to follow protocols for managing and storing bulk medical supplies.

Medical staff should be reminded to clean, sanitize, and disinfect clinical health care areas appropriately.

Medical staff should also be reminded to follow universal hand hygiene precautions. Implementing random spot checks may help with compliance.

Table 11. Health Care Environment

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	5	6	0	45%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	5	6	0	45%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	9	2	0	82%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	3	6	2	33%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	11	0	0	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)	2	9	0	18%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	3	8	0	27%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	10	0	1	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	4	7	0	36%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	1	8	2	11%
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): 45%

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

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

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(55%)

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 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 if staff transferred patients with their medical equipment and gave correct medications before patients left. In addition, our inspectors evaluated the ability of staff to communicate vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals; and inspectors confirmed if staff sent complete medication transfer packages to the receiving institution. For patients who returned from off-site hospitals or emergency rooms, inspectors reviewed whether staff appropriately implemented the recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

Results Overview

Compared with Cycle 5, LAC's performance worsened for this indicator. For patients transferring into the institution, our inspectors found incomplete initial nurse health screenings, a lack of medication continuity, and delayed pending specialty appointments. LAC performed acceptably for patients transferring out to other institutions. For patients returning from an off-site hospital, we identified a lack of medication continuity. All of these factors resulted in an ***inadequate*** rating for this indicator.

Case Review Results

The OIG clinicians reviewed cases in which patients transferred into or out of the institution, or returned from an off-site hospitalization or emergency room. Case reviewers identified 28 deficiencies, 11 of which were significant.[25]

Transfers In

We found LAC's medical process for patients transferring into the institution to be subpar. Compliance testing showed R&R nurses scored poorly when performing initial health screenings (MIT 6.001, 8%). Analysis of the compliance data showed that while most nurses completed the screening forms on time, they rarely completed the forms thoroughly.

25. Significant deficiencies occurred in cases 1, 2, 3, 23, 25, 26, 32, and 67.

Our case review found that R&R nurses evaluated newly arrived patients timely and performed adequate assessments.

Compliance testing showed poor medication continuity for newly arrived patients (MIT 6.003, 50%). Analysis of the compliance data showed that nurses administered some of the patient's daily medications twice, and did not document pertinent information on the medication administration record. Case review found that LAC did not ensure medication continuity in three out of five cases reviewed:

- In case 1, the patient did not receive his evening antibiotic and antiviral medications. In addition, he missed three doses of his acid reflux medication.
- In case 2, the patient with hypertension did not receive his blood pressure medications for almost two weeks. This placed the patient at risk for possible hypertension complications.
- In case 32, the patient with chronic lung disease arrived without his inhalers: a rescue inhaler for almost two weeks and a maintenance inhaler for two months. This placed the patient at risk for respiratory complications.

LAC provided sufficient provider follow-up for transfer-in patients (MIT 1.002, 79%). Our case review testing showed similar results. Four of the five high-risk patients received their appointments timely. There was one minor delay in provider follow-up:

- In case 33, the newly arrived high-risk patient was scheduled for a provider follow-up in seven days. However, the appointment occurred five days late.

Compliance testing also found that LAC performed poorly in scheduling timely specialty appointments for patients who transferred in with preapproved specialty referrals (MIT 14.001, 40%). Case review did not identify any missed or delayed preapproved specialty referrals.

Transfers Out

LAC's transfer-out process was acceptable. Case review testing found that the nurses performed face-to-face evaluations and transferred the patients with their durable medical equipment and medications. However, compliance testing found that the nurses transferred some patients without their durable medical equipment and did not record the status of the missing equipment on the transfer documents. Compliance testing also found missing essential medications from the transfer packet (MIT 6.101, 60%).

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high-risk for lapses in care. They can require more care and place strain on the institution's resources. Successful health information

transfer is necessary for good quality care. A lapse in care can result in serious consequences for these patients.

LAC did not perform well when patients returned from the hospital. Compliance testing found the continuity of hospital-recommended medications to be problematic (MIT 7.003, 24%). In contrast, compliance testing showed excellent provider follow-up after hospital discharges (MIT 1.007, 100%).

Our clinicians reviewed 44 hospital and emergency department return cases. We identified 22 deficiencies, nine of which were significant.[26] Most of these deficiencies were related to incomplete nursing assessments and lack of medication continuity. The following are examples:

- In case 7, the patient returned from the hospital with a diagnosis of pneumonia, and he did not receive his inhaler. This placed him at risk for respiratory complications. In addition, he received his antibiotic, anti-inflammatory, and hepatitis C medications a day late.
- In case 22, the patient returned from the hospital after having surgery. The nurse did not assess the patient's lungs or bowel sounds. In addition, the nurse documented that the patient's skin was intact, which was not reflective of the patient's condition, as the patient had abdominal staples.
- In case 25, the patient with glaucoma returned from the hospital, and he did not receive his eye drop medications until one month later. He also received the medication for his enlarged prostate 11 days late and his acid-reflux medication 16 days late.
- In case 26, the patient returned from the hospital after having abdominal surgery, and the nurse did not assess his bowel sounds.
- In case 30, the patient with hypertension returned from the hospital and received his blood pressure medication 19 days late. The patient also had a history of coccidioidomycosis (the fungal lung infection known as valley fever), and he received his antifungal medication two days late.

Compliance testing found that staff retrieved discharge documents timely (MIT 4.003, 85%), and the providers reviewed and signed the documents timely (MIT 4.005, 96%).

Clinician On-Site Inspection

Our inspectors interviewed the LAC nurses, who were knowledgeable about their job duties and the transfer process. We met with the nurse managers to discuss some of our findings, and they indicated they would provide additional education and training to their staff.

26. Significant events occurred in cases 1, 3, 7, 23, 25, 26, and 67.

Recommendations

Medical leadership should ensure that transfer-in and hospital-discharge patients receive medications timely.

Nursing leadership should remind nursing staff to perform complete assessments for patients returning from the hospital.

Please see the **Medication Management** indicator for further recommendations.

Compliance Testing Results

Table 12. Transfers

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	2	23	0	8%
For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	24	0	1	100%
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	9	9	7	50%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	3	2	0	60%
				Overall percentage (MIT 6): 55%

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

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

Table 13. Other Tests Related to Transfers

	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) *	19	5	1	79%
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) *	25	0	0	100%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	17	3	5	85%
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) *	24	1	0	96%
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) *	6	19	0	24%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	13	12	0	52%
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%
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) *	8	12	0	40%

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

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

Medication Management

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(28%)

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

Results Overview

Compared with Cycle 5, LAC did not perform well. We identified the following medication processes that showed room for improvement: the timely provision of newly prescribed medications, the continuity of chronic care medications, and the continuity of hospital-discharge medications. In addition, LAC did not ensure medication continuity for patients transferring into the institution. On the other hand, we found the following medication processes *adequate*: the continuity of medications for patients in the CTC and the monitoring of patients taking TB medications. Considering all these factors, the OIG rated this indicator ***inadequate***.

Case Review Results

The OIG clinicians reviewed 61 cases related to medication management and found 39 deficiencies, 10 of which were significant.[27]

New Medication Prescriptions

We found that staff did not administer new medications on time. Case review testing and compliance testing found that patients did not receive their newly prescribed medications timely (MIT 7.002, 48%).[28] The following are case review examples:

- In case 24, the patient had suffered a foot injury. The provider ordered a pain medication to start on the same day. However, the patient received the pain medication four days later, after he reported not receiving the medication.
- In case 25, the patient had a low potassium blood level. The provider ordered a potassium supplement to start on the same day, however, the patient received the medication two days late.

27. Significant deficiencies occurred twice in case 2, and once in cases 3, 7, 17, 23, 25, 26, 32, and 67.
28. Deficiencies occurred in cases 3, 7, 19, 22, 26, 30, and 49.

Chronic Care Medication Continuity

LAC had difficulty ensuring medication continuity for patients with chronic conditions. Our compliance testing showed patients often did not received their chronic care medications timely (MIT 7.001, 8%). Our case review testing also showed opportunities for improvement in 12 cases.[29] The following are case review examples:

- In case 3, the patient did not receive his folic acid for one month. The nurse noted the medication was not available.
- In case 17, the patient had high blood pressure. He did not receive his blood pressure medication for one month. This placed the patient at risk for possible complications from high blood pressure. The patient also had valley fever (a fungal lung infection) and did not receive his antifungal medication for one month.
- In case 25, the patient had chronic lung disease. He did not receive his maintenance inhalers for two months. This placed the patient at risk for respiratory complications.

Hospital-Discharge Medications

LAC did not ensure that patients received their medications recommended by the hospitalists on time. Compliance testing showed patients often did not receive their medications timely (MIT 7.003, 24%). Case review testing also confirmed these findings. Please refer to the **Transfer** indicator for additional details.

Specialized Medical Housing Medications

CTC patients generally received their medications timely. Although compliance testing showed some delays in medication delivery (MIT 13.004, 60%), the OIG clinicians found these delays were not clinically significant, since most patients only missed one dose of their medications.[30] Please refer to the **Specialized Medical Housing** indicator for additional details.

Transfer Medications

LAC did not adequately ensure medication continuity for patients transferring into the institution. Our compliance testing showed poor medication continuity, and our case review testing showed similar results (MIT 6.003, 50%).

LAC's transfer-out process was acceptable. Our case review testing showed that all patients transferred with a five-day supply of medications. However, our compliance testing showed that LAC did

29. Deficiencies occurred in cases 2, 3, 7, 9, 10, 17, 19, 20, 21, 25, 26, and 60.
30. During our case review, we found three deficiencies in one case (case 21).

not always transfer patients with their medications (MIT 6.101, 60%). Please refer to the **Transfers** indicator for additional details.

Medication Administration

Case review testing found that LAC nurses administered medications properly in most cases, except in the following two cases:

- In case 3, the nurse incorrectly administered a heart medication twice in the morning and did not administer the evening dose. On numerous occasions, the nurses administered the blood pressure medication without following the provider's ordered parameters.
- In case 21, the provider requested that the patient's heart medication be held when his heart rate dropped below 50 beats per minute. However, the patient's heart rate was 82 beats per minute, and the nurse did not administer the medication.

OIG compliance testing examined how LAC staff administered and monitored patients taking TB medications. Nurses correctly administered TB medications as prescribed (MIT 9.001, 91%). However, the nurses often did not monitor these patients correctly (MIT 9.002, 9%). LAC nurses did not fully document TB symptoms for monitoring.

Clinician On-Site Inspection

We interviewed medication nurses, who were knowledgeable about the medication process and their patient population. These nurses attended the clinic huddles and notified the providers of expiring medications and medication refusals. Some medication nurses reported that the electronic health record system helped decrease medication errors. We met with the pharmacists and nurse managers to discuss some of our findings. LAC reported that new systems and training were implemented to help improve the medication process.

Recommendations

Medical and pharmacy leadership should ensure that chronic care, transfer-in, and hospital-discharged patients receive medications timely. Hospital medications should be timely reconciled.

Medical and pharmacy leadership should ensure proper storage of all medications.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in three of 10 clinic and medication line locations (MIT 7.101, 30%). In seven locations, we found one or more of the following deficiencies: narcotics inventory was not performed by two licensed nursing staff; nurses did not verify the proper destruction of controlled substances; nurses did not record the administration date, time, dose to be administered, or document the patient's institutional number, or failed to sign the narcotics logbook; and nurses did not store narcotic medications under double lock when not in active use. In addition, one clinic was not free of discrepancy when we performed a spontaneous count with the pharmacist. In addition, one clinic had an extra narcotic medication when compared against the inventory report during the spontaneous count with the pharmacist.

LAC did not appropriately store and secure nonnarcotic medications in any of its clinic and medication line locations (MIT 7.102, 0%). In 11 locations, we identified one or more of the following deficiencies: medication carts and a refrigerator remained unlocked when not in active use, the medication area lacked a designated area for medications to be returned to the pharmacy, the medication area lacked storage space for medications, and the clinic did not have an effective inventory process to account for all medications stored in the Omnicell. In addition, our inspectors and LAC pharmacists found the actual number of medications stored did not match the Omnicell inventory report when we compared the actual count against the inventory report.

Staff kept medications protected from physical, chemical, and temperature contamination in three of the 11 clinic and medication line locations (MIT 7.103, 27%). In eight locations, we found one or more of the following deficiencies: staff did not separate storage of oral and topical medications, staff did not consistently record the room and refrigerator temperature, and staff stored food in the medication preparation area and medication refrigerator.

Staff successfully stored valid, unexpired medications in two of the 10 applicable medication line locations (MIT 7.104, 20%). In eight locations, the following deficiencies occurred: nurses did not label the multiple-use medication with the date it was opened, nurses did not label a multiple-use medication vial 28 days from the date the medication was opened or according to manufacturer guidelines, nurses did not store liquid solutions according to manufacturer guidelines, and expired medication was found stored in the clinic.

Nurses exercised proper hand hygiene and contamination control protocols in seven of eight locations (MIT 7.105, 88%). In one clinic, we observed that nurses neglected to wash or sanitize their hands before each subsequent regloving.

Staff in six of eight medication preparation and administration areas demonstrated appropriate administrative controls and protocols during medication preparation (MIT 7.106, 75%). In one location, the nurse did not maintain unissued medication in its original labeled packaging. In another location, when interviewed, staff could not articulate the policy requirement concerning the reconciliation process of new medications received from the pharmacy with the physicians' orders.

Staff in three of eight medication preparation and administration areas demonstrated appropriate administrative controls and protocols during medication administration (MIT 7.107, 38%). In five locations, we observed one or more of the following deficiencies: the medication nurses did not reliably observe patients while they swallowed or injected direct observation therapy medications; medication nurses did not appropriately administer medication as ordered by the provider; the medication nurse failed to scan several patients' medications prior to administration; a supervising nurse, when interviewed, could not articulate the steps required by policy in reporting a medication error to the pharmacist-in-charge; a nurse did not document the accurate injection location in the medication administration record summary; a nurse was unable to identify the medication expiration date prior to administration; and nurses did not follow insulin protocols properly. When handling insulin prior to administration, medication nurses must verify the insulin was kept in the refrigerator according to the manufacturers' temperature guidelines, and they must perform a quality control check of the glucometer before performing a patient's diabetic line.

In addition to the above findings, our compliance inspectors observed the following issues with medication practices or storage during their on-site inspection:

- The OIG inspector observed a specialty provider administering an expired eye drop solution. In several other instances, we also found expired medications being administered to patients. Medication error reports were generated as a result of these findings that had not been discovered before this medical inspection.

Pharmacy Protocols

LAC did not follow general security, organization, and cleanliness management protocols in its main and remote pharmacies. We observed the following deficiencies: the pharmacists did not lock the narcotics storage area when not in active use and left the key unsecured, and pharmacists did not separately store oral and topical medications. As a result, the institution scored zero percent in this test (MIT 7.108).

In its pharmacy, LAC did not properly store nonrefrigerated medication. We found expired medications stored in the pharmacy. In addition, we found personal food items belonging to staff stored within the medication preparation area. As a result, the institution scored zero percent in this test (MIT 7.109).

The institution did not properly store refrigerated or frozen medications in the pharmacy. The pharmacy monitored and recorded the refrigerator and freezer temperatures once a day. However, the CCHCS Health Care Department Operations Manual required temperatures shall be monitored twice daily during hours of operation. In addition, staff did not separately store oral and topical medication pending to be restocked or reissued. As a result, the institution scored zero percent in this test (MIT 7.110).

The pharmacist-in-charge also did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the pharmacist did not correctly complete several medication area inspection checklists (CDCR Form 7477). These errors resulted in a score of zero percent in this test (MIT 7.111).

We examined 24 medication error reports. The pharmacist-in-charge timely or correctly processed only five of these 24 reports (MIT 7.112, 21%). For 19 reports, we found one or more of the following deficiencies:

- the pharmacist-in-charge did not document pertinent data relating to the error,
- the pharmacist-in-charge did not notify the patient or the prescribing physician of the medication error,
- the pharmacist-in-charge did not document the recommended changes to correct the medication error, and
- the pharmacist-in-charge did not provide documentation that a pharmacy follow-up review was performed.

Nonscored Tests

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

The OIG interviewed patients in isolation units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Eight of 10 applicable patients interviewed indicated they had access to their rescue medications. Two patients did not have their rescue inhalers on their person. One patient indicated that custody staff took his inhaler along with his property, while the other patient refused to cooperate with the interview. We promptly notified LAC's CEO of the concern, and health care management immediately reissued replacement inhalers to both patients (MIT 7.999).

Table 14. Medication Management

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001) *	2	22	1	8%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	12	13	0	48%
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) *	6	19	0	24%
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) *	13	12	0	52%
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%
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)	3	7	2	30%
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)	0	11	1	0
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	3	8	1	27%
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)	2	8	2	20%
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)	7	1	4	88%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	6	2	4	75%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	3	5	4	38%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	0	1	0	0%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	0	1	0	0%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	1	0	0%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	5	19	0	21%
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 isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 7): 28%

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

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

Table 15. Other Tests Related to Medication Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	9	9	7	50%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	3	2	0	60%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	10	1	0	91%
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) *	1	10	0	9%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	6	4	0	60%

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

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

Preventive Services

Overall Rating ***Inadequate***

Case Review Rating **(N/A)**

Compliance Score ***Inadequate*** **(68%)**

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. If the department designated the institution as high risk for coccidioidomycosis (valley fever), our inspectors tested the institution's ability to transfer out patients quickly. The OIG rated this indicator solely based on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. OIG case review clinicians do not rate this indicator.

Recommendations

Nursing leadership should remind nursing staff to fully document and address all TB symptoms in their monitoring assessments.

Compliance Testing Results

Table 16. Preventive Services

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	10	1	0	91%
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)	1	10	0	9%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	7	18	0	28%
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 50 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	25	0	0	100%
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)	8	2	15	80%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 9): 68%

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

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

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

Nursing Performance

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses (RNs), licensed vocational nurses (LVNs), psychiatric technicians (PTs), and certified nursing assistants (CNAs). Our clinicians evaluated nurses' ability to make timely and appropriate assessments and interventions. We also evaluated the institution's nurses' documentation for accuracy and thoroughness. Clinicians reviewed nursing performance in 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 overall nursing performance, our clinicians understand that nurses perform numerous aspects of medical care. As such, specific nursing quality issues are discussed in other indicators, such as **Emergency Services**, **Specialty Services**, and **Specialized Medical Housing**.

Results Overview

LAC nurses generally delivered acceptable nursing care. However, our clinicians identified opportunities for improvement in several areas of the nursing process described in the subcategories below. These nursing process errors did not appear to place patients at significant risk of harm. Considering all these factors, the OIG rated this indicator ***adequate***.

Case Review Results

The OIG clinicians reviewed 344 nursing encounters in 62 cases. Of the nursing encounters we reviewed, 186 were in the outpatient setting. We identified 151 nursing deficiencies, most of which were considered minor, but 13 were significant.[31]

Nursing Assessment and Intervention

Generally, LAC nurses provided timely assessments and appropriate interventions. Nonetheless, LAC nurses occasionally did not thoroughly evaluate their patients. Fortunately, most of the time this did not impact their patients' outcomes. The following are examples:

- In case 3, on numerous occasions, the nurses administered a heart medication without first checking the patient's heart rate and blood pressure as ordered by the provider.
- In case 26, the patient complained of bloody stools. The nurse did not thoroughly assess the patient's abdomen. In addition, the

31. Significant deficiencies occurred twice in cases 1, 3, and 66. Significant deficiencies occurred once in cases 10, 19, 25, 26, 27, 58, and 60.

nurse did not thoroughly review the patient's record, and thus did not recognize that the patient had refused his medication for inflammatory bowel disease.

- In case 58, the patient had an infected ankle wound. He complained of increased pain, swelling, and stiffness. The nurse did not thoroughly assess the patient's ankle.

Nursing Documentation

LAC nurses did not always document thoroughly and consistently, especially in the areas of wound care. The following are examples of poor documentation:

- In case 18, the nurses noted wound care was completed. However, the nurses did not document the appearance of the wound.
- In case 19, the nurses did not consistently document the size of the patient's wound or the appearance of the drainage.
- In case 22, the patient was scheduled for wound care. The nurse noted vital signs, but did not document the appearance of the wound.

Nursing Sick Call

Our clinicians reviewed 95 sick call requests. The clinic nurse saw an average of 12 patients per day, and the staff reported no nursing appointment backlog. Most nurses performed timely evaluations for patients with symptoms. However, we found clinic nurses did not always perform thorough assessments. Most deficiencies did not affect the patients' care. The following are examples:

- In case 53, the patient complained of hip and leg pain. The nurse did not evaluate the patient's lower extremity strength or the steadiness of his gait.
- In case 59, the patient complained of a large, sore bump between his eyes. The nurse noted the patient had a mass on his forehead without measuring or indicating the size of the mass. In addition, the nurse noted a provider follow-up would be initiated. However, the nurse did not order the appointment.

Emergency Services

The first medical responder and TTA nurses displayed opportunities for improvement in the areas of assessment, interventions, and documentation. These are discussed in the **Emergency Services** indicator.

Transfers

LAC nurses evaluated newly arrived patients timely, but did not always complete the initial health screening form thoroughly. In addition,

nurses performed incomplete nursing assessments for patients who returned from a community hospital. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

CTC nurses performed timely assessments and evaluated their patients frequently. However, we found deficiencies in the areas of assessment and intervention. Please refer to the **Specialized Medical Housing** indicator for additional details.

Specialty Services

The nurses generally provided appropriate care for patients returning from off-site specialty and telemedicine appointments. However, the nurses did not always provide requested records to the specialist. Please refer to the **Specialty Services** indicator for additional details.

Medication Management

The nurses generally administered medications properly. The **Medication Management** indicator provides further information.

Clinician On-Site Inspection

The OIG clinicians spoke with nurses in the TTA, CTC, R&R, specialty services, utilization management, outpatient clinics, and medication areas. We attended organized clinic huddles. The clinic staff was knowledgeable and familiar with their patient population. We also attended a well-organized population health management meeting that focused on the management of chronic medical conditions such as diabetes and hypertension.

We also met with the nurse managers to discuss some of our case review findings. The managers acknowledged several opportunities for improvement and planned to implement training based on our findings. The nurses reported that their supervisors were supportive and available when needed.

Recommendations

Nursing leadership should remind nursing staff to provide complete patient assessments in outpatient clinics.

Nursing leadership should remind nursing staff to completely document wound care.

Provider Performance

In this indicator, OIG case review clinicians evaluated the quality of care the institution's providers (physicians, physician assistants, and nurse practitioners) delivered. Our clinicians assessed the institution's providers' ability to evaluate, diagnose, and manage 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. The OIG assessed provider care through case review only and performed no compliance testing for this indicator.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

Results Overview

LAC providers delivered good patient care. They generally made appropriate assessments and decisions, and performed well in managing chronic medical conditions and in reviewing medical records. There were occasions when the providers did not appropriately reconcile the patient's medications. These errors were not widespread. The OIG rated this indicator ***adequate.***

Case Review Results

In our inspection, we found a total of 31 deficiencies. Of these, six were significant.[32] In addition, the OIG clinicians examined the care quality in 25 comprehensive case reviews.

Assessment and Decision-Making

In most cases, LAC providers made appropriate assessments and sound medical plans. They generally diagnosed medical conditions correctly, ordered appropriate tests, and referred their patients to proper specialists. The OIG clinicians identified only two significant deficiencies related to poor decision making:

- The two significant deficiencies were in case 19, as the provider made a poor decision in managing the patient's acute anemia (low blood count) and did not address the positive fecal occult blood test (FOBT) appropriately. The patient was also taking nonsteroidal anti-inflammatory drugs (NSAIDs), which can worsen a potential gastrointestinal bleed. The decrease in the patient's hemoglobin in combination with the positive FOBT should have raised the concern for an acute gastrointestinal bleed. The provider did not address the drop in the hemoglobin or refer the patient to a gastrointestinal specialist to evaluate the anemia. In addition, the provider did not stop the aspirin and NSAIDs, which can worsen a potential gastrointestinal bleed.

32. Significant deficiencies occurred twice in cases 19 and 26, and once in cases 1 and 23.

Review of Records

LAC providers generally performed well in reviewing medical records when patients returned from hospitalizations or specialty appointments. OIG clinicians identified only one significant deficiency related to reviewing a hospital record:

- In case 1, while in the hospital, the patient had a new lung lesion, which was biopsied. The provider did not review the hospital-discharge note or follow up on the lung biopsy pathology report to determine if the lung lesion was benign. Furthermore, a repeat chest X-ray three weeks after the hospitalization showed that the patient's previously known lung nodule had increased in size, and the provider did not act upon this finding.

LAC providers generally performed well in reviewing the medication administration record and in reconciling patients' medications. However, OIG clinicians identified two significant deficiencies related to the provider not reviewing the medication administration record or continuing a patient's essential medications:

- In case 23, the patient returned from hospitalization for a sickle cell crisis, and the provider did not restart his sickle cell medications. Subsequently, two weeks later, the patient presented with another sickle cell crisis.
- In case 26, the provider did not review the medication administration record adequately and thus did not renew the patient's antifungal medication for disseminated coccidioidomycosis (valley fever, a widespread fungal infection). Subsequently, the patient developed a neck abscess due to disseminated coccidioidomycosis, requiring antifungal medication indefinitely.

Emergency Care

LAC providers generally made appropriate triage decisions when patients presented emergently to the TTA. In addition, the providers were available for consultation with the TTA nursing staff. We did not identify any significant provider deficiencies in emergency care.

Chronic Care

LAC providers performed well in managing chronic medical conditions such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease.

LAC had an effective Coumadin (blood thinning medication) clinic to manage patients on anticoagulants. A clinical pharmacist working with a provider appropriately monitored the INR (a blood test used for monitoring how well the body clots blood) and adjusted oral anticoagulants.

Specialty Services

LAC providers generally referred appropriately and reviewed specialty reports timely. The providers also timely addressed the specialist's recommendations. OIG clinicians identified only one significant deficiency:

- In case 26, the ophthalmologist treated the patient for a corneal ulcer and recommended that the patient follow up in one week for reassessment. The provider did not order the recommended specialty follow-up.

Documentation Quality

LAC providers generally documented outpatient and TTA encounters on the same day. Most progress notes were dictated.

Provider Continuity

LAC providers were assigned to specified clinics to ensure continuity of care. Two providers were assigned to each clinic, so they both were familiar with all the patients. During the period of review, the OIG clinicians did not identify any significant issues related to provider continuity.

Clinician On-Site Inspection

At LAC, the morning huddles were organized and led by providers, and were attended by nurses, laboratory technicians, office technicians, custody staff, and care coordinators. The team discussed patients who returned from hospitalization or a specialty appointment with their respective recommendations. The nurses also informed the provider of expiring medications.

OIG clinicians attended a weekly provider meeting. The chief physician and surgeon discussed a proposition for a standardized pre-visit questionnaire for all patients. The providers reviewed the assessment for disabilities such as hearing, vision, and mobility impairment. The providers also discussed possible improvements for the provider line.

OIG clinicians also attended a population health management meeting, which was conducted by the chief physician and surgeon. The providers identified patients with elevated blood sugar levels suggestive of poorly controlled diabetes and discussed approaches to reach diabetic goals for these patients. The providers also identified patients who were not compliant, and the unit psychiatrist suggested approaches to manage these difficult patients.

At the time of the OIG inspection, LAC had 11 full-time providers with one vacancy. The providers were enthusiastic about their work and were generally satisfied with nursing, diagnostic, and specialty services. The chief medical executive and the chief physician and surgeon were committed to patient care and to collaborating with the providers for quality improvement. The providers were supportive of the chief medical executive and the chief physician and surgeon, and overall morale was good.

Recommendations

The chief physician and surgeon should remind providers to thoroughly reconcile medications for patients returning from hospitalizations.

Specialized Medical Housing

In this indicator, OIG inspectors evaluated whether the institution follows appropriate policies and procedures when admitting patients to on-site inpatient facilities, including completion of timely nursing and provider assessments. The case review assesses all aspects of medical care related to these housing units, including quality of provider and nursing care. At the time of our inspection, LAC's only specialized medical housing unit was a CTC.

Overall Rating ***Adequate***

Case Review Rating ***Adequate***

Compliance Score ***Adequate*** **(84%)**

Results Overview

The compliance testing showed that LAC scored well in this indicator. The OIG clinicians found that LAC providers saw their patients in the CTC timely and provided adequate care. The nurses performed timely admission assessments and generally provided acceptable care. Some of the nurses' assessments were incomplete, and the nurses also did not always implement the provider orders. Overall, the OIG rated this indicator ***adequate***.

Case Review Results

The OIG clinicians reviewed eight CTC cases, which included 27 provider events and 18 nursing events. We identified 14 deficiencies, two of which were significant. The two significant events occurred in one case.[33]

Provider Performance

LAC providers delivered good care. The providers performed thorough evaluations, made sound medical plans, and reviewed test results and consultations timely. The compliance testing showed that the providers completed all the admission history and physical examinations without delay (MIT 13.002, 100%) and rounded on patients at clinically appropriate intervals (MIT 13.003, 78%). The OIG clinicians reviewed 27 provider encounters and did not identify any deficiencies related to provider performance.

Nursing Performance

The CTC nurses performed timely admission assessments on the day of admission (MIT 13.001, 80%). Case review also showed that the nurses completed admission assessments on time.

33. Significant deficiencies occurred in case 66.

The CTC nurses conducted regular rounds and generally provided good care. However, at times, the nurses' assessments were incomplete and the nurses did not always implement the providers' orders. The following are case review examples:

- In case 66, the patient had a PICC line (an invasive intravenous line). The CTC nurses did not change the patient's PICC line dressing every seven days as ordered by the provider. The patient also had a urinary catheter, and the nurses did not change the catheter within 30 days. Furthermore, the patient had multiple wounds, and the nurses did not consistently perform daily wound care as ordered by the provider. These assessments fell below nursing standards of care, which placed the patient at greater risk for infection.
- In case 68, the patient with a recent coronary artery bypass graft complained of shortness of breath, and the CTC nurse did not use a stethoscope to listen to the patient's lung sounds.

Medication Administration

The compliance testing showed that newly admitted patients sometimes missed doses of their medications (MIT 13.004, 60%). However, when the OIG clinicians reviewed the data, we found that the delays were not clinically significant. We identified three minor opportunities for improvement in our case review testing. The following is a case review example:

- In case 21, the patient was discharged from the CTC to a housing unit, and his pain medication was not reviewed or renewed. Subsequently, the patient missed five doses.

Clinician On-Site Inspection

The CTC had 16 medical beds, two of which were negative pressure rooms for respiratory isolation. At the time of our inspection, eight patients occupied the 16-bed unit. Our compliance testing found that the call light system was functional and working.

LAC had a designated CTC provider who made daily rounds with nursing staff and weekly grand rounds with the chief physician and surgeon. The provider expressed satisfaction with the nursing staff and the ancillary services. When the designated provider was not available, other LAC providers delivered patient care in the CTC.

Recommendations

We offer no specific recommendations for this indicator.

Compliance Testing Results

Table 17. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Prior to 4/2019: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice? Effective 4/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001) *	8	2	0	80%
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	10	0	0	100%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *, †	7	2	1	78%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	6	4	0	60%
For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells? (13.101) *	1	0	0	100%
				Overall percentage (MIT 13): 84%

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

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

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

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(75%)

Specialty Services

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

Results Overview

LAC provided satisfactory specialty services for its patients. LAC is designated as an intermediate facility with many clinically complex patients requiring multiple specialty services. Because of this, LAC has robust specialty services. During case review, the OIG clinicians often encountered complex patients requiring multiple specialty services. One patient saw 10 different specialists. LAC specialty staff performed well in coordinating multiple specialty service appointments for these complex patients. LAC scored poorly in compliance testing; however, the OIG clinicians reviewed a higher number of events and found that most specialty appointments were completed timely, and most specialty reports were timely retrieved. The OIG rated this indicator ***adequate***.

Case Review Results

OIG clinicians reviewed 217 events related to **Specialty Services**, including 142 specialty consultations and procedures. There were 41 deficiencies in this category, only five of which were significant.[34]

Access to Specialty Services

Compliance testing showed that all samples of routine-priority specialty appointments were completed timely (MIT 14.007, 100%), but less than half of the high-priority specialty appointments were completed timely (MIT 14.001, 40%). Patients transferred into LAC with preapproved specialty services; less than half of their specialty appointments were completed timely (MIT 14.010, 40%).

OIG case reviewers identified good specialty access at LAC. We reviewed a higher number of specialty events—142 high- and routine-priority specialty appointments—and found only five deficiencies. One was considered significant, and this deficiency was discussed in the **Access to Care** indicator.[35] The OIG clinicians also assessed five transfer-in cases and did not identify any missed or delayed specialty appointments.

34. Significant deficiencies occurred twice in case 27 and once in cases 25, 26, and 68.
35. A significant deficiency occurred in case 68.

Provider Performance

LAC providers generally referred appropriately, reviewed specialty reports timely, and addressed the specialist recommendations. The OIG clinicians identified one significant deficiency related to a provider who did not address a specialist's recommendation.[36] This deficiency is discussed in the **Provider Performance** indicator.

Nursing Performance

LAC specialty nurses reviewed requests for specialty services and appropriately arranged for specialty appointments. The TTA nurses generally made appropriate assessments and interventions for patients returning from off-site and telemedicine specialty appointments. The nurses also informed the providers of the specialists' recommendations, obtained orders, and scheduled timely provider follow-up appointments. However, the specialty nurses did not always provide pertinent patient records for the specialist to review.[37] The OIG clinicians reviewed 75 nursing encounters related to specialty services and identified 20 deficiencies. Only one was considered significant as follows:

- In case 27, the thoracic surgeon evaluated the patient for a lung mass and documented that the patient arrived without CT scan reports. The specialty nurses did not provide the requested studies for the surgeon to review at the time of the visit. This resulted in a suboptimal consultation.

Health Information Management

LAC performed adequately in retrieving and in reviewing the specialty reports. While compliance testing showed that high-priority specialty reports were not always promptly retrieved and reviewed (MIT 14.002, 47%), most routine-priority specialty reports were retrieved and reviewed in a timely manner (MIT 14.008, 87%). The OIG clinicians identified 10 deficiencies related to health information management, nine of which were not clinically significant. Only two case reviews were considered significant:

- In case 25, the patient had a nuclear myocardial perfusion scan,[38] and the medical staff did not retrieve the report.
- In case 27, the thoracic surgeon saw the patient for a lung mass, but the medical staff did not retrieve the high-priority consultation report until 13 days later.

36. A significant deficiency occurred in case 26.
37. Deficiencies occurred in cases 3, 21, and 27.
38. The nuclear myocardial perfusion scan is a radioactive stress-imaging test used to show how well blood flows through the heart muscle. This is in contrast to the myocardial treadmill test whereby the patient actively runs on a treadmill, which indirectly shows how well blood flows through the heart muscle by monitoring the electrocardiogram (EKG) measurement during the run.

Clinician On-Site Inspection

LAC used numerous off-site and telemedicine specialty services. The specialty nurses processed on average 20 specialty appointments daily. The specialty office technician tracked and retrieved specialty reports. LAC staff stated that some specialists did not provide dictated consultations; however, these specialists always provided handwritten reports with recommendations on the same day of consultation. Some specialists even communicated with the specialty nurses or providers to discuss their recommendations.

Recommendations

Medical leadership should evaluate processes to ensure completion of high-priority specialty referrals and timely retrieval of high-priority specialty reports.

Medical leadership should ensure timely completion of preapproved specialty services for transfer-in patients.

Medical leadership should remind the specialty nurses to provide pertinent medical records for the specialists to review at specialty appointments.

Compliance Testing Results

Table 18. Specialty Services

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	6	9	0	40%
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) *	7	8	0	47%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	12	0	3	100%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004) *	N/A	N/A	N/A	N/A
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) *	N/A	N/A	N/A	N/A
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	N/A	N/A	N/A	N/A
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) *	15	0	0	100%
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) *	13	2	0	87%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	4	0	11	100%
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) *	8	12	0	40%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	15	5	0	75%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	17	3	0	85%
			Overall percentage (MIT 14):	75%

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

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

Table 19. Other Tests Related to Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *, †	22	7	1	76%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	14	6	10	70%

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

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

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

Administrative Operations

Overall Rating ***Inadequate***

Case Review Rating **(N/A)**

Compliance Score ***Inadequate*** **(68%)**

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 if the institution conducted the required emergency response drills. Inspectors also assessed whether the Quality Management Committee (QMC) met regularly and addressed program performance adequately. In addition, the inspectors examined if the institution provided training and job performance reviews for its employees. They checked whether staff possessed current, valid professional licenses, certifications, and credentials. The OIG rated this indicator solely based on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians typically do not rate this indicator.

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

Recommendations

The EMRRC should ensure the checklist form in the incident package is fully completed.

Nonscored Results

We obtained CCHCS Death Review Committee (DRC) reporting data. Eight unexpected (Level 1) deaths occurred during our review period. The DRC must complete its death review summary report within 60 calendar days of the death. When the DRC completes the death review summary report, it must submit the report to the institution's CEO within seven calendar days after completion. In our inspection, we found the DRC did not complete any death review reports promptly; the DRC finished four reports 55 to 156 days late, respectively, and submitted them to the institution's CEO 67 to 165 days after that. The remaining four reports were overdue at the time of the OIG's inspection (MIT 15.998).

Compliance Testing

Table 20. Administrative Operations

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	0	0	1	N/A
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	3	9	0	25%
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)	1	3	0	25%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the inmates' grieved issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103)	7	3	0	70%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	9	1	0	90%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	8	3	0	73%
Did the providers maintain valid state medical licenses? (15.106)	12	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? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information.			
				Overall percentage (MIT 15): 68%

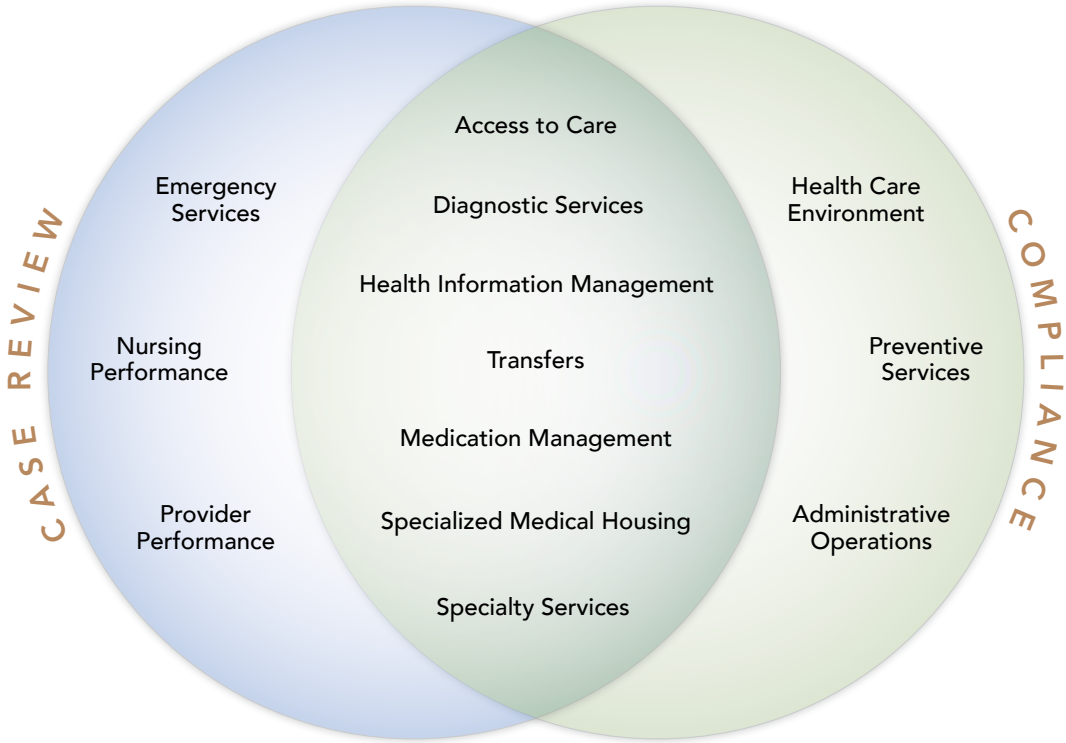
Source: The Office of the Inspector General medical inspection results.

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 LAC



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

Case Reviews

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

Table A–1. Case Review Definitions

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

The OIG eliminates case review selection bias by sampling using a rigid methodology. No case reviewer selects the samples he or she reviews. Because the case reviewers are excluded from sample selection, there is no possibility of selection bias. Instead, nonclinician 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 standardized protocol and select samples for clinicians to review. Samples are obtained per the case review methodology shared with stakeholders in prior cycles. Our physician and nurse reviewers test the samples by performing comprehensive or focused case reviews.

Case Review Testing Methodology

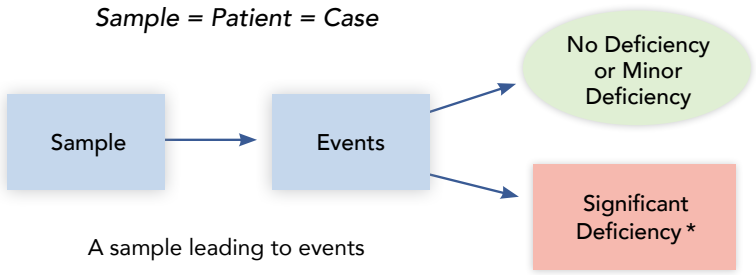
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

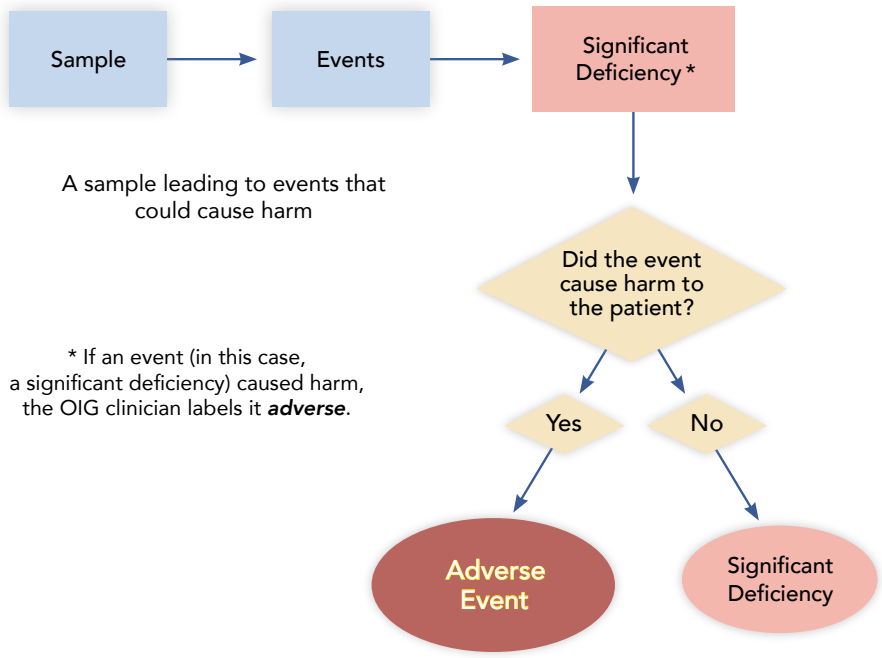
Figure A–2. Case Review Testing

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***.



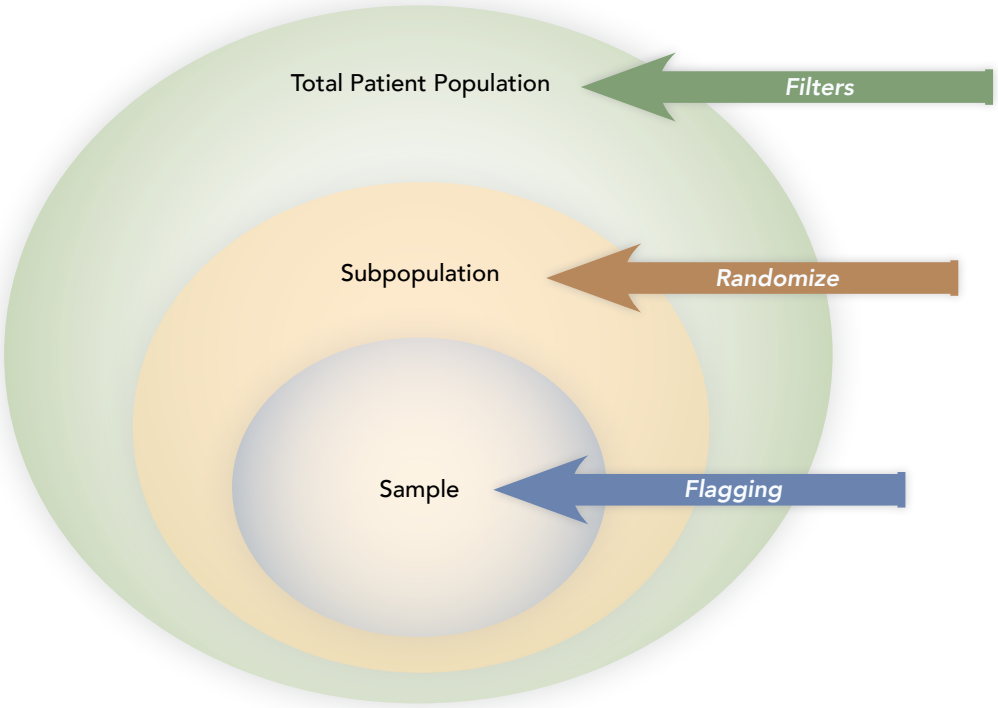
Source: The Office of the Inspector General medical inspection analysis.

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 also 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*** (greater than 85 percent), ***adequate*** (between 75 percent and 85 percent), or ***inadequate*** (less than 75 percent).

Indicator Ratings and the Overall Medical Quality Rating

To reach an overall quality rating, our inspectors collaborate and examine all the inspection findings. We consider the case review and the compliance testing results for each indicator. After considering all the findings, our inspectors reach consensus on an overall rating for the institution.

Appendix B: Case Review Data

Table B–1. Case Review Sample Sets

Anticoagulation	3
CTC/OHU	4
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	28
Specialty Services	4
	68

Table B–2. Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	7
Anticoagulation	3
Arthritis/Degenerative Joint Disease	8
Asthma	19
COPD	8
Cancer	9
Cardiovascular Disease	3
Chronic Kidney Disease	28
Chronic Pain	14
Cirrhosis/End-Stage Liver Disease	4
Coccidioidomycosis	2
Deep Venous Thrombosis/Pulmonary Embolism	17
Diabetes	7
Gastroesophageal Reflux Disease	16
Gastrointestinal Bleed	2
HIV	3
Hepatitis C	33
Hyperlipidemia	25
Hypertension	34
Mental Health	21
Migraine Headaches	0
Rheumatological Disease	3
Seizure Disorder	6
Sleep Apnea	1
Thyroid Disease	3
	285

Table B–3. Case Review Events by Program

Diagnosis	Total
Diagnostic Services	250
Emergency Care	42
Hospitalization	44
Intrasystem Transfers In	5
Intrasystem Transfers Out	5
Not Specified	2
Outpatient Care	479
Specialized Medical Housing	60
Specialty Services	307
	1,194

Table B–4. Case Review Sample Summary

MD Reviews Detailed	25
MD Reviews Focused	0
RN Reviews Detailed	16
RN Reviews Focused	41
Total Reviews	82
Total Unique Cases	68
Overlapping Reviews (MD & RN)	14

Appendix C: Compliance Sampling Methodology

California State Prison, Los Angeles County

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)	35	MedSATS	• 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	30	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	20	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	20	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	20	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	23	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	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	11	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	5	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	14	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	Isolation Unit KOP Medications	1	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation 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	11	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 (51 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary)	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–008	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–004	Specialized Health Care Housing Unit	10	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MIT 13.101	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	MedSATS	• Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	N/A	MedSATS	• Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	MedSATS	• Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MIT 14.010	Specialty Services Arrivals	20	MedSATS	• 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
		None	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.001	N/A	—	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	2	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	11	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	12	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff ◦ Providers (ACLS) ◦ Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
	Nursing Staff New Employee Orientations	All		
	Death Review Committee	10		
MIT 15.110			Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998			OIG summary log: deaths	• Between 35 business days & 12 months prior • Health Care Services death reviews

California Correctional Health Care Services' Response

March 20, 2020

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

Dear Mr. Wesley:

Due to the situation with COVID-19, California State Prison, Los Angeles County is unable to review the draft report of the Office of the Inspector General (OIG) Medical Inspection Results conducted from June to September 2020. Although it is likely LAC may have potential disputes with the OIG findings, all resources are currently focused on direct patient care and containment of the coronavirus. The Office of the Receiver has reviewed the draft report for LAC and CCHCS will acknowledge the OIG findings.

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

Sincerely,

DeAnna Gouldy
Associate Director
Risk Management Branch
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Katherine Tebrock, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
Duane Reeder, Director (A), Health Care Policy and Administration, CCHCS
R. Steven Tharratt, M.D., M.P.V.M., FACP, Director, Health Care Operations, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Lara Saich, Deputy Director, Policy and Risk Management Services, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director (A), Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, Clinical Information and Improvement Services, CCHCS
Christopher Podratz, Regional Health Care Executive, Region III, CCHCS
Felix Igbinosa, M.D., Regional Deputy Medical Executive, Region III, CCHCS
Sherry Robeson-Loftis, R.N., Regional Nursing Executive, Region III, CCHCS
Christina Galstian, Ph.D., Chief Executive Officer, LAC
Amanda Oltean, Staff Services Manager II, Program Compliance Section, CCHCS
Allan Blackwood, Staff Services Manager I, Program Compliance Section, CCHCS
Misty Polasik, Staff Services Manager I, OIG

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

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Cycle 6
Medical Inspection Report

for

California State Prison
Los Angeles County

OFFICE *of the*
INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
July 2020

OIG