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Independent Prison Oversight

June 2024

Cycle 7 Medical Inspection Report

Wasco State
Prison



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Introduction

Pursuant to California Penal Code section 6126 et seq., the Office of the Inspector General (the OIG) is responsible for periodically reviewing and reporting on the delivery of the ongoing medical care provided to incarcerated people¹ in the California Department of Corrections and Rehabilitation (the department).²

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

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

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

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

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

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

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

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

We completed our seventh inspection of the institution, and this report presents our assessment of the health care provided at this institution during the inspection period from July 2022 to December 2022.⁴

⁴ Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between November 2021 and March 2022, anticoagulation review between January 2023 to March 2023, and emergency cardiopulmonary (CPR) reviews between March 2022 and June 2022.

Summary: Ratings and Scores

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



The OIG rated the case review component of the overall health care quality at WSP *inadequate*.



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

OIG clinicians (a team of physicians and nurse consultants) reviewed 54 cases, which contained 925 patient-related events. They performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our OIG clinicians acknowledged institutional structures that catch and resolve mistakes that may occur throughout the delivery of care. After examining the medical records, our clinicians completed a follow-up on-site inspection in May 2023 to verify their initial findings. The OIG physicians rated the quality of care for 18 comprehensive case reviews. Of these 18 cases, our physicians rated 14 *adequate* and four *inadequate*. Our physicians found no adverse events during this inspection.

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 418 patient records and 1,336 data points, and used the data to answer 100 policy questions. In addition, we observed WSP's processes during an on-site inspection in February 2023.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in 14 health care indicators.⁵

⁵ The indicator for **Prenatal and Postpartum Care** did not apply to WSP.

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

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

MIT Number	Health Care Indicators	Ratings			Scoring Ranges		
		Proficient	Adequate	Inadequate	100% – 85.0%	84.9% – 75.0%	74.9% – 0
		Case Review		Compliance			
		Cycle 7	Change Since Cycle 6*	Cycle 7	Cycle 6	Change Since Cycle 6*	
1	Access to Care	Adequate	↓	82.1%	94.0%	↓	
2	Diagnostic Services	Adequate	↑	60.8%	55.0%	=	
3	Emergency Services	Adequate	=	N/A	N/A	N/A	
4	Health Information Management	Inadequate	↓	83.6%	87.0%	=	
5	Health Care Environment [†]	N/A	N/A	43.2%	79.0%	↓	
6	Transfers	Adequate	=	78.3%	62.0%	↑	
7	Medication Management	Adequate	=	49.6%	63.0%	=	
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A	
9	Preventive Services	N/A	N/A	78.5%	72.0%	↑	
10	Nursing Performance	Inadequate	↓	N/A	N/A	N/A	
11	Provider Performance	Inadequate	↓	N/A	N/A	N/A	
12	Reception Center	Adequate	↓	70.4%	61.0%	=	
13	Specialized Medical Housing	Inadequate	↓↓	85.0%	85.0%	↑	
14	Specialty Services	Inadequate	↓	81.7%	82.0%	=	
15	Administrative Operations [†]	N/A	N/A	74.9%	78.0%	↓	

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

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

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

Medical Inspection Results

Deficiencies Identified During Case Review

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

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

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 11 of the 14 indicators applicable to WSP. Of these 11 indicators, OIG clinicians rated six **adequate** and five **inadequate**. The OIG physicians also rated the overall adequacy of care for each of the 18 detailed case reviews they conducted. Of these 18 cases, 14 were **adequate** and four were **inadequate**. In the 925 events reviewed, there were 301 deficiencies, 88 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 WSP:

- Correctional treatment center (CTC) nurses performed timely admission assessments and care plans.
- Nurses performed well in the transfer-out process and the reception center (RC) intake process for assessments and screenings.
- Patients frequently received new medications timely.

Our clinicians found the following weaknesses at WSP:

- Provider outpatient assessments were often incomplete with lapses in decision-making and poor documentation.
- Nursing assessment and interventions showed opportunities for improvement.
- Medication management was problematic for chronic care and specialized medical housing (SMH) medications.

⁶ For a further discussion of an adverse event, see Table A-1.

Compliance Testing Results

Our compliance inspectors assessed 11 of the 14 indicators applicable to WSP. Of these 11 indicators, our compliance inspectors rated one *proficient*, five *adequate*, and five *inadequate*. We tested policy compliance in **Health Care Environment**, **Preventive Services**, and **Administrative Operations** as these indicators do not have a case review component.

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

- Nurses and providers did an excellent job completing nursing and provider assessment of patients admitted to the specialized medical housing within required time frames.
- Medical staff performed well in scanning health care services request forms, specialty service reports, and community hospital discharge reports.
- Nurses at WSP reviewed health care services request forms and conducted face-to-face encounters within required time frames. In addition, WSP housing units contained adequate supplies of health care services request forms.

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

- WSP's medical warehouse and clinics stored multiple medical supplies that had expired.
- Nurses did not regularly inspect emergency medical response bags and treatment cart.
- Staff did not always ensure patients receive their chronic care medications within required time frames. Poor medication continuity occurred for patients returning from hospitalizations, for patients transferring from county jails, and transferring into, within, and laying over at WSP.
- Staff did not properly store nonnarcotic refrigerated and nonrefrigerated medications.
- Staff did not consistently follow universal hand hygiene precautions either during patient encounters, or while distributing medications to patients.

Institution-Specific Metrics

Wasco State Prison (WSP), located in Wasco, Kern County, houses medium-custody general population, reception center, and minimum-custody incarcerated people. At the time of our inspection, the incarcerated population was 3,761. WSP is designated as a *reception center*, providing general outpatient health care services through its 11 clinics, which handle nonurgent requests for medical services. Patients needing urgent or emergent care are treated in its triage and treatment area (TTA), and inpatient health services in its correctional treatment center (CTC).⁷

In February 2023, the Health Care Services Master Registry showed WSP had a total population of 3,761. A breakdown of the medical risk level of the WSP population as determined by the department is set forth in Table 2 below.⁸

Table 2. WSP Master Registry Data as of February 2023

Medical Risk Level	Number of Patients	Percentage*
High 1	48	1.3%
High 2	164	4.4%
Medium	1,567	41.7%
Low	1,982	52.7%
Total	3,761	100.0%

* Percentages may not total 100% due to rounding.

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 2-1-23.

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

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

According to staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 3 below, WSP had one vacant executive leadership position, 2.5 primary care provider vacancies, 0.7 nursing supervisor vacancy, and 14.2 nursing staff vacancies.

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

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	12.0	15.2	156.2	188.4
Filled by Civil Service	4.0	9.5	14.5	142.0	170.0
Vacant	1.0	2.5	0.7	14.2	18.4
Percentage Filled by Civil Service	80.0%	79.2%	95.4%	90.9%	90.2%
Filled by Telemedicine	0	1.5	0	0	1.5
Percentage Filled by Telemedicine	0	12.5%	0	0	0.8%
Filled by Registry	0	2.0	0	19.0	21.0
Percentage Filled by Registry	0	16.7%	0	12.2%	11.1%
Total Filled Positions	4.0	13.0	14.5	161.0	192.5
Total Percentage Filled	80.0%	108.3%	95.4%	103.1%	102.2%
Appointments in Last 12 Months	1.0	3.0	5.0	31.0	40.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave ‡	0	0	0	5.0	5.0
Adjusted Total: Filled Positions	4.0	13.0	14.5	156.0	187.5
Adjusted Total: Percentage Filled	80.0%	108.3%	95.4%	99.9%	99.5%

* Executive Leadership includes the Chief Physician and Surgeon.

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

‡ In Authorized Positions.

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

Source: Cycle 7 medical inspection preinspection questionnaire received on February 1, 2023, from California Correctional Health Care Services.

Population-Based Metrics

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

HEDIS Results

We considered WSP's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. Currently, only one HEDIS measure is available for review: poor HbA1c control, which measures the percentage of diabetic patients who have poor blood sugar control. WSP's results compared favorably with those found in State health plans for this measure. We list the applicable HEDIS measures in Table 4.

Comprehensive Diabetes Care

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

Immunizations

Statewide comparative data were also not available for immunization measures; however, we include these data for informational purposes. WSP had a 35 percent influenza immunization rate for adults 18 to 64 years old. The influenza immunization rate for adults 65 years of age and older was not available.⁹ The pneumococcal immunization rate was also not available.¹⁰

Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. WSP had a 50 percent colorectal cancer screening rate.

⁹ The HEDIS sampling methodology requires a minimum sample of 10 patients to have a reportable result. The sample for older adults did not yield a full sample.

¹⁰ The pneumococcal vaccines administered are the 13, 15, and 20 valent pneumococcal vaccines (PCV13, PCV15, and PCV20), or 23 valent pneumococcal vaccine (PPSV23), depending on the patient's medical conditions. For the adult population, the influenza or pneumococcal vaccine may have been administered at a different institution other than the one where the patient was currently housed during the inspection period.

Table 4. WSP Results Compared With State HEDIS Scores

HEDIS Measure	WSP Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (>9.0%)‡,§	6%	38%	28%	20%
HbA1c Control (<8.0%)‡	71%	–	–	–
Blood Pressure Control (<140/90)‡	84%	–	–	–
Eye Examinations	44%	–	–	–
Influenza—Adults (18–64)	35%	–	–	–
Influenza—Adults (65+)	N/A	–	–	–
Pneumococcal—Adults (65+)	N/A	–	–	–
Colorectal Cancer Screening	50%	–	–	–

Notes and Sources

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

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

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

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

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

Recommendations

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

Access to Care

- Medical leadership should determine the root causes of challenges in providing timely provider reception center (RC) health care assessment, chronic care follow-up appointments, routine specialty and follow-up appointments, and nurse-to-provider referrals, and should implement remedial measures as appropriate.

Diagnostic Services

- Medical leadership should determine the root cause of challenges to notification and endorsement of routine and STAT laboratory results and should implement remedial measures as appropriate to ensure STAT laboratory tests are performed and providers notified within required time frames.
- Medical leadership should ascertain the causes of the untimely provision of laboratory services and should implement remedial measures as appropriate.

Emergency Services

- Nursing leadership should determine the root cause of challenges that prevent staff in completing thorough assessments, timely interventions, and accurate documentation after an emergent event and implement remedial measures as indicated.
- The Emergency Medical Response Review Committee (EMRRC) should thoroughly review emergency response events and ensure the emergency response checklist review has identified the specific findings or training issues.

Health Information Management

- Medical leadership should ensure all specialty reports, including on-site specialty reports, are timely endorsed by providers.
- Medical leadership should establish a mechanism to ensure either the specialist or on-site primary care providers timely endorse all diagnostic studies that were ordered by on-site specialty providers and are reported in the medical record.
- Medical leadership should determine the root cause of challenges in sending patient notification letters communicating laboratory tests and pathology results, and should implement remedial measures as appropriate, including ensuring clinic providers create patient notification letters with all four elements required by CCHCS policy.

Health Care Environment

- Executive leadership should consider performing random spot checks to ensure clinics, medical storage rooms, and restrooms are cleaned properly and timely.
- Medical leadership should remind staff to follow all applicable steps of the universal hand hygiene procedure. Implementing random spot checks could improve compliance.
- Executive leadership should consider performing random spot checks to ensure medical supply storage areas, located outside the clinics, store medical supplies adequately.
- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) and treatment cart logs to ensure the EMRBs and treatment carts are regularly inventoried and sealed.

Transfers

- Nursing leadership should determine the root cause of challenges that prevent nurses in thoroughly completing the initial health screening process including answering all questions and documenting an explanation for all “Yes” answers before the patient is transferred to the housing unit and implement remedial measures as appropriate.

Medication Management

- The institution should consider developing and implementing measures to ensure staff timely make available and administer medications to patients and document administering medications in the EHRS as described in CCHCS policy and procedures.

Preventive Services

- Nursing leadership should analyze the challenges to ensuring nursing staff monitor and address symptoms of patients receiving TB medications according to CCHCS guidelines and take necessary remedial measures.
- Nursing leadership should analyze the challenges in ensuring patients at the highest risk of coccidioidomycosis (Valley Fever) are monitored and transferred in a timely manner.
- Medical and nursing leadership should analyze the challenges related to the untimely provision of preventive vaccines to chronic care patients and implement remedial measures as appropriate.

Nursing Performance

- Nursing leadership should analyze the challenges to nurses performing thorough, detailed assessments and interventions during patients' appointments and reinforce the audits already implemented.

Provider Performance

- Medical leadership should analyze the causes of poor provider documentation, including updating the patient problem lists, and implement remedial measures as appropriate.
- Medical leadership should emphasize the necessity and importance of appropriate provider EHRs chart review at each patient appointment.
- Medical leadership should clarify for providers the tasks required for RC-focused health care assessments, appropriate durations for follow-up, and expectations of the yard providers at the initial appointment after completing focused health care assessments.

Reception Center

- Medical leadership should determine causative factors related to the untimely provision of patients' RC screening laboratory tests and provider communication of test results to their patients as stated in CCHCS policy.
- Nursing leadership should analyze the challenges to nursing staff on following CCHCS policies and procedures for coccidioidomycosis (Valley Fever) skin test reading and implement remedial measures as appropriate.

Specialized Medical Housing

- Nursing leadership should analyze the causes of CTC nurses not completing daily assessments thoroughly and implement remedial measures as appropriate.
- Medical leadership should analyze the causes of CTC providers not completing appropriate documentation, EHRs chart reviews, and not addressing important medical issues.

Specialty Services

- CCHCS and WSP medical leadership should consider developing and implementing strategies to improve communication with county jails to ensure WSP can be prepared for the medical needs of high-risk patients on their arrival.
- Medical leadership should determine causative factors related to the untimely provision or scheduling of patients' specialty service appointments and implement remedial measures as appropriate.

Access to Care

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

Ratings and Results Overview

Case Review Rating
Adequate

Compliance Rating and Score
Adequate (82.1%)

Compared with Cycle 6, during which WSP excelled at access to care, our case review clinicians found WSP's Cycle 7 performance was sufficient. Nurses reviewed patient health care requests for services timely and completed face-to-face visits with patients within one business day for symptomatic sick calls. Outpatient clinic and specialized medical housing provider access was good. Providers saw patients after transfer-in, posthospitalization, and follow-up care after high-priority specialty services; however, they usually did not perform new reception center patient history and physical examinations within required time frames, even for high-risk patients. We also found specialty services appointments that should have been ordered urgently. Considering all factors, the OIG rated the case review component of this indicator **adequate**.

Compliance testing showed WSP performed sufficiently in providing access to care. Staff performed excellently in reviewing patient sick call requests and completing face-to-face encounters, while showing good performance in completing provider follow-up appointments for patients returning from specialty services. However, WSP scored low in completing follow-up appointments for patients with chronic care conditions, patients transferring into the institution, and patients returning from hospitalization. Factoring in all the information, the OIG rated the compliance testing component of this indicator **adequate**.

Case Review and Compliance Testing Results

OIG clinicians reviewed 202 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events that required WSP to generate appointments. We identified 16 deficiencies relating to **Access to Care**, eight of which were significant.¹¹

Access to Care Providers

Access to clinic providers is an integral part of patient care in health care delivery. WSP's performance was mixed in providing access to provider-ordered follow-up appointments.

¹¹ Deficiencies occurred in cases 2, 7, 8, 10, 13, 16, 17, 20, 21, 52, and 53. Significant deficiencies occurred in cases 2, 7, 16, 20, 21, and 52.

Case review found three nonsignificant deficiencies in the scheduling of outpatient provider appointments, while compliance testing showed access to chronic care follow-up appointments (MIT 1.001, 64.0%) and access to nursing and to primary care provider sick call referrals (MIT 1.005, 71.4%) needed improvement.¹²

Access to Specialized Medical Housing Providers

WSP provided excellent access to specialized medical housing providers. OIG clinicians did not identify any deficiencies.

Access to Clinic Nurses

WSP performed well in access to nurse sick calls and provider-to-nurse referrals. Compliance testing found WSP performed excellently in reviewing patient health care requests for services the same day they were received (MIT 1.003, 100%) and in completing face-to-face appointments with patients within one business day for symptomatic sick calls (MIT 1.004, 94.3%). Our clinicians reviewed 71 nursing sick call requests and identified one nonsignificant deficiency related to clinic nurse access.¹³

Access to Specialty Services

WSP's performance was mixed in referrals to specialty services. Compliance testing determined WSP maintained a very good completion rate of high-priority (MIT 14.001, 86.7%), and excellent completion rates of medium-priority (MIT 14.004, 100%) and routine (MIT 14.007, 100%) appointments. Case review found WSP on-site services such as hemodialysis and podiatry visits occurred timely; however, WSP performed poorly in obtaining off-site specialty appointments due to either providers not ordering services timely or the appointments occurring outside of compliance. In three instances, patients received delayed or no care because the necessary specialty services were not ordered due to lack of specialty service appointment availability.¹⁴

Follow-Up After Specialty Services

WSP performed well in ensuring provider follow-up after specialty services appointments occurred within required time frames. Compliance testing revealed nearly all provider appointments after specialty services occurred within required time frames (MIT 1.008, 92.7%). OIG clinicians identified one nonsignificant deficiency in case 10. However, most specialty referrals reviewed were not high priority and, therefore, did not require a provider follow-up appointment per CCHCS policy.¹⁵

Follow-Up After Hospitalization

WSP's performance in provider hospital follow-up was mixed. Compliance testing found WSP's performance needed improvement; providers inconsistently saw the patient timely

¹² Deficiencies in provider access occurred in cases 10, 13, and 17.

¹³ A deficiency in nurse access occurred in case 16.

¹⁴ Required specialty services were not ordered or delayed due to unavailability of specialists in case 20 and two instances in case 52.

¹⁵ <https://cchcs.ca.gov/wp-content/uploads/sites/60/HC/HCDOM-ch03-art1.11.pdf>

following hospitalization (MIT 1.007, 64.7%). Case review examined three hospitalizations, and patients were seen timely on return in each case.

Follow-Up After Urgent or Emergent Care

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

Follow-Up After Transferring Into WSP

Access to care for patients who had recently transferred into WSP was poor. Compliance testing showed access to intake appointments for newly arrived patients needed improvement (MIT 1.002, 52.2%). Our clinicians evaluated 12 transfer-in events; three were transfers from other prisons, and nine were new RC patients. We found no delays in following up after transferring in from other prisons; however, three significant deficiencies were identified with the provider RC health care assessment as identified below:

- In case 2, the newly arrived patient did not receive the required provider RC health care assessment until 14 days after the compliance date.
- In case 7, an elderly male with history of daily alcohol abuse, known high blood pressure, and gastroesophageal reflux transferred into WSP from the county jail. The patient was seen by a provider for the RC health care assessment 15 days late.
- In case 20, the patient with high-risk medical conditions including end-stage kidney disease on dialysis, diabetes, heart failure, possible bladder cancer, and blood in the urine was not seen for the provider RC health care assessment until 15 days after arrival. This high-risk patient should have been seen urgently.

This topic is also discussed in the **Reception Center** and **Provider Performance** indicators. Case review did not identify any access deficiencies for nursing RC appointments.

Clinician On-Site Inspection

Our case review clinicians spoke with WSP's medical and nursing leadership, and schedulers regarding WSP's access to care. WSP has a dedicated hemodialysis unit, operated by a contract vendor and overseen by WSP leadership. WSP also has a two-bed TTA, a CTC, an RC, and multiple medical clinics. Medical leadership stated space has been a significant challenge and new projects to correct this are underway. The RC is being expanded to allow new patient medical, dental, visual, and mental health evaluations to occur in one location. The TTA and two clinics are also being expanded.

WSP is one of the few RCs in the State prison system, and medical leadership reported this institution provides intake and short-term patient housing. Its mission is to ensure patients are medically stable until they are transferred to their next institution, which should happen without significant delay. WSP medical leadership and providers

discussed how this can provide a challenge of balancing acute needs prior to transfer versus waiting for treatment until transferred when more long-term care can be provided.

Both scheduling management and medical leadership stated provider follow-up after RC arrival was poor due to COVID-19 and quarantine. COVID-19 testing occurred prior to transfer from the county jails per protocol, and only patients with negative COVID-19 tests could be accepted. In addition, patients were tested again multiple times at WSP prior to release from quarantine. Nursing staff saw patients as scheduled; however, providers did not perform patient RC health care assessments as needed. We spoke with medical leadership and asked why providers did not see newly arrived patients timely. The chief medical executive (CME) responded this was due to a shortage of personal protective equipment (PPE), as well as low levels of non-health-care custody and physician staff. However, the CME's written responses indicated the physicians were fully staffed. In addition, initial nurse visits were timely, and no PPE or custody issues were mentioned as obstacles for timely completing their visits.

WSP has a waiver from the California Department of Public Health, which extends the duration between provider appointments in the CTC for up to 14 days and in the outpatient housing unit (OHU) for up to 30 days. This extension improves provider access compliance in specialized medical housing units.

Compliance On-site Inspection and Discussion

Patients had excellent access to health care services request forms in all six housing units inspected (MIT 1.101, 100%).

Compliance Testing Results

Table 5. Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001)	16	9	0	64.0%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	12	11	2	52.2%
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)	33	2	0	94.3%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005)	5	2	28	71.4%
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)	1	0	34	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007)	11	6	2	64.7%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	38	3	4	92.7%
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): 82.1%				

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

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

Table 6. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003)	14	2	4	87.5%
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days (prior to 07/2022) or five working days (effective 07/2022)? (12.004)	17	3	0	85.0%
Was a written history and physical examination completed within the required time frame? (13.002)	10	0	0	100%
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	4	1	10	80.0%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004)	15	0	0	100%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	7	1	7	87.5%
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)	6	2	7	75.0%

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

Recommendations

- Medical leadership should determine the root causes of challenges in providing timely provider RC health care assessment, chronic care follow-up appointments, routine specialty and follow-up appointments, and nurse-to-provider referrals, and should implement remedial measures as appropriate.

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's performance in timely completing radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly. In addition, in Cycle 7, we examined the institution's performance in timely completing and reviewing immediate (STAT) laboratory tests.

Ratings and Results Overview

Case Review Rating
Adequate

Compliance Rating and Score
Inadequate (60.8%)

As in Cycles 5 and 6, WSP performed well in radiology test completion, pathology report results retrieval, and provider test result endorsement. Staff performed sufficiently in completing initial intake screening and routine laboratory testing; however, we identified several significant deficiencies. In addition, important point-of-care urine dip tests were not available, causing a delay of care to ill patients. Taking these factors into consideration, the OIG's case review team rated this indicator **adequate**.

Compliance testing showed WSP performed exceptionally in providing radiology services and in endorsing radiology, laboratory, and pathology results. However, WSP needed improvement in completing routine and important STAT (immediate) laboratory tests and generating patient letters that included all required key elements. On balance, the OIG rated the compliance testing component of this indicator **inadequate**.

Case Review and Compliance Testing Results

We reviewed 189 diagnostic events and found 38 deficiencies, eight of which were significant. Most of the nonsignificant deficiencies were due to missing patient results letters or missing result letter components. Of the eight significant deficiencies, four related to test completion and the other four pertained to the unavailability of important point-of-care urine analysis testing.¹⁶

Test Completion

WSP diagnostic test completion results were mixed. Both compliance testing and case review found WSP performed excellently when completing radiology services (MIT 2.001, 100%). WSP completed all tests timely and obtained reports. However, compliance testing found the institution performed poorly in completing routine and STAT laboratory services (MIT 2.004, 50.0% and MIT 2.007, 40.0%) within required time frames. The case review team identified seven laboratory test completion deficiencies, three of which were significant. The significant deficiencies were found in the following cases:

¹⁶ Deficiencies occurred in cases 1, 2, 8-12, 14-17, 19-21, 53, and 54. Significant deficiencies occurred in cases 10, 14, 16, and 20.

- In case 16, a follow-up blood count laboratory test for an anemic (low red blood cell counts) hemodialysis patient was ordered to be completed in four days. The test was not performed as ordered.
- In case 20, the provider ordered a urine laboratory test to be performed in nine days for a patient with a history of bladder cancer and symptoms of blood in the urine. However, the test was not completed as ordered.
- Also in case 20, the provider ordered a blood test to follow up with a patient just released from the hospital with severe anemia. The test was ordered to be performed in four days; however, it was not completed until eight days later. For a patient with potential blood loss, follow-up blood work is critical to ensure the patient is stable.

Case review found a pattern in which three of nine RC patients' screening laboratory tests were either not completed or not completed timely:

- In case 2, several RC screening laboratory tests were collected one day late.
- In case 7, the patient's intake screening laboratory tests, including tests for tuberculosis, syphilis, HIV, hepatitis, and chicken pox immunity were completed 13 days late.
- In case 54, the newly arrived patient returned from an outside hospital. The patient's screening intake laboratory tests for syphilis, HIV, hepatitis panels, and tuberculosis were not reconciled on the patient's return and were not completed. The provider reordered them a few months later.

Case review found four significant delays in patient care due to lack of urine dipstick tests at WSP in cases 10, 14, and 20. POC urine dipstick tests are rapid urine analysis tests that can be performed in the clinic. Below are examples of significant deficiencies related to the lack of this test at WSP:

- In case 10, the registered nurse (RN) contacted the provider about a diabetic patient complaining of left-side flank pain during urination. The provider ordered urinalysis to be done in seven days. A urine dipstick test should have been performed immediately for assessment of the patient's symptoms; however, this test was not available.
- Also in case 10, the licensed vocational nurse (LVN) informed the provider the patient had a critically elevated blood sugar of 500. A urine dipstick test to evaluate for ketoacidosis should have been performed; however, this test was not available.¹⁷
- In case 14, the RN contacted the provider for the patient's complaint of severe abdominal pain, nausea, headache, and dizziness lasting for one week.

¹⁷ Diabetic ketoacidosis is a diabetic complication in which the patient's body produces excess blood acids called ketones. This condition can be life-threatening and requires the patient to be hospitalized for treatment. Ketones can be identified quickly by point of care tests, such as a urine dipstick.

A urine dipstick test should have been performed; however, this test was not available.

- In case 20, the RN assessed the patient who was complaining of blood in the urine. This can be a symptom of urinary tract infection, which requires immediate treatment. The provider could not order the necessary POC urine dipstick test because it was unavailable.

We classified these deficiencies as patient care environment deficiencies that are discussed further in the **Clinician On-Site Inspection** area below.

Health Information Management (HIM)

HIM performance for diagnostic reports was mixed. Staff retrieved laboratory and diagnostic results promptly and sent them to providers for review. Compliance testing showed providers endorsed both radiology (MIT 2.002, 90.0%) and laboratory (MIT 2.005, 100%) results timely; however, they performed poorly in communicating the radiology and laboratory results to patients (MIT 2.003, 40.0% and MIT 2.006, 10.0%). Case review findings were consistent. Our clinicians found issues with missing patient results letters or letter components; however, none of those deficiencies was considered severe.

Compliance testing found nurse notification of STAT laboratory test results was poor (MIT 2.008, 20.0%). In contrast, health care providers performed excellently in endorsing the STAT laboratory test results within required time frames (MIT 2.009, 100%). Case review identified one minor endorsement deficiency in case 3.

WSP performed well in obtaining pathology reports, and providers endorsed the reports within required time frames (MIT 2.010, 80.0%, and MIT 2.011, 100%); however, providers never communicated these pathology results to patients within required time frames (MIT 2.012, zero).

OIG clinicians identified a pattern in which blood tests were ordered by the on-site hemodialysis kidney specialist, but these results in patients' medical records were not endorsed by either the specialist or providers. Provider endorsements indicate laboratory studies were reviewed. Only one deficiency, however, was considered significant:

- In case 16, the patient's blood count test was low, showing a significant drop from the previous test. This can indicate acute, life-threatening bleeding or red blood cell destruction. The laboratory tests were ordered by the specialist and were available for review in the EHRS, but they were not endorsed by any on-site provider. The on-site providers were not aware of the acute drop in blood count and did not order a timely workup to investigate the cause.

These deficiencies are discussed further in the **Clinician On-Site Inspection** area below.

Clinician On-Site Inspection

We met with medical and nursing leadership, diagnostic management and staff, and hemodialysis unit RNs. Diagnostic leadership stated radiology was fully staffed during the review period; however, two laboratory positions are currently vacant.

Diagnostic leadership mentioned COVID-19 did not affect radiology but affected laboratory services in multiple ways during the review period. The laboratory was short-staffed due to staff illness. During this period, patient transfers from county jails increased, which increased required tests for both COVID-19 routine screenings and ISUDT urine toxicology testing.¹⁸ The leadership further reported, during the six-month review period, 7,000 COVID-19 tests were performed. COVID-19 quarantine restrictions and related patient access also contributed to a laboratory backlog.

The on-site hemodialysis unit (HDU), which is run by a contracted vendor, performs the kidney specialty-ordered laboratory tests, processed through WSP's laboratory. Those laboratory results are entered into a patient's medical record for all staff to access. This is beneficial because on-site providers have access to the laboratory testing. Also, potential kidney transplant recipients require immediate, up-to-date medical information to be included in their transport packages should a transplant kidney become available. HDU nursing stated they review all patient laboratory work from the day before, they inform patients of the test results on the next dialysis appointment (which usually occurs three times a week), and manage abnormal laboratory work by established protocols or contact the kidney specialist. Medical leadership remarked the nephrologist has remote access to patient medical records and reviews the results in a timely manner, but is not required to endorse patient laboratory results. At times, this makes it difficult to determine whether an on-site WSP provider is aware of laboratory test results unless a progress note is documented in the EHRS or a follow-up order is entered.

We took these processes into consideration in our review of the cases. CCHCS policy states all laboratory testing must be endorsed by a provider and patients should be notified of the results.¹⁹ In addition, a medical provider should be reviewing the complete medical record and responding accordingly. To be consistent with policy, the OIG cited a lack of endorsements and missing patient results letters when there was no evidence the results were communicated to the patient. However, we did not consider those deficiencies as severe except for the one instance discussed above. At times, we found evidence in the EHRS that, although the specialty-ordered laboratory work was not endorsed, the nephrologist was reviewing and acting on the results because follow-up orders were being entered in the EHRS. Because of the established dialysis protocols provided to us at the on-site inspection, we did not usually cite for missing nephrology progress notes that would detail why the additional laboratory tests were ordered. Continuity of care and a clear medical record is critical to patient safety regardless of the source of the medical record data. We did, therefore, cite missing progress notes when medical decision-making regarding new laboratory orders was not clear.

¹⁸ ISUDT is the Integrated Substance Use Disorder Treatment program.

¹⁹ Refer to <https://cchcs.ca.gov/wp-content/uploads/sites/60/HC/HCDOM-ch03-art1.14.pdf>.

Compliance Testing Results

Table 7. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001)	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	9	1	0	90.0%
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	40.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	5	5	0	50.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	10	0	0	100%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	1	9	0	10.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	4	6	0	40.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	2	8	0	20.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	10	0	0	100%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	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): 60.8%				

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

Recommendations

- Medical leadership should determine the root cause of challenges to notification and endorsement of routine and STAT laboratory results and should implement remedial measures as appropriate to ensure STAT laboratory tests are performed and providers notified within required time frames.
- Medical leadership should ascertain the causes of the untimely provision of laboratory services and should implement remedial measures as appropriate.

Emergency Services

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

Ratings and Results Overview

Case Review Rating
Adequate

Compliance Rating and Score
Not Applicable

WSP performed satisfactorily for emergency services. Case review found staff generally delivered timely and appropriate care, and providers performed well with emergency care. However, we also found opportunities for improvement in nursing assessment, interventions, and documentation. In addition, WSP's EMRRC did not identify some nurses' deficiencies we identified. Factoring in all the information, the OIG rated this indicator **adequate**.

Case Review Results

We reviewed 18 urgent and emergent events in 12 cases.²⁰ We found 18 emergency-related deficiencies, three of which were significant.²¹

Emergency Medical Response

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

Cardiopulmonary Resuscitation Quality

During this period, we reviewed five cases in which cardiopulmonary resuscitation (CPR) was initiated.²² Custody and medical staff generally worked cohesively to provide care, move the patient to the TTA for additional interventions, and transfer the patient to a higher level of care. Staff activated the 9-1-1 system from the scene. Below is one case of a delay in interventions. The patient was pronounced dead by EMS at the institution:

²⁰ Urgent and emergent events occurred in cases 1-7, 14, 15, and 18-20.

²¹ Emergency deficiencies occurred in cases 1-3, 5, 15, and 18-20. Significant deficiencies occurred in cases 5 and 20.

²² CPR occurred in cases 3-7.

- In case 5, medical emergency care was provided to an unconscious patient due to a possible drug overdose. Nurses documented the patient was found with shallow irregular respiration, as well as no spontaneous respirations, and a weak and thready carotid pulse. Nurses did not reassess the patient's respiratory status while en route to the TTA. Also, the documentation on the patient's neurological status was inconsistent. When nursing staff initially found the patient did not have spontaneous respirations prior to arriving in the TTA, nurses did not document either the rate of the shallow respirations or the carotid pulse rate and did not initiate high-flow oxygen via a bag valve mask. Nurses also did not initiate the automated external defibrillator (AED) on scene when the patient had a weak and thready carotid pulse until the patient had no pulse eight minutes later in the TTA.

Provider Performance

Providers generally performed well in urgent situations, emergent situations, and after-hours care. They frequently documented the emergent events, although the OIG found missing provider documentation in two cases. However, our clinicians found no significant provider performance deficiencies.

Nursing Performance

Nurses performed very well during emergent events. The TTA nurses responded promptly when a medical alarm was activated, made sound medical decisions, and timely consulted a provider. However, we identified opportunities for improvement when nurses did not provide a thorough patient assessment or reassessment. The following are examples:

- In case 1, nurses provided emergency care for an unconscious patient due to a possible overdose. However, nurses did not assess neurological status after the initial assessment in the TTA until EMS arrived approximately 14 minutes later. In addition, the OIG found time-line documentation discrepancies in which nurses documented vital signs, neurological status, a skin assessment, and radial pulse after the patient had departed for the hospital.
- In case 15, nurses provided emergency care for a patient who fell on the way to dialysis and complained of right ankle pain. The nurse did not assess range of motion in the right ankle, provide support to immobilize the right ankle pending a STAT X-ray per provider orders, and did not obtain orders for either crutches or a temporary wheelchair.
- In case 20, the patient had a witnessed fall and an unwitnessed fall. Early in the review period, the patient had a witnessed fall, which was due to weakness in his legs, and the LVN consulted with the RN. However, the RN did not document the phone consultation and did not perform a postfall assessment until over six hours later. Later in the review period, the patient had an unwitnessed fall, which was due to the broken wheelchair, and the patient hit his head. We identified deficiencies with the documentation time line, missing vital signs checks including orthostatic blood pressure, incomplete assessments of the extremities, a lack of a risk assessment for

falling, and a lack of a reassessment for a low pulse rate. Lastly, the RN did not consult with the provider for the unwitnessed fall.

Nursing Documentation

Nurses in the TTA usually performed thorough documentation for emergent events. Although we identified deficiencies for time lines and medication administration, these did not affect overall patient care.²³

Emergency Medical Response Review Committee

The EMRRC met monthly. The OIG compliance team found incomplete checklists (MIT 15.003, zero). Our clinicians found clinical reviews were performed by the nursing supervisors; however, they did not identify incomplete assessments or conflicting time lines.²⁴

Clinician On-Site Inspection

Our clinicians toured the TTA during our on-site inspection. The TTA has two beds, which provided sufficient space for emergency care, and also one crash cart, one Omnicell, an AED, and an EMRB.²⁵ The TTA was staffed with two RNs per shift.

At the time of our inspection, the chief nurse executive (CNE) reported the current TTA would be moved to the new diagnostic area, pending completion in June 2023. In the new diagnostic area, the TTA would have five TTA beds and be in the same location as the RC provider, mental health, laboratory, and dental facilities.

In addition, WSP had started training the medical staff on the new emergency medical response (EMR) procedures during our on-site inspection. WSP planned to implement the new EMR training throughout the institution in September 2023 after 80 percent of staff were to have been trained. We were informed the dialysis contract nurses were not involved in the new EMR training because they were not required to respond to alarms. If the on-site dialysis area experienced an emergency, the dialysis nurses were instead required to activate the alarm, and the WSP staff was expected to respond to the emergency.

²³ Deficiencies in TTA nursing documentation occurred in cases 1, 3, 5, and 20.

²⁴ EMRRC deficiencies occurred in cases 1, 3, 5, 19, and 20.

²⁵ An Omnicell is an automated medication dispensing machine.

Recommendations

- Nursing leadership should determine the root cause of challenges that prevent staff in completing thorough assessments, timely interventions, and accurate documentation after an emergent event and implement remedial measures as indicated.
- The EMRRC should thoroughly review emergency response events and ensure the emergency response checklist review has identified the specific findings or training issues.

Health Information Management

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

Ratings and Results Overview

Case Review Rating
Inadequate

Compliance Rating and Score
Adequate (83.6%)

Case review found WSP performed poorly in health information management. Although emergency documentation was fair, and providers usually endorsed diagnostic test results timely, patient test results letters were often missing or had missing components. We identified several clinically significant delayed and missing hospital and specialty reports. In addition, on-site specialty progress notes were not endorsed, which led to delays in patient care. After reviewing all aspects, the OIG case review rated the case review component of this indicator **inadequate**.

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

Case Review and Compliance Results

We reviewed 927 events and found 43 deficiencies related to HIM. Of these 43 deficiencies, 10 were significant.²⁶

Hospital Discharge Reports

The quality of WSP's retrieval of hospital discharge reports was mixed. Compliance testing found WSP staff satisfactorily retrieved hospital discharge records and scanned them into the EHRS timely (MIT 4.003, 84.2%). Frequently, WSP staff obtained complete discharge summaries that primary care providers reviewed (MIT 4.005, 89.5%). OIG clinicians reviewed nine hospital events and identified three HIM deficiencies involving

²⁶ Deficiencies occurred in cases 1, 2, 9, 11–17, 19, 20, 52, and 53. Significant deficiencies occurred in cases 12, 16, 20, 52, and 53.

poor retrieval and scanning of hospital records, one of which was considered significant. The significant deficiency is below:

- In case 4, the patient was hospitalized for six days with a mandibular fracture and brain bleed. During hospitalization, the patient developed an abnormal heart rhythm. WSP staff did not scan Critical cardiology consultation reports, cardiac test results, and a neurosurgery consultation report into the EHRS until eight months later. Moreover, even once these important documents were scanned in the EHRS, no providers endorsed any document.

We identified other deficiencies in the following cases:

- In case 20, the patient was seen in the hospital emergency room for dialysis and having blood in the urine. WSP staff did not scan the hospital emergency room discharge report until one and a half months later.
- Also in case 20, the patient returned from the hospital where a bladder mass biopsy was performed. The preliminary hospital pathology report documented the mass as an adenocarcinoma, with the final report pending. WSP staff did not obtain the final pathology result report.

Specialty Reports

The institution's management of specialty reports results also varied. Compliance testing showed WSP performed very well in retrieving specialty reports (MIT 4.002, 90.0%). Compliance testing also showed providers endorsed high-priority specialty reports excellently (MIT 14.002, 100%). However, improvement was needed in endorsing medium-priority and routine-priority specialty reports (MIT 14.005, 60.0% and MIT 14.008, 66.7%).

Our case review clinicians reviewed 97 specialty events, 44 of which required WSP's staff to obtain, scan, and endorse reports. Of those 44 events, the OIG identified 17 deficiencies related to HIM, eight of which were significant.

In addition, on-site specialty consultations were not endorsed.²⁷ We discuss these findings further in the **Specialty Services** indicator.

Diagnostic Reports

WSP's performance with diagnostic reports was mixed. Both compliance testing and case review found providers endorsed diagnostic studies timely; however, providers usually did not communicate the results to the patient timely. Additionally, nurses often did not notify providers of STAT laboratory test results, but providers performed well in endorsing STAT results, once received.

Neither the ordering specialist nor an on-site provider endorsed specialty-ordered diagnostic reports. Please refer to the **Diagnostic Services** indicator for more detailed discussion about diagnostics.

²⁷ Specialty health information management deficiencies occurred in cases 9, 12, 15, 16, 20, 52, and 53. Significant deficiencies occurred in cases 12, 20, 52, and 53.

Urgent and Emergent Records

OIG clinicians reviewed 18 emergent care events and found nurses' and providers' documentation of events was fair. We identified errors in nursing documentation and missing provider progress notes. Refer to the **Emergency Services** indicator for additional information regarding emergency care documentation.

Scanning Performance

Scanning performance at WSP was poor. Compliance testing showed WSP needed improvement in correctly scanning, labeling, and filing patient records (MIT 4.004, 54.2%). Case review clinicians identified 16 mislabeled, misfiled, or late records in eight cases. Seven of the deficiencies were significant.²⁸ These deficiencies are included above in the **Hospital Discharge Reports** and **Specialty Reports** areas.

Clinician On-Site Inspection

OIG clinicians met with medical leadership, specialty staff, and HIM management to discuss HIM processes, successes, and challenges. The HIM manager has been in her position for over 17 years and is knowledgeable about processes and WSP. The manager reported HIM was short-staffed with two vacant part-time positions, one health record technician (HRT) II supervisor, and one office assistant on intermittent medical leave for extended periods during the review period.

During the on-site discussion with us, HIM leadership and staff stated documents we had identified as missing were in fact in the EHRS. However, we determined these documents were not retrieved by WSP staff until after the OIG on-site letter cited the missing documents.

At the on-site inspection, we learned the receipt of specialty reports is managed by the specialty services office technician, as well as specialty and utilization management nursing staff. Utilization management nursing has remote access to one of the local hospital's records, and specialty nursing has electronic access to some of the off-site specialty reports. If remote access is unavailable, nursing staff requests the missing specialty documentation. All retrieved documentation is then forwarded to HIM for scanning and to providers for review and endorsement.

²⁸ Deficiencies occurred in cases 4, 9, 14–16, 20, 52, and 53. Significant deficiencies occurred in cases 4, 52, and 53.

Compliance Testing Results

Table 8. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient’s electronic health record within three calendar days of the encounter date? (4.001)	20	0	15	100%
Are specialty documents scanned into the patient’s electronic health record within five calendar days of the encounter date? (4.002)	27	3	15	90.0%
Are community hospital discharge documents scanned into the patient’s electronic health record within three calendar days of hospital discharge? (4.003)	16	3	0	84.2%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients’ files? (4.004)	13	11	0	54.2%
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)	17	2	0	89.5%
Overall percentage (MIT 4): 83.6%				

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

Table 9. Other Tests Related to Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	9	1	0	90.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	10	0	0	100%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	2	8	0	20.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	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)	15	0	0	100%
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)	9	6	0	60.0%
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)	10	5	0	66.7%

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

Recommendations

- Medical leadership should ensure providers timely endorse all specialty reports, including on-site specialty reports.
- Medical leadership should establish a mechanism to ensure either the specialist or on-site primary care providers timely endorse all diagnostic studies that were ordered by on-site specialty providers and are reported in the medical record.
- Medical leadership should determine the root cause of challenges in sending patient notification letters communicating laboratory tests and pathology results, and should implement remedial measures as appropriate, including ensuring clinic providers create patient notification letters with all four elements required by CCHCS policy.

Health Care Environment

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

Ratings and Results Overview

Case Review Rating
Not Applicable

Compliance Rating and Score
Inadequate (43.2%)

In this cycle, multiple aspects of WSP's performance in the health care environment were poor. Medical supply storage areas both inside and outside the clinics contained expired medical supplies, had compromised sterile medical supply packaging, or had medical supplies stored directly on the floor. In addition, several areas of the examination rooms were unsanitary; EMRB logs were missing staff verification or inventorying had not been performed; several clinics did not meet the requirements for essential core medical equipment and supplies; and staff did not regularly sanitize their hands before and after examining patients. These factors resulted in an **inadequate** rating for this indicator.

Compliance Testing Results

Outdoor Waiting Areas

We examined outdoor patient waiting areas (see Photo 1). Health care and custody staff reported existing waiting areas had sufficient seating capacity. Staff reported the outdoor waiting area was only used when the indoor waiting area was at capacity.

Indoor Waiting Areas

We also inspected indoor waiting areas (see Photo 2, next page). Health care and custody staff reported existing waiting areas contained sufficient seating capacity. Depending on the population, patients were either placed in the clinic waiting area or held in individual modules (see Photo 3, next page). During our inspection, we did not observe overcrowding in any of the clinics' indoor waiting areas.



Photo 1. Outdoor waiting area (photographed on 2-16-23).



Photo 2. Indoor waiting area (photographed on 2-16-23).



Photo 3. Individual waiting modules (photographed on 2-16-23).

Clinic Environment

Of the 12 clinics we observed, 10 provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 83.3%). In one clinic, the blood draw station was in close proximity to the patient waiting area, which hindered auditory privacy. In the remaining clinic, the stations for checking vital signs and drawing blood were in close proximity to the patient waiting area, which similarly hindered auditory privacy.

Of the 12 clinics we observed, six contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 50.0%). In the remaining six clinics, we observed one or more of the following deficiencies: nursing staff providing services to multiple patients at the same time in the examination room, which hindered auditory privacy (see Photo 4); torn covers on examination tables, examination room chairs, and physical therapy equipment; an examination room sink, a counter, and drawers in disrepair; unidentified examination room supplies; and clinics with unsecured confidential medical records.



Photo 4. Multiple patients received service at the same time, hindering auditory privacy (photographed on 2-15-23).

Clinic Supplies

Only two of the 12 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 16.7%). We found one or more of the following deficiencies in 10 clinics: expired medical supplies (see Photos 5 and 6), unidentified or inaccurately labeled medical supplies, compromised sterile medical supply packaging, cleaning materials stored with medical supplies, personal items belonging to staff stored with medical supplies, and long-term storage of food belonging to staff in the medical supply storage room (see Photo 7, next page).



Photo 5. Expired medical supplies dated September 2022 (photographed on 2-16-23).

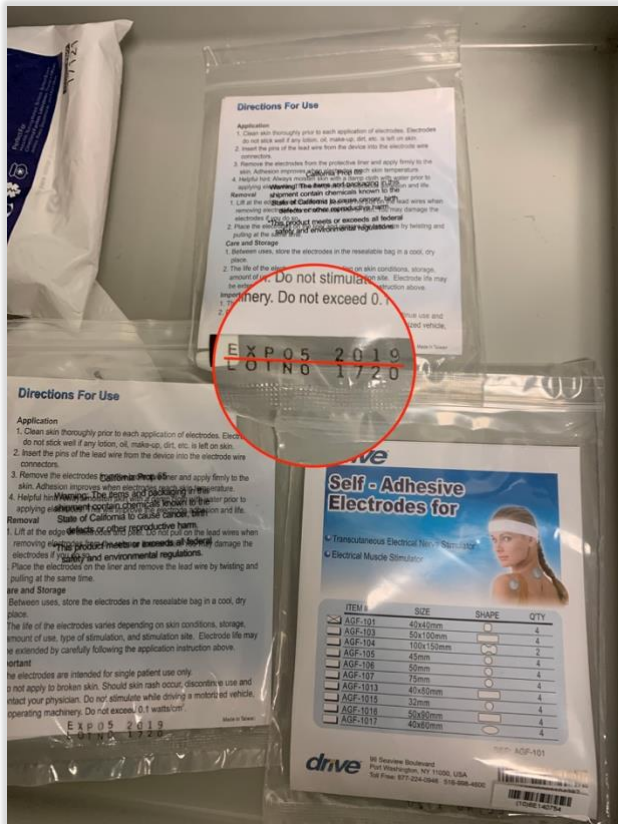


Photo 6. Expired medical supplies dated May 2019 (photographed on 2-16-23).



Photo 7. Staff members stored food on a long-term basis in the medical supply storage room (photographed on 2-15-23).

Only five of the 12 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 41.7%). The remaining seven clinics lacked medical supplies or contained improperly calibrated or nonfunctioning equipment. The missing items included examination table paper, lubricating jelly, tongue depressors, a peak flow meter and tips, EMRBs, and a nebulization unit. In one clinic, staff had not properly calibrated an automated vital signs machine and had no functioning thermometer. In another clinic, the Snellen eye chart did not have a corresponding distance line marked on the floor or a wall. In a third clinic, staff had not completed test log documentation for defibrillator performance within the last 30 days. In addition, several clinic daily glucometer quality control logs were either inaccurate or incomplete.

We examined EMRBs to determine whether they contained all essential items. We also checked whether staff inspected the bags daily and inventoried them monthly. Only two of the nine applicable EMRBs passed our test (MIT 5.111, 22.2%). We found one or both of the following deficiencies with seven EMRBs: staff failed to ensure the EMRBs' compartments were sealed and intact, or staff had not inventoried the EMRBs when seal tags were replaced. In addition, the treatment carts in the TTA did not meet the minimum inventory level at the time of our inspection.



Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). We found medical supplies stored directly on the floor (Photo 8) and compromised sterile medical supply packaging. In addition, the warehouse manager did not maintain a temperature log for medical supplies stored in the medical warehouse that did provide manufacturer’s temperature guidelines (Photo 9, below).

Photo 8. Medical supplies stored directly on the floor (photographed on 2-15-23).

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

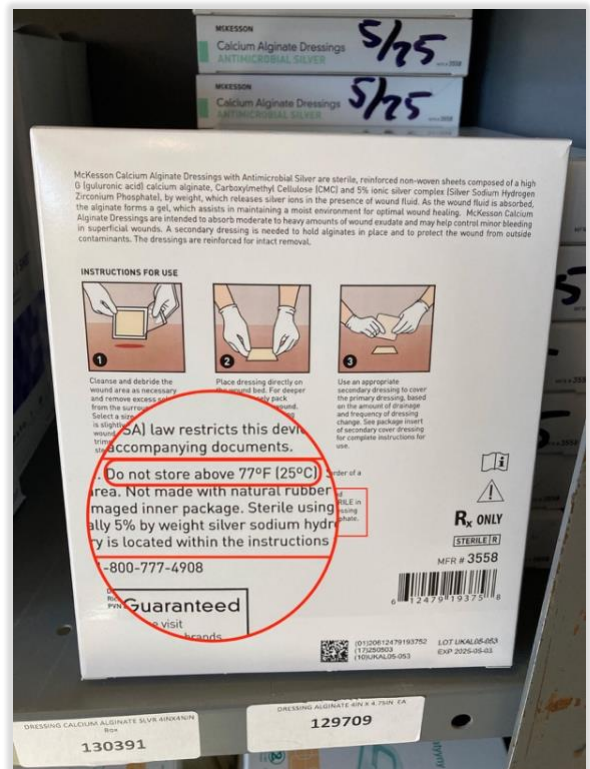


Photo 9. Manufacturer’s temperature guidelines listed on medical supplies were not followed (photographed on 2-15-23).

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected three of 12 clinics (MIT 5.101, 25.0%). In nine clinics, we found one or more of the following deficiencies: unmaintained cleaning logs; unsanitary medical supply locations including storage shelves (Photo 10), a medical supplies cart, a medical supplies bin, an examination room sink, an examination room cabinet under the sink, and an examination room soap dispenser; and unsanitary medical equipment including clinic gurneys and mattresses in the TTA. In three locations, we found damaged and unsanitary examination room floors (Photo 11, next page), and, in one of those three locations, biohazardous waste was not emptied the previous day.

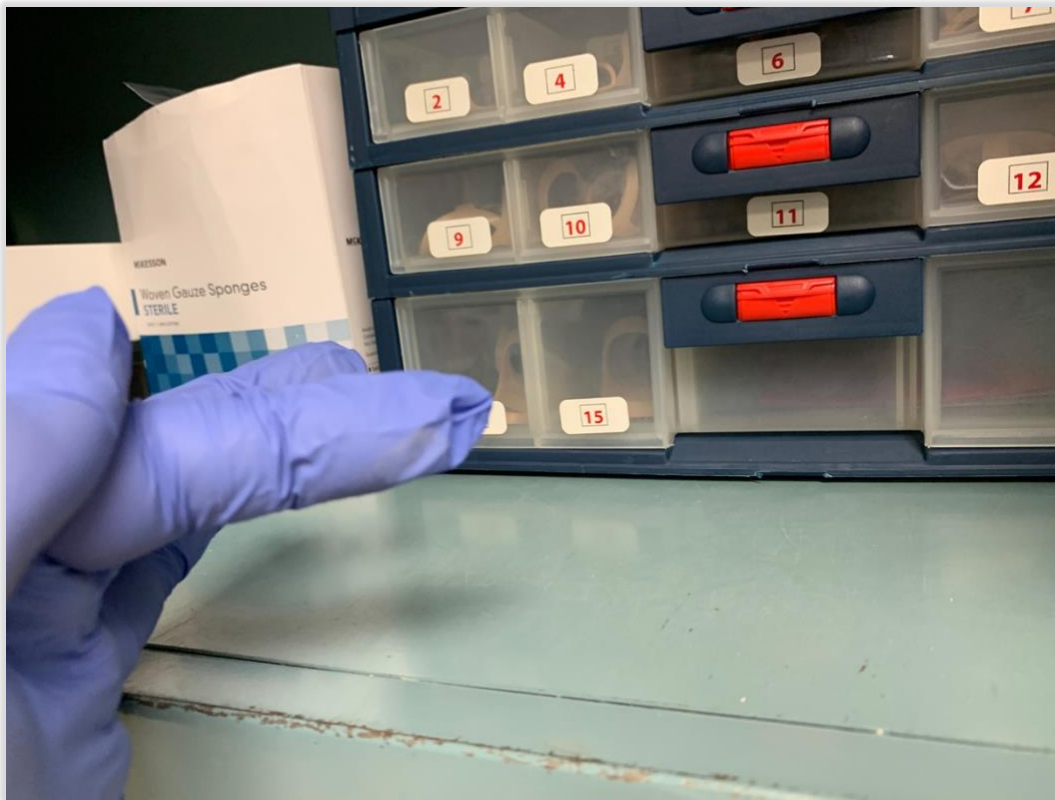


Photo 10. Unsanitary medical supply shelf (photographed on 2-14-23).



Photo 11. Damaged and unsanitary examination room floor (photographed on 2-14-23).

Staff in six of 12 clinics properly sterilized or disinfected medical equipment (MIT 5.102, 50.0%). In six clinics, we found one or both of the following deficiencies: staff did not mention disinfecting the examination table as part of their daily start-up protocol, and staff either did not have a good understanding of or did not follow the institution's sterilization cleaning protocols.

We found operating sinks and hand hygiene supplies in the examination rooms in seven of 12 clinics (MIT 5.103, 58.3%). All 12 clinics had operating sinks; however, in five clinics, the patient restrooms lacked either antiseptic soap or disposable hand towels.

We observed patient encounters in 11 of 12 applicable clinics. In seven clinics, staff did not wash their hands before applying gloves or after examining their patients (MIT 5.104, 36.4%).

Health care staff in 11 of 12 clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 91.7%). In one clinic, we

found biohazardous waste stored in an unlabeled location, and the examination room was missing a sharps container.

Physical Infrastructure

We gathered information to determine whether the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely and adequate health care. When we interviewed health care managers, they did not have concerns about the facility's infrastructure or its effect on the ability of staff to provide adequate health care. At the time of inspection, the institution had three infrastructure projects underway, which management believed would improve the delivery of care at WSP:

- Project SP 1: Expansion of the A Yard clinic, which began in 2015, was delayed due to the COVID-19 pandemic and was expected to have been completed by March 2023.
- Project SP 6: Expansion of the TTA clinic, which had been completed, was pending activation due to the delay of Construction Project SP 7. The TTA was expected to have been activated by summer 2023.
- Project SP 7: A diagnostic and receiving and releasing (R&R) expansion and modification project at WSP, which began in 2015, was delayed due to the COVID-19 pandemic and was expected to have been completed by March 2023.

Despite the delay of the projects described above, the CEO did not believe this negatively impacted the institution's current ability to provide good patient care (MIT 5.999).

Compliance Testing Results

Table 10. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	3	9	0	25.0%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	6	6	0	50.0%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	7	5	0	58.3%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	4	7	1	36.4%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	11	1	0	91.7%
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	10	0	16.7%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	5	7	0	41.7%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	10	2	0	83.3%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	6	6	0	50.0%
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)	2	7	3	22.2%
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): 43.2%				

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

Recommendations

- Executive leadership should consider performing random spot checks to ensure clinics, medical storage rooms, and restrooms are cleaned properly and timely.
- Medical leadership should remind staff to follow all applicable steps of the universal hand hygiene procedure. Implementing random spot checks could improve compliance.
- Executive leadership should consider performing random spot checks to ensure medical supply storage areas, located outside the clinics, store medical supplies adequately.
- Nursing leadership should direct each clinic nurse supervisor to review the monthly EMRB and treatment cart logs to ensure the EMRBs and treatment carts are regularly inventoried and sealed.

Transfers

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

Ratings and Results Overview

Case Review Rating
Adequate

Compliance Rating and Score
Adequate (78.3%)

Case review found WSP staff performed satisfactorily in this indicator. Nurses performed well in completing initial assessments for newly arrived patients to WSP and completed the disposition sections of the form thoroughly. Providers evaluated patients timely for both newly arrived patients and patients returning from a hospitalization or emergency room in the community. We also found the R&R nurses evaluated transfer-out patients timely, completed transfer packages, and ensured adequate supplies of medications were provided prior to patients transferring out of the institution. Case review did not identify significant deficiencies for patients returning from off-site hospitalizations or emergency rooms. However, we identified opportunities for improvement in nursing assessment, interventions, and documentation. Factoring in all the information, OIG rated the case review component of this indicator **adequate**.

Compared with Cycle 6, WSP's compliance testing performance improved for this indicator. Staff performed excellently in completing assessment and disposition section of the screening process and in ensuring transfer packets for departing patients include the required documents and medications. However, staff needed improvement in completing initial health screening forms and in ensuring medication continuity for newly transferred patients. Consequently, the OIG rated the compliance testing component of this indicator **adequate**.

Case Review and Compliance Testing Results

We reviewed 20 events in 14 cases in which patients transferred into or out of the institution or returned from visits to an off-site hospital or an emergency room. We identified 12 deficiencies, three of which were significant.²⁹

Transfers In

The transfer-in process had mixed results for compliance testing and the clinician review. The compliance team review revealed R&R nurses needed to improve in thoroughly completing the initial health screening form (MIT 6.001, 52.0%); however, the nurses' performance was excellent in completing the assessment and disposition section of the form (MIT 6.002, 100%). OIG clinicians reviewed five events in three cases in which patients transferred into the facility from other institutions, and found the R&R nurses evaluated newly arrived patients adequately and ordered provider appointments within required time frames.

The compliance team found WSP needed improvement in medication continuity at the time of transfer (MIT 6.003, 61.1%). WSP also needed improvement in medication continuity for patients who transferred within the institution (MIT 7.005, 56.0%). In addition, WSP performed poorly in medication continuity for patients en route with layovers at the institution (MIT 7.006, 40.0%). Our clinicians found two significant deficiencies related to medication continuity.³⁰ These deficiencies are discussed in the **Medication Management** indicator.

Compliance testing found providers only intermittently saw newly arrived patients within necessary time frames (MIT 1.002, 52.2%). In contrast, the case review clinicians found providers timely saw newly arrived patients in the cases they reviewed.

Transfers Out

WSP's transfer-out process was satisfactory. Our clinicians found the R&R nurses evaluated patients timely, completed transfer packages, and ensured adequate supplies of medications were provided prior to patients transferring out of the institution. OIG clinicians reviewed four transfer-out cases and found one deficiency related to documentation.³¹

Compliance testing found patients who transferred out of the institution always had their medications and required documents (MIT 6.101, 100%).

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at a high risk for lapses in care quality. Because these patients typically have experienced severe illness or injury, they require more care and increase strain on the institution's resources. In addition, because these patients have complex medical issues, successful health

²⁹ Deficiencies occurred in cases 20, 23, 24, 26, 52, and 54. Significant deficiencies occurred in cases 23, 24, and 52.

³⁰ Medication continuity interruption occurred in cases 23 and 24.

³¹ A transfer-out deficiency occurred in case 26.

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

Compliance testing showed WSP needed improvement in providing follow-up appointments within required time frames for patients returning from hospitalizations and emergency room evaluations (MIT 1.007, 64.7%). This is discussed further in the **Access to Care** indicator.

WSP performed satisfactorily in retrieving and scanning hospital records (MIT 4.003, 84.2%). Additionally, compliance testing found providers performed very well in reviewing and endorsing documents timely (MIT 4.005, 89.5%)

Our clinicians reviewed eight hospitalizations and emergency care cases. We found eight deficiencies, one of which was significant.³² Four deficiencies in three cases related to nursing performance. We identified opportunities for improvement in nursing performance in the following examples:

- In case 7, an RN evaluated the patient after returning from the community emergency department for acute gastroenteritis. The nurse documented an elevated pulse rate, but did not reassess the pulse.
- In case 20, nurses evaluated the patient, who was on hemodialysis and had a dialysis shunt, after the patient returned from the emergency department and again from the community hospital after an admission. Nurses did not assess the patient's dialysis shunt after either return.
- In case 52, the patient returned from the hospital, but nurses did not notify the provider or the utilization management nurse the patient returned without specialty consult reports for cardiology, ear, nose, and throat (ENT), and neurosurgery, each of which occurred during hospitalization.

Compliance testing showed WSP performed poorly in medication continuity when patients returned from hospitalization (MIT 7.003, 11.8%). Our clinicians identified one deficiency, which was not considered significant.³³

Clinician On-Site Inspection

During the on-site inspection, the clinicians were informed a dedicated transfer nurse completed all the transfer packets due to the large volume of transfers. In addition, extra staff assisted on days when large buses transported high numbers of incarcerated people who were transferring out. R&R RNs were staffed on various shifts 24 hours each day.

Please see the **Reception Center** indicator for additional information.

³² Hospitalization and emergency care deficiencies occurred in cases 20, 52, and 53. A significant deficiency occurred in case 52.

³³ A hospital-return medication deficiency occurred in case 20.

Compliance Testing Results

Table 11. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001)	13	12	0	52.0%
For endorsed patients received from another CDCR institution: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	24	0	1	100%
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	11	7	7	61.1%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	5	0	0	100%
Overall percentage (MIT 6): 78.3%				

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

Table 12. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient’s clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	12	11	2	52.2%
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)	11	6	2	64.7%
Are community hospital discharge documents scanned into the patient’s electronic health record within three calendar days of hospital discharge? (4.003)	16	3	0	84.2%
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)	17	2	0	89.5%
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)	2	15	2	11.8%
Upon the patient’s transfer from one housing unit to another: Were medications continued without interruption? (7.005)	14	11	0	56.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006)	4	6	0	40.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	8	5	0	61.5%

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

Recommendations

- Nursing leadership should determine the root cause of challenges that prevent nurses in thoroughly completing the initial health screening process including answering all questions and documenting an explanation for all “Yes” answers before the patient is transferred to the housing unit and implement remedial measures as appropriate.

Medication Management

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

Ratings and Results Overview

Case Review Rating
Adequate

Compliance Rating and Score
Inadequate (49.6%)

Case review found WSP had a mixed performance in this indicator. Staff performed well in ensuring patients timely receive medications during transfer-in or transfer-out, while in reception center, and after community hospitalizations. Staff also performed well in timely providing newly prescribed medications. However, we identified several examples in which chronic care and CTC medications were not provided timely or at all. Factoring in all the information, the OIG rated the case review component of this indicator **adequate**.

In compliance testing, WSP performed poorly overall. The institution showed good performance in providing patients with newly prescribed medications as ordered and in employing general security controls with narcotic medications in storage areas. However, WSP needed to improve its medication continuity for patients with chronic care and hospital discharge medications as well as for patients newly arrived from the reception center, patients transferring within the institution, and patients temporarily housed in WSP. On balance, the OIG rated the compliance testing component of this indicator **inadequate**.

Case Review and Compliance Testing Results

We reviewed 107 events in 26 cases related to medications and found 23 medication deficiencies, 10 of which were significant.³⁴

New Medication Prescriptions

Compliance testing found 92.0 percent of new medications were available or administered timely (MIT 7.002). Our clinicians found two deficiencies, one of which was

³⁴ Medication deficiencies occurred in cases 2, 9, 12, 15, 19, 20, 21, 23, 24, 52, 53, and 54. Significant deficiencies occurred in cases 20, 21, 23, 24, 53, and 54.

significant.³⁵ The significant deficiency is further detailed in the **Reception Center** indicator.

Chronic Medication Continuity

During this review period, WSP performed poorly in chronic medication continuity. Compliance testing showed patients sporadically received their chronic care medications within required time frames (MIT 7.001, 26.3%). In these samples, patients did not receive medications timely for high blood pressure, high cholesterol, diabetes, and seizures. Case review found several cases in which chronic care medications were not provided timely or were not provided at all,³⁶ as described in the following examples:

- In case 9, during September 2022, the patient received two 30-day supplies of a KOP blood pressure medication, two days apart.³⁷
- In case 20, during November 2022, the dialysis patient did not receive an important potassium-lowering medication several times on the nondialysis days as ordered.³⁸ This could have potentially resulted in elevated potassium levels, which would have increased the medical risk for this dialysis patient.
- In case 21, the patient was receiving a medication to treat chronic hepatitis C; however, the patient did not receive the medication from June 2022 to September 2022 due to the medication not being available.

Hospital Discharge Medications

Compliance testing showed staff rarely provided patients with their discharge medications on return from an off-site hospitalization or emergency room evaluations (MIT 7.003, 11.8%). In these test samples, nursing staff did not provide a reason for the patient refusing medications, and staff did not timely provide medications to treat infections, high blood pressure, cholesterol, narcotic dependence, seizures, or to decrease calcium levels. In contrast, our clinicians found staff performed well in ensuring patients received their medications after a community hospital evaluation. Our clinicians identified one deficiency, which was not considered significant.³⁹

Specialized Medical Housing Medications

Compliance testing revealed patients admitted to the CTC occasionally received their medications timely (MIT 13.003, 40.0%). In two samples, patients received diabetic and seizure medications one day late. In other samples, the pharmacy did not timely fill and dispense medications including those for high blood pressure, cholesterol, pain, and

³⁵ New medications were not received timely in cases 15 and 20.

³⁶ Chronic care medications were not received timely occurred in cases 2, 9, 12, 20, 21, 23, 24, and 52. Significant deficiencies occurred in case 20, 21, 23, and 24.

³⁷ KOP means “keep on person” and refers to medications in which a patient can keep and self-administer according to the directions provided.

³⁸ The medication was sodium zirconium cyclosilicate (Lokelma).

³⁹ A hospital discharge medication deficiency occurred in case 20.

blood clots. Our clinicians identified five deficiencies related to medication management; three were considered significant.⁴⁰

- In case 52, during September 2022, the patient did not receive two doses of a blood pressure medication (metoprolol). Furthermore, one day in October, the nurse administered this medication three times to the patient instead of two times.
- In case 53, the patient with rectal cancer and severe diarrhea was ordered to have intravenous (IV) fluids throughout the review period. However, the CTC nurses did not administer the IV fluids as ordered for October and December 2022.
- In case 54, during October 2022, the CTC nurses did not consistently check the diabetic patient's blood sugar before administering the evening dose of insulin. In addition, during October 2022, the patient's blood sugar readings were intermittently at high levels, and nursing staff did not notify the provider of the need for further management of these high blood sugar levels.

Transfer Medications

For transfer medications, WSP needed to improve with medication continuity at the time of transfer (MIT 6.003, 61.1%) and for patients who transferred within the institution (MIT 7.005, 56.0%). WSP performed poorly for patients en route with layovers at the institution for concerns related to medication continuity (MIT 7.006, 40.0%). Compliance testing revealed patients who transferred in from county jails only sporadically received medications timely as ordered (MIT 7.004, 33.3%). In three of the samples, patients received their medications later than the ordered start time. Our clinicians found two significant deficiencies related to transfer-in medication continuity⁴¹ as seen in the two cases below:

- In case 23, the patient with heart disease did not receive the KOP aspirin for a month after arriving to the institution.
- In case 24, the transfer-in patient had a duplication of medication orders to treat cholesterol, urinary retention, and Parkinson's disease. Subsequently, the patient received double the evening doses for these conditions.

OIG clinicians found one significant deficiency related to medication continuity as it related to a lapse in the care of patients arriving from the county jail: a dialysis patient did not receive the following medications as ordered: antibiotic, pain, and medication to lower phosphorus levels.

⁴⁰ Deficiencies occurred cases 52, 53, and 54. Significant deficiencies occurred in cases 53 and 54.

⁴¹ Transfer medication deficiencies occurred in cases 23 and 24. Both deficiencies were significant.

Medication Administration

Staff performed very well in ensuring TB medications were administered timely (MIT 9.001, 88.0%). Compliance testing also found nurses sometimes monitored patients taking TB medications as required by policy (MIT 9.002, 72.0%).

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians met with the pharmacist-in-charge (PIC) and the CNE to discuss specific medication-related deficiencies. They informed us they were receiving approximately 400 RC patients a week and could provide medications in a timely way with the current processes implemented. The RC area had an Omnicell, and an RN and an RC provider reviewed medications to prevent lapses in medication continuity. The PIC reported no general obstacles with providing medication services. During after-hours, nursing staff could obtain medications from the Omnicell or clinic stock, or contact the on-call pharmacist as needed. The institution had recently added an outside vendor pharmacy service to help with providing after-hours medications as needed. The PIC reported the main issues with medication continuity for patients arriving from the county jails, or discharged from a higher level of care, were high cost or unusual medications that took more time to procure. The PIC also reported ISUDT had greatly affected pharmacy services; as of December 31, 2022, WSP had 428 ISUDT patients and 503 active ISUDT medication orders.

OIG clinicians toured the medication administration areas and found nurses were knowledgeable concerning the medication administration process. Medication administration areas were clean and organized, and they did not have a backlog of KOP medications to administer. Medication nurses attended huddles and discussed medication compliance and nonadherence, expiring medications, and medication continuity for patients transferring to the care team, those new to the institution, or those who were returning from the hospital.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in eight of nine clinic and medication line locations (MIT 7.101, 88.9%). In one location, narcotic medications were not properly secured or stored during transport as required by CCHCS policy.

WSP appropriately secured and stored nonnarcotic medications in eight of 11 clinic and medication line locations (MIT 7.102, 72.7%). In three locations, we observed one or both of the following deficiencies: nurses did not maintain unissued medication in its original labeled packaging; the medication room lacked a clearly labeled designated area for medications to be returned to the pharmacy; and a daily security check treatment cart log entry was incomplete.

Staff kept medications protected from physical, chemical, and temperature contamination in only two of the 11 clinic and medication line locations (MIT 7.103, 18.2%). In nine locations, we found one or more of the following deficiencies: staff did not consistently record the room temperatures; staff did not consistently record the refrigerator temperatures or keep the temperature within the acceptable range; staff did

not store oral and topical medications separately; and the medication refrigerator was unsanitary.

Staff successfully stored valid, unexpired medications in nine of the 11 applicable medication line locations (MIT 7.104, 81.8%). In two locations, nurses did not label the multiple-use medications as required by CCHCS policy.

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

Staff in five of seven medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 71.4%). In two locations, medication nurses did not describe the process they followed when reconciling newly received medication and the medication administration record (MAR) against the corresponding physicians' orders.

Staff in three of seven medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 42.9%). In four locations, we observed one or more of the following deficiencies: medication nurses did not distribute medications to patients within the time frame of one hour before or one hour after the normal distribution time; a medication nurse did not consistently observe patients while they swallowed direct observation therapy medications and did not consistently verify patients' identification prior to administration; and medication nurses did not follow the CCHCS care guide when administering Suboxone medication, that is, medication nurses did not provide counseling for 30 seconds to ensure the Suboxone medication adhered to the patient's mouth.

Pharmacy Protocols

WSP always followed general security, organization, and cleanliness management protocols in its pharmacy (MIT 7.108, 100%). However, in its pharmacy, staff did not properly store nonrefrigerated medication. We also found medication stored in an inaccurately labeled container. As a result, the institution scored zero for this test (MIT 7.109).

The institution properly stored refrigerated or frozen medications in the pharmacy (MIT 7.110, 100%).

The PIC did not thoroughly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the pharmacist present at the time of the medication area inspection did not correctly complete the inspection checklist (CDCR form 7477) in several medication areas. These errors resulted in a score of zero for this test (MIT 7.111).

We examined 20 medication error reports. The PIC timely or correctly processed only three of these 20 reports (MIT 7.112, 15.0%). For 17 reports, we found one or more of the following deficiencies: the PIC did not provide a medication error follow-up review form, the PIC did not document the patient had been notified of a medication error, and the PIC did not document the recommended changes to correct the medication error from occurring in the future.

Nonscored Tests

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

The OIG interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. All 10 applicable patients interviewed indicated they had access to their rescue medications (MIT 7.999).

Compliance Testing Results

Table 13. Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001)	5	14	6	26.3%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	23	2	0	92.0%
Upon the patient’s discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003)	2	15	2	11.8%
For patients received from a county jail: Were all medications ordered by the institution’s reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004)	2	4	14	33.3%
Upon the patient’s transfer from one housing unit to another: Were medications continued without interruption? (7.005)	14	11	0	56.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006)	4	6	0	40.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	8	1	3	88.9%
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)	8	3	1	72.7%
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)	2	9	1	18.2%
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)	9	2	1	81.8%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	3	4	5	42.9%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	5	2	5	71.4%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	3	4	5	42.9%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution’s pharmacy properly store nonrefrigerated medications? (7.109)	0	1	0	0
Pharmacy: Does the institution’s pharmacy properly store refrigerated or frozen medications? (7.110)	1	0	0	100%
Pharmacy: Does the institution’s pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	3	17	0	15.0%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
Overall percentage (MIT 7): 49.6%				

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

Table 14. Other Tests Related to Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	11	7	7	61.1%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	5	0	0	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	22	3	0	88.0%
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)	18	7	0	72.0%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	4	6	0	40.0%

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

Recommendations

- The institution should consider developing and implementing measures to ensure staff timely make available and administer medications to patients and document administering medications in the EHRS, as described in CCHCS policy and procedures.

Preventive Services

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

Ratings and Results Overview

Case Review Rating
Not Applicable

Compliance Rating and Score
Adequate (78.5%)

WSP had a mixed performance in this indicator. The institution performed well in administering TB medications, screening patients annually for TB, offering patients an influenza vaccine for the most recent influenza season, and offering colorectal cancer screening for patients from ages 45 through 75. However, WSP only intermittently monitored patients taking prescribed TB medications, rarely offered required immunizations to chronic care patients, and intermittently transferred out patients who had the highest risk of coccidioidomycosis (Valley Fever) infection to an appropriate facility. Overall, the OIG rated this indicator **adequate**.

Compliance Testing Results

Table 15. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	22	3	0	88.0%
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)	18	7	0	72.0%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	25	0	0	100%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	23	2	0	92.0%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	5	12	8	29.4%
Are patients at the highest risk of coccidioidomycosis (Valley Fever) infection transferred out of the facility in a timely manner? (9.009)	17	8	0	68.0%
Overall percentage (MIT 9): 78.5%				

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

Recommendations

- Nursing leadership should analyze the challenges to ensuring nursing staff monitor and address symptoms of patients receiving TB medications according to CCHCS guidelines and take necessary remedial measures.
- Nursing leadership should analyze the challenges in ensuring patients at the highest risk of coccidioidomycosis (Valley Fever) are monitored and transferred in a timely manner.
- Medical and nursing leadership should analyze the challenges related to the untimely provision of preventive vaccines to chronic care patients and implement remedial measures as appropriate.

Nursing Performance

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

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

Ratings and Results Overview

Case Review Rating
Inadequate

Compliance Rating and Score
Not Applicable

WSP's overall nursing performance was poor. Case review found nurses frequently performed incomplete nursing assessments in the outpatient and specialized medical housing settings. In addition, we identified areas for improvement with untimely and inappropriate nursing interventions. However, nurses performed well in caring for patients in the RC, patients returning from the hospital, and patients returning from off-site specialty appointments. Nonetheless, considering all these factors, OIG rated this indicator *inadequate*.

Case Review Results

We reviewed 206 nursing encounters in 51 cases. Of the nursing encounters we reviewed, 125 occurred in the outpatient setting, and 71 were sick call requests. We identified 77 nursing performance deficiencies, 19 of which were significant.⁴²

Outpatient Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interviews) and objective (observation and examination) elements. Our clinicians identified 48 outpatient nursing deficiencies, 14 of which were considered significant.⁴³ These deficiencies included nurses in the medical clinics did not

⁴² Nursing performance deficiencies occurred in cases 1-3, 5, 7, 10, 11, 13-15, 18-21, 24, 26, 32, 34, 39, 42, 43, 45-49, and 52-54. Significant deficiencies occurred in cases 5, 7, 10, 14, 20, 32, 39, and 47.

⁴³ Outpatient nursing deficiencies occurred in cases 1, 2, 7, 10, 11, 13-15, 18-21, 32, 34, 39, 42, 43, and 45-49. Significant deficiencies occurred in cases 7, 10, 14, 20, 32, 39, and 47.

always properly triage a symptomatic sick call that required a same-day evaluation, and nurses frequently performed incomplete nursing assessments. Examples of incomplete assessments, interventions, and delays in same-day sick call evaluations are listed below:

- In case 7, the patient submitted a sick call request for pain in the groin on the right side and in the right leg with concerns of possible infection or kidney stone. In addition, during the face-to-face encounter, the patient reported pain in both the lower back and the right-upper leg. The sick call nurse did not inquire concerning the time of onset and the duration of symptoms, review medication compliance, perform a skin assessment, or assess urinary signs and symptoms. In addition, the nurse did not document if the provider was notified of the lower-back symptoms or inquire if any further laboratory work-up was needed.
- In case 14, the patient complained of abdominal pain, vomiting, headache, dizziness, and orange-colored urine. The sick call nurse did not perform a complete abdominal assessment, which includes listening to bowel sounds and inquiring about the last bowel movement, the stool color, and vomiting. In addition, the nurse did not assess the skin or the urinary system for any signs and symptoms. Furthermore, the nurse reassessed the patient for abdominal pain one week later, and the patient continued to have severe abdominal pain and tenderness. However, the nurse did not consult with the provider for a further plan of care.
- In case 20, nurses evaluated the patient suspected of having bladder cancer, who arrived to WSP from the county jail. The patient submitted multiple sick call requests to see the urologist for his bladder cancer and complained of blood in the urine for several months, as well as diarrhea. The patient also requested a renewal of an antibiotic (Amoxicillin), which the patient previously had received after a knee infection, and had been informed by the outside community hospital provider that he would need for the rest of his life. The sick call nurse scheduled the patient to follow-up with the provider in 14 days. In addition, the nurse ordered a 14-day follow-up with a provider instead of consulting with the provider on the patient's report of blood in the urine and for the antibiotic renewal. During multiple sick call nurse evaluations for diarrhea and blood in the urine, the nurse frequently did not assess the abdomen, inquire on the frequency of the diarrhea episodes, inquire on the frequency and color of the blood in the urine, or notify the provider when the antidiarrheal medication was not effective.
- In case 39, the patient with congestive heart failure, hypertension, diabetes, hyperlipidemia, and end-stage renal disease on hemodialysis submitted a sick call request for excruciating daily leg cramps. The sick call nurse did not schedule a same day appointment for the urgent symptom for possible blood clots. In addition, the nurse did not listen to the heart and lung sounds or obtain subjective information concerning the aggravating and relieving factors of the cramps during the face-to-face evaluation.
- In case 47, the sick call nurse did not schedule a same-day appointment for the patient reporting vomiting blood, who was at risk of internal bleeding and increased blood loss. The sick call nurse evaluated the patient the next day, and the patient reported having vomited blood for a couple of weeks and

of being constipated. However, the nurse did not do a complete assessment of the abdomen and skin, nor obtain objective information on the vomiting frequency and description of the vomit, such as whether it looked like coffee grounds or had bright red blood in it. In addition, the nurse did not consult with the provider for a further plan of care.

Outpatient Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. Nurses generally documented care appropriately.

Case Management

OIG clinicians reviewed five cases in which patients were evaluated by a care manager or care coordinator.⁴⁴ Case review identified five deficiencies in evaluating patients for care management and care coordinator appointments, none of which was significant.⁴⁵ The following are examples:

- In case 14, the care management nurse evaluated the patient for hypertension and ordered blood pressure checks weekly for one month. However, the nurse did not schedule an appointment for a blood pressure follow-up or contact the provider with the blood pressure reading.
- In case 20, nursing staff intermittently completed vital signs checks on the patient after dialysis. In addition, on several occasions, the patient's pulse was low, and nurses did not recheck the pulse. Last, nursing staff only intermittently completed a full set of vital signs checks to include the respirations, the pulse, and the temperature.

Emergency Services

OIG clinicians reviewed 18 urgent or emergent events. Nurses generally responded timely to emergent events. However, their assessments, interventions, and documentation showed room for improvement, which we detail further in the **Emergency Services** indicator.

Hospital Returns

We reviewed nine nursing events in eight cases that involved returns from off-site hospitals or emergency rooms. The clinicians identified four deficiencies, none of which was significant.⁴⁶ Nurses generally performed good nursing assessments, interventions, and documentation. Please refer to the **Transfers** indicator for further details.

⁴⁴ Patients were evaluated by the care manager or care coordinator in cases 12-14, 17, and 20.

⁴⁵ Deficiencies occurred in cases 14 and 20, none of which was significant.

⁴⁶ Deficiencies occurred in cases 20, 52, and 53.

Transfers

We reviewed seven cases involving transfer-in and transfer-out processes. The compliance team found the R&R nurses did not always thoroughly complete the initial health screening form; however, nurses did well in completing the assessment and disposition section of the form. WSP also performed poorly with medication continuity at the time of transfer for both patients who transferred within the institution and patients en route with layovers at the institution. Please refer to the **Transfers** indicator for further details.

Reception Center

OIG clinicians reviewed nine cases with patients who arrived at the RC and found two nursing deficiencies, one of which was significant.⁴⁷ Compliance testing found nurses performed well in completing the initial health screening forms thoroughly, timely signing and completing the assessment and disposition portion of the health screening form. Please refer to the **Reception Center Arrivals** indicator for further details.

Specialized Medical Housing

We reviewed three CTC cases with a total of 16 nursing events. We identified 10 nursing deficiencies, none of which was significant.⁴⁸ Nurses generally performed timely assessments and frequently evaluated patients. However, we identified opportunities for improvement in completing thorough assessments and interventions. For more specific details, please refer to the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed 20 events in 10 cases in which patients returned from an off-site specialist appointment. We identified two deficiencies, one of which was significant.⁴⁹ Nursing staff appropriately assessed patients, reviewed specialist findings and recommendations, and consulted with the provider. Please refer to the **Specialty Services** indicator for more information.

Medication Management

OIG clinicians examined 107 events involving medication management and found 23 medication deficiencies, 10 of which were significant.⁵⁰ Both case review and compliance scores showed poor performance in specialized medical housing and chronic care medication continuity. In contrast, WSP had mixed results for medication continuity for patients returning from the hospital or transferring, or for RC patients. Please refer to the **Medication Management** indicator for additional details.

⁴⁷ Deficiencies occurred in cases 2 and 20. A significant deficiency occurred in case 20.

⁴⁸ CTC nursing performance deficiencies occurred five times in case 54, four times in case 52, and once in case 53. There were no significant deficiencies.

⁴⁹ Deficiencies occurred in cases 20 and 53. A significant deficiency occurred in case 20.

⁵⁰ Medication deficiencies occurred in cases 2, 9, 12, 15, 19–21, 23, 24, and 25. Significant deficiencies occurred in cases 20, 21, 23, 24, 53, and 54.

Clinician On-Site Inspection

Our clinicians spoke with nurse supervisors and nurses in the TTA, CTC, R&R, specialty services, outpatient clinics, and medication administration areas. We observed huddles were well attended by the care team, were organized, and pertinent information was reported. We also attended the CTC huddle that included the utilization nurse and the mental health provider.

On the sensitive needs yard, the clinic nurses reported evaluating approximately 30 patients per day, and staff reported no appointment backlog. This yard had two RNs and one RN floater who worked in multiple areas. This area had a dormitory setting with approximately 800 patients. The senior registered nurse (SRN) II reported voluntary overtime was provided for the RNs on the weekends to help prevent sick call backlogs due to the large volume of sick calls on Fridays and on the weekends. The LVNs perform daily wound care, and the RNs provide weekly wound care evaluations. During the clinician case review period, we had no wound care sample cases to evaluate. Staff reported the main priority was sick call evaluations. Care management issues, such as laboratory orders and vaccinations, were addressed during population management meetings.

We met with nursing leadership, who addressed our findings and acknowledged opportunities for quality improvement. During our case review period, we found COVID-19 quarantine rounding orders were notated in the EHRS; however, we found no corresponding nursing rounding documentation. Nursing leadership provided a CCHCS COVID-19 memorandum that allowed WSP to export and print a paper list of patients who were on COVID-19 quarantine from the COVID Monitoring Registry. Nurses no longer needed to document these quarantine rounds in the EHRS unless the patient was symptomatic. Nursing leadership provided us with the paper list of patients on COVID-19 quarantine about whom we had questions.

Nursing leadership reported SRN IIs were responsible for conducting 10 sick call audits each month per nursing staff. In addition, SRN IIs audited the medication administration areas. WSP informed us clinic RNs acted as care managers, and clinic LVNs performed care coordinator duties, which included providing vaccinations, conducting vital signs checks, and distributing durable medical equipment and diabetic supplies. Clinic RNs explained that most of the care management was completed during population management meetings by discussing any significant cases and ordering any needed appointments or laboratory tests.

At the time of the on-site inspection, WSP informed us they had a nine percent nursing vacancy, with most of the vacancies being RNs. The CNE reported challenges with staffing were due to uncompetitive salaries compared with salaries offered to nurses in the community. Staff had been attending hiring events at job fairs and local colleges. In addition, students from San Joaquin Valley College performed clinical rounding at WSP with medical assistants (MAs) and LVNs, which gave WSP an opportunity to recruit them as well, for the future.

Recommendations

- Nursing leadership should analyze the challenges to nurses performing thorough, detailed assessments and interventions during patients' appointments and reenforce the audits already implemented.

Provider Performance

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

Ratings and Results Overview

Case Review Rating
Inadequate

Compliance Rating and Score
Not Applicable

WSP providers performed poorly overall in delivering care. Although providers performed satisfactorily in assessments and decision making, documentation, chronic care, and emergency services, we identified lack of follow-up, inappropriate time frame orders, poor differential diagnosis, and incomplete history taking. We also found instances in which poor record review and possible superficial provider care may have contributed to either patient harm or missed treatment opportunities. After careful consideration of all factors, the OIG rated this indicator **inadequate**.

Case Review Results

OIG clinicians reviewed 120 medical provider encounters and identified 116 deficiencies, 32 of which were significant.⁵¹ In addition, our clinicians examined the quality of care in 18 comprehensive case reviews. Of these 18 cases, we rated 14 **adequate** and four **inadequate**.

Outpatient Assessment and Decision-Making

OIG clinicians found many assessment and decision-making deficiencies. We frequently found incomplete history-taking, poor differential diagnosis and assessments, a lack of follow-up, and orders for inappropriate time frames. Examples include the following cases:

- In case 7, during the initial patient health assessment, the patient with significant cardiac risk factors complained of indigestion symptoms. The provider did not consider the patient's symptoms could have been from cardiac causes and did not perform an appropriate diagnostic examination.

⁵¹ Deficiencies occurred in cases 1, 2, 7, 9–22, and 52–54. Significant deficiencies occurred in cases 7, 10, 13–16, 20–21, 52, and 56.

Unfortunately, the patient died of a heart attack approximately one month later.

- In case 10, the RN contacted the provider about a diabetic patient who had pain in the left side with urination, which could indicate a kidney stone or kidney infection. The provider ordered a laboratory urinalysis to be done in seven days. Since urine dipstick testing was not immediately available, the urinalysis should have been ordered STAT or same day. The provider also ordered a follow-up appointment in 14 days, but the patient should have been assessed more urgently.
- In case 16, the provider saw the patient who had an acute significant drop in red blood cells, which can be a sign of internal bleeding. The provider did not consider gastroenterological causes or internal bleeding in the differential diagnosis and did not perform an appropriate diagnostic examination.
- In case 20, the provider who performed the initial history and physical did not address the patient's documented history of suspected bladder cancer and did not order a follow-up to ensure this potential condition was addressed. Another provider then ordered the chronic care appointment to address the bladder cancer and other unaddressed chronic medical conditions; however, that provider did not address the bladder cancer, delaying care to the patient.

Outpatient and RC Review of Records

As an RC, review of medical records is especially important. OIG clinicians found providers did not always carefully review medical records. We identified 13 deficiencies related to poor medical-record review, four of which were considered significant.⁵² In two of the nine RC cases reviewed, we determined poor record review and possible superficial care by providers may have either contributed to patient harm or resulted in persistently missed medical issues throughout the review period. Examples of significant deficiencies include those in the following cases:

- In case 7, the patient's intake laboratory test results indicated a positive test result for tuberculosis.⁵³ Providers did not address this abnormal laboratory result during the review period.
- Also in case 7, the provider performed the initial patient health care assessment. However, the provider did not review the patient's medical record from previous incarcerations, which included diagnoses of dyslipidemia and partial blockage of the main arteries going to the brain.⁵⁴ Because the provider missed these diagnoses, the provider did not consider ordering aspirin or other treatment for cardiovascular disease. Unfortunately, the patient died a few weeks later of a heart attack.

⁵² Deficiencies occurred in cases 7, 12, 14, 15, 17, 19, 20, 22, 53, and 54. Significant deficiencies occurred in cases 7, 15, 20, and 54.

⁵³ QuantiFERON-TB Gold Plus is a test used to detect tuberculosis.

⁵⁴ Dyslipidemia is a condition with abnormal levels of blood lipids, such as cholesterol and triglycerides.

- In case 20, the patient's transfer documentation from the county jail showed the patient had chronic heart failure, coronary artery disease, glaucoma, and a history of gastric bypass, in addition to multiple other medical conditions. Providers did not acknowledge or address these conditions in either the medical documentation or the provider assessments and plans during the six-month review period.

Emergency Care

Providers made appropriate triage decisions when patients arrived at the TTA for emergency treatment. Although providers were available for consultation with TTA nursing staff, we identified four minor deficiencies related to poor or lack of provider emergency documentation.⁵⁵

Chronic Care

Providers need to improve in managing patients' chronic medical conditions. Several significant deficiencies in chronic care occurred because providers had not adequately reviewed the patient's medical record, were unaware of medical problems that required follow-up, or made poor assessments regarding the chronic state of certain illnesses. Examples include the following cases:

- In case 12, the provider sent the patient an ultrasound results letter stating his results were normal or unchanged; however, no prior ultrasound had been completed, and the new results indicated the patient had cirrhosis (liver disease), which was not normal and required both a follow-up and avoidance of liver toxic substances. The provider did not discuss the diagnosis or the need for liver care with the patient and did not develop an appropriate assessment and plan.
- In case 15, throughout the review period and for over one year, the primary care provider did not address the high-risk patient's lung condition that required inhaled medications or the chronic use of blood thinners in either progress notes or assessments and plans. The patient was on a lung medication without a documented medical indication. This high-risk patient did not have a chronic care appointment for at least eight months, and providers addressed only acute problems during this period.
- In case 16, the provider ordered the patient to have a chronic care appointment combined with a follow-up after a transplant surgeon evaluated the patient. At the appointment, the provider did not address the high-risk patient's chronic medical conditions.

Outpatient and CTC Documentation Quality

As it had been in the Cycle 6 inspection, poor documentation continued to be a problem at WSP in Cycle 7. OIG clinicians identified over 50 deficiencies that included missing provider progress notes, incomplete documentation, cloned progress notes with inaccurate assessments and plans, and providers not updating patients' lists of

⁵⁵ Emergency documentation deficiencies occurred in cases 19 and 20. None was significant.

concerns.⁵⁶ In many instances, it was very difficult to determine what history the provider had obtained and what care was provided to the patient. The CTC provider, who is responsible for some of the most ill patients, frequently cloned progress notes with incorrect and outdated information. Other providers frequently made medical decisions without documenting any medical reasoning, or the documentation was missing important components such as a review of systems or physical examinations. Examples of documentation deficiencies were discussed in the following cases:

- In case 14, the provider saw the patient whose CT scan indicated the patient had cirrhosis (liver disease). The provider did not add cirrhosis to the patient’s problem list in the patient’s electronic medical records to ensure both appropriate follow-up treatment and the avoidance of liver-toxic substances or medications, did not advise the patient of the presence of cirrhosis, and did not develop an appropriate assessment and plan.
- In case 15, the RN contacted the provider about a patient who fell on the way to hemodialysis and had significant ankle pain. The provider ordered an X-ray and pain medication, and reviewed and endorsed the X-ray, but did not document an assessment or a plan for the patient.
- In case 54, the specialized medical housing provider had previously increased the patient’s long-acting insulin medication; however, in the next two weeks, the provider documented in all the progress notes to increase the insulin, which already had been done. In addition, the provider documented an incorrect assessment and plan for high blood pressure, repeating “start low dose amlodipine” in each progress note for six weeks after that medication had already been started.

Provider Continuity

The cases we reviewed showed most patients initially saw several providers for care due to the intake nature of an RC. One provider would see the patient for a focused health care assessment prior to transfer to the yard, and once transferred, provider continuity was generally good.

Clinician On-Site Inspection

OIG clinicians met with medical leadership and providers to discuss challenges, achievements, and deficiencies. As an RC, WSP had developed a specialized system called “Diagnostics” whereby new departmental patients, approximately 400 arriving per week, could be assessed for dental, mental health, and medical screenings. Nurses performed the initial health assessments on the day of arrival; ordered intake screening laboratory work; and scheduled the provider, mental health, dental, and RN follow-up appointments based on patient acuity level. Providers were required by policy to perform an RC-focused health care assessment for each newly arrived patient within five business days; however, we identified delays. Medical leadership, scheduling staff, and providers reported providers did not see the newly arrived patients until they were out of 10- to 14-day

⁵⁶ Documentation deficiencies occurred in 7, 9, 11, 13–15, 17, 18, 20, 21, 52, and 54.

quarantine. Nurses, however, performed their initial health assessments within required time frames.

In the case reviews, we found different levels of care from providers regarding the required provider RC-focused health care assessment. CCHCS RC policies detail the requirements.⁵⁷ Some providers only completed durable medical equipment requirements and did cursory reviews. Providers frequently did not complete physical exams and often did not address chronic medical conditions. At our on-site visit, we received conflicting responses from different providers about what they believed they were required to do for an RC-focused health care assessment. One provider stated they only order durable medical equipment; several mentioned they do not handle any chronic medical conditions regardless of severity; others stated they only handle urgent or emergent issues. We also found providers did not thoroughly address chronic care issues and sometimes did not timely order the follow-up appointment to address them. OIG clinicians found this particularly concerning because yard providers stated they relied heavily on the information from the provider RC-focused health care assessments.

We found generally poor provider documentation throughout the institution and extensive progress note cloning in the CTC. HIM management stated cloned progress notes were not acceptable, but providers were permitted to insert personalized saved phrases into their documentation. HIM reported their department did monitor for cloned progress notes in the CTC and sent a Physician Deficiency Detailed Report to the CME and chief physician and surgeon (CP&S) when cloned progress notes were found. HIM staff sent reminders to providers and to the CP&S about this report via email. WSP did not provide our clinicians with copies of the Physician Deficiency Detailed Report or email follow-ups to support whether this process occurred or was effective.

The WSP CME was very highly regarded by those providers we interviewed, as was the CP&S. The CP&S was relatively new to this position and was not available to speak with during our inspection. All providers felt supported by both the CME and the CP&S. Providers felt they had good peer rapport and a good working group. Some long-term physicians had recently retired. The CME acknowledged difficulty recruiting new providers because other surrounding institutions offered a 15 percent pay differential, which was not authorized at WSP. At the time of our inspection, CCHCS telemedicine providers and several registry providers were filling the positions. Some registry providers traveled extensive distances for their daily work, but stated they believed the travel was worth it because they enjoyed the management and the work at WSP.

We discussed the poor documentation with medical leadership. When we asked about progress note brevity or missing progress notes, both providers and medical leadership expressed their belief this was acceptable documentation. The lack of negative feedback in the provider performance reviews regarding a need to improve documentation confirmed this belief. Medical leadership also reported WSP had no guidelines for appropriate documentation. Poor documentation increased risk of medical errors, including missed diagnostic examinations, and created extra work for medical staff caring for the patient. Just prior to our on-site inspection, CCHCS had developed a provider documentation policy, in which WSP medical leadership would train their staff to follow.

⁵⁷ HCDOM 3.1.8, Reception Center, c.2.A-C.

Recommendations

- Medical leadership should analyze the causes of poor provider documentation, including updating the patient problem lists, and implement remedial measures as appropriate.
- Medical leadership should emphasize the necessity and importance of appropriate provider EHRS chart review at each patient appointment.
- Medical leadership should clarify for providers the tasks required for RC-focused health care assessments, appropriate durations for follow-up, and expectations of the yard providers at the initial appointment after completing focused health care assessments.

Reception Center

This indicator focuses on the management of medical needs and continuity of care for patients arriving from outside the department's system. The OIG review includes evaluating the institution's performance in 1) providing and documenting initial health screenings, initial health assessments, continuity of medications, and completion of required screening tests; 2) addressing and providing significant accommodations for disabilities and health care appliance needs; and 3) identifying health care conditions needing treatment and monitoring. Patients reviewed for reception center (RC) care are those received from nondepartmental facilities, such as county jails.

Ratings and Results Overview

Case Review Rating
Adequate

Compliance Rating and Score
Inadequate (70.4%)

WSP had a mixed performance in this indicator. Case review found nurses performed well in assessments, interventions, and documentation for patients arriving to the RC. However, we found opportunities for improvement in providers' assessments and providers' thorough review of patients' prior medical records. In addition, WSP also needed improvement in timely completing intake RC screening tests and provider's review of the test results. Taking all these aspects into consideration, the OIG rated the case review component of this indicator **adequate**.

Compliance testing showed WSP's overall performance improved for this indicator. WSP showed good performance in timely completing initial health screening forms, assessment and disposition sections of the screening process, and history and physical examinations. However, the institution needs to improve in offering and completing screening laboratory tests and Valley Fever skin tests as well as reviewing and communicating laboratory results. Factoring in all the information, the OIG rated the compliance testing component of this indicator **inadequate**.

Case Review and Compliance Testing Results

Our clinicians reviewed nine cases and identified 12 deficiencies, seven of which were significant.⁵⁸

Provider Access

RC provider access was mixed. Compliance testing revealed good provider access: providers often saw new patients received from county jails within the required time frame (MIT 12.003, 87.5%), and they frequently evaluated patients and performed history and physical examinations (H&Ps) within seven days (MIT 12.004, 85.0%). However, case review clinicians found poor provider access in several of the nine RC cases we reviewed. In three of these cases, patients were not seen until two weeks after their arrival. All

⁵⁸ Deficiencies occurred in cases 2, 7, and 20. Cases 2, 7, and 20 had significant deficiencies.

three cases were for patients with complex medication conditions who should have been seen urgently.⁵⁹ In addition, case review found multiple provider performance deficiencies in RC care in two of the nine cases: cases 7 and 20. The deficiencies included providers' poor review of records and lapses in addressing critical medical conditions. These deficiencies were discussed further in the **Access to Care and Provider Performance** indicators.

Compliance testing showed WSP needed improvement in offering and completing intake screening tests (MIT 12.005, 60.0%). Case review also found WSP performed poorly in completing initial screening tests and the provider's review of results, with deficiencies cited in cases 7 and 54. This was discussed further in the **Diagnostics and Provider Performance** indicators.

Nursing Performance

Compliance testing found nurses performed excellently in thoroughly completing the initial health screening forms (MIT 12.001, 95.0%), and nurses timely signed and completed the assessment and disposition portion of the health screening form (MIT 12.002, 100%).

OIG clinicians reviewed nine cases and found two nursing deficiencies, one of which was significant⁶⁰ as described below:

- In case 20, the nurse evaluated the new RC patient who had arrived from the county jail. The patient had multiple medical chronic care issues including suspected bladder cancer, blood in the urine for two months, diabetes, end-stage renal disease requiring dialysis, anemia, and high blood pressure. The patient reported a recent episode of blood in the urine. However, the nurse did not consult with the provider for a further plan of care for this high-risk patient and his reports of continued blood in the urine.

Clinician On-Site Inspection

During the clinician on-site inspection, WSP RC staff informed us they processed patients through the various steps in the intake procedure. The RNs and LVNs were well organized and fully staffed to handle a large number of patients. WSP staff informed us approximately 400 new RC patients arrived weekly.

Medical leadership reported difficulty in transferring the sickest patients to a higher acuity care institution for appropriate care. Medical leadership informed us, even though the placement committees reviewed the cases and assigned patients to other institutions, some higher acuity care institutions have created secondary hurdles the RCs had to overcome for a patient to be considered for transfer. Medical leadership stated, even after the initial approvals occurred, higher acuity care institution still commonly denied transfer for WSP patients. When this occurred, CCHCS headquarters and WSP medical leadership need to intervene, which delayed proper placement for the patient. As a high-volume RC, timely transferring patients to their ultimate destinations was critical.

⁵⁹ Significant deficiencies in RC provider access occurred in cases 2, 7, and 20.

⁶⁰ Deficiencies occurred in cases 2 and 20. Case 20 had a significant deficiency.

Staff stated a new diagnostic area would help in processing RC patients more efficiently with being able to offer provider, mental health, dental, and laboratory services. This may reduce delays in appointments for the RC process. In addition, the new diagnostic area would include five TTA beds. At the time of our inspection, construction was near completion for the diagnostic area, pending an opening date of June 5, 2023.

Compliance Testing Results

Table 16. Reception Center

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: Did nursing staff complete the initial health screening and answer all screening questions upon arrival of the patient at the reception center? (12.001)	19	1	0	95.0%
For patients received from a county jail: Did the RN complete the assessment and disposition section, and sign and date the completed health screening form upon patient's arrival at the reception center? (12.002)	18	0	2	100%
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)	14	2	4	87.5%
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days (prior to 07-2022) or five working days (effective 07-2022)? (12.004)	17	3	0	85.0%
For patients received from a county jail: Were all screening tests offered or completed within specified timelines? (12.005)	12	8	0	60.0%
For patients received from a county jail: Did the primary care provider review and communicate the intake test results to the patient within specified timelines? (12.006)	0	19	1	0
For patients received from a county jail: Was a coccidioidomycosis (Valley Fever) skin test offered, administered, read, or refused timely? (12.007)	13	7	0	65.0%
Overall percentage (MIT 12): 70.4%				

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

Table 17. Other Tests Related to Reception Center

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: Were all medications ordered by the institution's reception center provider made available, administered, or delivered to the patient within the required time frames? (7.004)	2	4	14	33.3%

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

Recommendations

- Medical leadership should determine causative factors related to the untimely provision of patients' RC screening laboratory tests and provider communication of test results to their patients as stated in CCHCS policy.
- Nursing leadership should analyze the challenges to nursing staff on following CCHCS policies and procedures for coccidioidomycosis (Valley Fever) skin test reading and implement remedial measures as appropriate.

Specialized Medical Housing

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

Ratings and Results Overview

Case Review Rating
Inadequate

Compliance Rating and Score
Proficient (85.0%)

WSP had a mixed performance in this indicator with case review. We found providers evaluated patients in the CTC timely but often performed poor EHRS patient chart reviews, did not document accurate evaluations, and did not provide documentation showing any supporting assessments for the plan of care. Nursing staff assessed patients routinely; however, nurses showed room for improvement in completing thorough nursing assessments, interventions, and documentation. Factoring in all the information, the OIG rated the case review component of this indicator **inadequate**.

Compliance testing showed WSP staff performed excellently in completing initial assessments, history, and physical examinations within the required time frame as well as in maintaining a functional call light system. One area for improvement was poor medication continuity for patients newly admitted to the CTC. Considering all the information, the OIG rated the compliance testing component of this indicator **proficient**.

Case Review and Compliance Testing Results

The CTC is a 16-bed unit, with 10 beds designated for medical patients. We reviewed three CTC cases that included 37 provider events and 16 nursing events. Due to the frequency of nursing and provider contacts in the specialized medical housing, we bundled up to two weeks of patient care into a single event. We identified 38 deficiencies, 11 of which were significant.⁶¹

Provider Performance

Providers delivered mixed specialized medical housing care. Compliance testing showed providers completed all admission history and physical examinations without delay (MIT 13.002, 100%). Case review also found providers performed well in timely completing

⁶¹ CTC deficiencies occurred in cases 52–54. Significant deficiencies occurred in cases 52–54.

admission history and physicals, and also timely completed patient follow-up appointments. However, in our three CTC cases, we identified 23 provider performance deficiencies, eight of which were significant.⁶² Provider documentation was poor, EHRS patient chart reviews were incomplete, and important medical conditions were not always addressed. Examples of significant deficiencies are below:

- In case 52, the patient returned from the hospital with extensive facial fractures and a brain bleed. The provider started a blood thinning medication for this patient, which increased the risk of the existing brain bleed. Although the scanned hospital records had recommendations to start the blood thinning medication, the hospital's records were incomplete at the time the provider endorsed them. Specifically, the scanned hospital records did not contain the neurosurgery and cardiac consultation reports to explain why the blood thinner was needed. In addition, the provider's supervisor, the CME, advised the provider not to start the blood thinner.
- In case 54, the provider evaluated a new patient for a CTC admission. The patient arrived with a low blood count and reduced kidney function. The provider did not thoroughly evaluate the patient for possible causes of the low blood count and reduced kidney function.
- Again, in case 54, the provider endorsed laboratory results indicating the patient's kidney function and low blood counts had worsened. The provider did not address the patient's worsening renal function and low blood counts, or order an additional diagnostic examination to determine the cause. In addition, the provider's progress notes did not document the latest abnormal laboratory results for almost five weeks after the results were available.

We also discuss the deficiencies in the **Provider Performance** indicator.

Nursing Performance

In both case review and compliance testing, patients admitted to the CTC received timely initial health assessments (MIT 13.001, 100%). Compliance testing showed the CTC maintained an operational call system to ensure patients had access to care (MIT 13.101, 100%). The case review clinicians found patients were assessed by nursing staff every shift, but the assessments were often incomplete. Of the 37 deficiencies we identified in the specialized medical housing cases, 10 deficiencies directly related to the quality of nursing care, none of which was significant.⁶³ Deficiencies mainly involved incomplete assessments. Examples are described below:

- In case 52, the patient was admitted to the CTC with facial fractures and a brain bleed. The admitting CTC nurse did not perform a detailed baseline assessment to include an assessment of the eyes, the surrounding facial area, and documentation of any missing teeth. However, three hours later, another nurse documented the patient had swelling to the right eye. Later in the

⁶² Provider performance deficiencies occurred in cases 52–54. Significant deficiencies occurred in cases 52 and 54.

⁶³ CTC nursing performance deficiencies occurred five times in case 54, four times in case 52, and once in case 53. None was significant.

review period, the patient reported increasing blurred vision in the right eye. The nurse did not perform a thorough eye examination to include a visual acuity test and assessment of pupils. In addition, the nurse did not notify the provider of the patient's symptoms.

- In case 54, the diabetic patient on insulin, with multiple complex conditions, including decreased kidney function, bilateral knee amputations, and a swallowing disorder, was admitted to the CTC after a hospitalization. The CTC nurse did not initiate care plans for the risk of aspiration or the risk for impaired skin integrity due to bowel and bladder incontinence. In another encounter, the patient complained of loose stools. For five days, the CTC nurses did not complete thorough GI assessments. In addition, during November 2022, CTC nurses intermittently documented the patient's blood-sugar checks on the medication administration record (MAR) without any orders to check the blood sugar level.

Medication Administration

Compliance testing revealed patients who were admitted to the CTC only occasionally received their medications timely (MIT 13.003, 40.0%).

Our clinicians identified five deficiencies related to medication management, three of which were considered significant.⁶⁴ We discuss this further in the **Medication Management** indicator.

Clinician On-Site Inspection

The CTC had 10 medical beds, six mental health beds, and two negative pressure rooms for respiratory isolation. At the time of our inspection, nine patients occupied the 10 medical beds, and six patients occupied the mental health beds.

The CTC was staffed 24 hours a day with RNs, LVNs, and psychiatric technicians (PT). Staffing included three RNs for the morning and evening shifts, and two RNs on the night shift. In addition, on the morning and evening shifts, an LVN and a PT were also assigned to the unit. WSP had one designated CTC provider, who made rounds with nursing staff and conducted daily morning huddles.

The case review clinicians attended the CTC daily huddle. The provider, the UM nurse, the SRN, nurses, and mental health staff all participated in the huddle, which was well organized.

⁶⁴ Medication deficiencies occurred in cases 52-54. Significant deficiencies occurred in cases 53 and 54.

Compliance Testing Results

Table 18. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission? (13.001)	10	0	0	100%
Was a written history and physical examination completed within the required time frame? (13.002)	10	0	0	100%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	4	6	0	40.0%
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101)	1	0	0	100%
For specialized health care housing (CTC, SNF, hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102)	0	0	1	N/A
Overall percentage (MIT 13): 85.0%				

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

Recommendations

- Nursing leadership should analyze the causes of CTC nurses not completing daily assessments thoroughly and implement remedial measures as appropriate.
- Medical leadership should analyze the causes of CTC providers not completing appropriate documentation, EHRS chart reviews, and not addressing important medical issues.

Specialty Services

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

Ratings and Results Overview

Case Review Rating
Inadequate

Compliance Rating and Score
Adequate (81.7%)

WSP performed poorly in specialty services with case review. Medical leadership approved requests for referral promptly, and follow-up provider appointments after specialty consultations occurred as ordered. On-site hemodialysis access for patients was good. However, we found cases in which critical specialty services were not ordered due to a lack of specialty availability. In addition, we identified provider delays in specialty orders, and providers did not order specialty follow-up appointments until after the specialty appointment was already scheduled. Providers did not review and endorse the on-site specialist's progress notes, which led to delayed medical care. We also found several instances of missing, but clinically significant, specialty services documentation. Overall, due to the severity of the findings, the OIG rated the case review component of this indicator **inadequate**.

Compliance testing showed WSP performed sufficiently in this indicator. WSP provided excellent access for medium- and routine-priority specialty services. The institution also performed well in providing access for high-priority specialty services, and subsequent follow-up appointments for high-, medium-, and routine-priority specialty services. However, WSP scored low in timely scheduling preapproved specialty services. Factoring in all the information, the OIG rated the compliance testing component of this indicator **adequate**.

Case Review and Compliance Testing Results

OIG clinicians reviewed 124 events related to specialty services, including 97 specialty encounters, 20 nursing encounters, and seven provider encounters. Of the 97 specialty encounters, nine were telemedicine specialty appointments, 20 were off-site procedures, 15 were off-site specialty consultations, and 49 were on-site specialty appointments. On-site specialty appointments included hemodialysis procedures, hemodialysis nephrologist monthly follow-ups, and referrals to the podiatrist, physical therapist, and registered dietician.⁶⁵ Due to the frequency of on-site hemodialysis procedures, we bundled these procedures into monthly events. Thus, one "hemodialysis event" may include up to 10

⁶⁵ Hemodialysis is procedure using a machine to filter blood when the kidneys are not functioning normally. A nephrologist is a specialist who treats kidney conditions and diseases.

“hemodialysis procedures.” We found 33 deficiencies in this category, 15 of which were significant.⁶⁶

Access to Specialty Services

WSP’s performance was mixed. Compliance testing found WSP performed excellently in completing most high-priority, medium-priority, and routine-priority specialty appointments within required time frames (MIT 14.001, 86.7%; MIT 14.004, 100%; MIT 14.007, 100%). Follow-up specialty appointments for high- and medium-priority referrals occurred in a satisfactory percentage of cases (MIT 14.003, 80.0%, and MIT 14.006, 87.5%); however, routine-priority specialty referral follow-up appointments only occurred 75.0 percent of the time (MIT 14.009).

Case review determined WSP performed poorly in obtaining off-site specialty access. We found eight off-site specialty access deficiencies, five of which were significant.⁶⁷ Examples of significant deficiencies include those described in the following cases:

- In case 20, the patient was transferred to WSP from a county jail, where he had been initially diagnosed with bladder cancer, had been evaluated by hematology and urology specialists, and was documented as likely having metastatic disease. He had a pending a cystoscopy when transferred to WSP.⁶⁸ The patient was not seen by a bladder cancer specialist for 80 days after arriving at WSP.
- Furthermore, in case 20, staff scheduled the initial urology appointment with a telemedicine urologist, who could not perform the critically necessary on-site cystoscopy and biopsy.⁶⁹ Over five months after arriving at the institution, the patient had still not received the required cystoscopy and biopsy. The patient became severely anemic and required transfer to the hospital. Fortunately, the hospital staff provided the patient the critically needed cystoscopy and biopsy.
- In case 52, the patient saw a neurosurgeon to follow up on brain bleeding after a head trauma. The neurosurgeon recommended the patient have an arterial embolization to block the potentially bleeding artery.⁷⁰ The procedure was not done. The on-site provider documented she did not order the procedure because WSP was unable to locate a service provider contracted with the department or CCHCS who could perform the procedure. WSP should have obtained the necessary services for this patient.
- In addition, in case 52, the patient sustained a bilateral lower jaw and a facial fracture. The hospital discharge instructions documented the hospital had scheduled the patient for surgery with the ENT specialist to ensure

⁶⁶ Deficiencies occurred in cases 9, 12, 14–17, 19–21, 52, and 53. Significant deficiencies occurred in cases 12, 16, 20, 21, 52, and 53.

⁶⁷ Deficiencies occurred in cases 17, 20, 21, 52, and 53. Significant deficiencies occurred in cases 20, 21 and 52.

⁶⁸ A cystoscopy is a procedure using a tube with a camera to examine the bladder and urinary tract.

⁶⁹ A biopsy is a medical procedure involving the extraction of sample cells or tissues for testing. It can help to diagnose conditions such as cancer.

⁷⁰ Arterial embolization is a procedure used to close a specific blood vessel.

appropriate healing and jaw alignment. However, WSP staff were unable to obtain a timely ENT appointment. Therefore, the patient's surgery did not occur, and the patient was not seen by an ENT specialist until almost one month after the initial injury.

Provider Performance

Case review found, once referrals were ordered, medical leadership approved them timely. In addition, compliance found provider postspecialty follow-up appointments almost always occurred timely (MIT 1.008, 92.7%).

OIG clinicians identified 12 deficiencies related to provider specialty ordering, following specialty recommendations, or ordering follow-up. Seven were considered significant.⁷¹ Examples include those in the following cases:

- In case 21, the provider evaluated the patient for a high-priority urology follow-up appointment for left hydronephrosis in the patient's only kidney.⁷² The provider documented he would order the specialty kidney scan that the urologist recommended; however, the provider did not enter the order until 20 days later.
- In case 20, the urologist recommended a whole-body positron emission tomography (PET) scan for a patient with a possible metastatic bladder cancer.⁷³ The patient had been incarcerated at WSP for over one month without treatment or specialty services. The provider ordered the scan as a medium-priority appointment instead of a high-priority one, which resulted in the delay of care.

Case review identified a best practice by the PT, who sent patient progress reports and requests for provider orders directly to providers via the message center, ensuring timely patient follow-up.

Nursing Performance

Nursing performed adequately in assessing patients who returned to the facility from off-site specialty appointments. Clinicians reviewed 20 nursing encounters and identified two deficiencies, one of which was significant.⁷⁴ This was discussed further in the **Nursing Performance** indicator.

Health Information Management

Compliance testing showed WSP providers performed excellently in retrieving and endorsing specialty reports (MIT 4.002, 90.0% and MIT 14.002, 100%), but needed

⁷¹ Deficiencies occurred in cases 9, 14, 19, 20, 21, 53, and 54. Significant deficiencies occurred in cases 20, 21, and 54.

⁷² Hydronephrosis is a condition of excess urine accumulating in the kidneys that causes swelling of the kidneys.

⁷³ A positron emission tomography (PET) scan is an imaging test of organs and soft tissues.

⁷⁴ Nursing performance deficiencies occurred in cases 20 and 53. A significant deficiency occurred in case 20.

improvement in provider endorsement of medium-priority and routine-priority specialty reports (MIT 14.005, 60.0% and MIT 14.008, 66.7%).

Our case review clinicians identified seventeen deficiencies related to HIM, eight of which were significant.⁷⁵ Examples of significant deficiencies include those in the following cases:

- In case 16, the on-site nephrologist evaluated the patient for hemodialysis, end-stage renal disease, and acute anemia. The nephrologist followed up on a recent laboratory test indicating the patient had worsening anemia. The nephrologist documented the anemia could have been due to hemolysis or laboratory error, ordered a repeat blood test, and recommended the patient be referred to a hematologist (blood specialist) if the patient was still anemic. Five days later, the patient's blood count test result remained low; however, the on-site WSP providers did not endorse either the on-site nephrologist's consultation progress notes or the nephrologist's laboratory test results. Thus, providers did not address the abnormal test results and missed the nephrologist's order regarding the hematology specialty referral.
- In case 52, the ENT specialist saw the patient for a follow-up appointment regarding a mandibular fracture. HIM did not scan the ENT consultation report until after our on-site questioning identified the missing documentation. As a result, HIM staff scanned the correct document nearly eight months after the ENT consultation occurred.
- In case 53, the patient was scheduled to see a hematology specialist. The November hematology specialty consultation report was missing from the EHRS. After our on-site questions identified this missing report, the OIG found the report was subsequently scanned into the EHRS. Again, as a result, the provider endorsed and scanned this report nearly six months after the specialty appointment.

OIG clinicians found providers did not endorse on-site specialty consultation progress notes, including nephrology, podiatry, and physical therapy progress notes. Unendorsed on-site specialty progress notes were problematic in that providers were not only unaware of the specialist's status reports on the patient, but providers could not then follow any specialty recommendations included in those reports. Examples include the following cases:

- In case 20, the on-site kidney specialist documented the patient required referral to a urinary system specialist for suspected bladder cancer. The specialist's progress note was not endorsed; consequently, the WSP provider did not write an order for the specialty referral for 25 more days, 40 days after the patient's arrival to WSP.

⁷⁵ Specialty health information management deficiencies occurred in cases 9, 12, 15, 16, 20, 52, and 53. Significant deficiencies occurred in cases 12, 20, 52, and 53.

- Also in case 20, the kidney specialist evaluated the patient and documented Epogen must be discontinued due to the patient's possible bladder cancer.⁷⁶ The specialist's report was not endorsed by a provider; thus, WSP providers did not discontinue the medication until over one month later. However, this error was mitigated because, although the order for Epogen remained active, the hemodialysis unit did not administer Epogen during this time.

Clinician On-Site Inspection

We discussed specialty services with WSP medical leadership, UM nurses, HIM, specialty supervisors and staff, nurses, and providers. As an RC, providers and medical leadership stated most specialty referrals were delayed until patients arrived at their home institutions, except for critically needed services such as emergency care and hemodialysis. Since WSP is an RC with limited capacity, transferring patients to their home institutions as expediently as possible was necessary. Ordering nonurgent referral could have required a medical hold and delayed the patient's transfer. If a patient was transferred with a medical referral already ordered and the home institution was located outside the WSP service region, the referral would need to be canceled and reissued at the home institution. Medical leadership reported patients may refuse services because, at RCs, they could not accumulate points toward early release, receive visitors or packages, and were denied other "perks" until they were sent to the home institution.

We learned medical leadership did not require primary care providers to review or endorse on-site specialty progress notes, which could delay patient care. In addition, medical leadership did not expect primary care providers to review or endorse nephrology-ordered laboratory work, which may also delay patient care.

WSP had an on-site HDU with six bays, run by a contracted vendor. This on-site specialty unit increased availability to the dialysis patients and may have mitigated patient transport costs. Medical leadership reported this HDU supported both WSP and North Kern Valley State Prison. The HDU nurses managed the daily unit operation through documented nurse protocols to handle many significant medical conditions such as anemia, abnormal potassium levels, and fluid overload or deficit. The HDU nurses contacted the kidney specialist if there were abnormal laboratory test results or changes in the patient's condition. A kidney specialist evaluated each dialysis patient once a month.

The CCHCS headquarters renal transplant team evaluated end-stage renal disease and dialysis patient for kidney transplant. Once a kidney was identified for a patient, at least two months of medical records must be available and sent along with the patient to the renal transplant specialist within very short time frames. Having the laboratory work and direct entry of HDU specialty paperwork immediately accessible expedited this process.

Medical leadership reported challenges with poor communication from sending county jails regarding patient health requirements. The CME stated WSP had received new dialysis patients from county jails who had elevated blood pressures and swelling due to increased fluid in the body, requiring immediate dialysis; however, the sending county jail often did not notify WSP the patient was arriving or what medical treatment would be

⁷⁶ Epogen is a medication used to treat anemia, a condition with low red blood cell count. Epogen can accelerate tumor growth and may increase risks for cancer patients.

needed on arrival. By not communicating this information to WSP, patients may be at a higher medical risk and could have required emergency hospital evaluations if WSP staff were unable to coordinate care within their institution.

Specialty services staff stated, due to cross-training staff, they did not experience staff shortages; however, they had shortages in some specialty services. During the review period, optometry services had a large backlog of 200 to 300 patients, due to the absence of the optometrist. However, we did not identify deficiencies with this specialty in our case reviews. In addition, the physical therapist no longer provided service to WSP. Staff reported optometry and physical therapy were the most difficult specialty services to obtain.

Compliance Testing Results

Table 19. 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)	13	2	0	86.7%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	15	0	0	100%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	4	1	10	80.0%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004)	15	0	0	100%
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)	9	6	0	60.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	7	1	7	87.5%
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)	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	6	2	7	75.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	8	5	0	61.5%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	N/A	N/A	N/A	N/A
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	N/A	N/A	N/A	N/A
Overall percentage (MIT 14): 81.7%				

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

Table 20. 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) *	38	3	4	92.7%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	27	3	15	90.0%

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

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

Recommendations

- CCHCS and WSP medical leadership should consider developing and implementing strategies to improve communication with county jails to ensure WSP can be prepared for the medical needs of high-risk patients on their arrival.
- Medical leadership should determine causative factors related to the untimely provision or scheduling of patients' specialty service appointments and implement remedial measures as appropriate.

Administrative Operations

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

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

Ratings and Results Overview

Case Review Rating
Not Applicable

Compliance Rating and Score
Inadequate (74.9%)

WSP's performance was mixed in this indicator. While the institution scored well in some applicable tests, it showed room for improvement in several areas. During our review period, the EMRRC did not complete any required checklists. In addition, the institution conducted a medical emergency response drill, but with incomplete documentation. The institution did not consistently report patient deaths in a timely manner to CCHCS. Lastly, nurse educators intermittently ensured nurses who administered medication had completed their annual competency testing in a timely manner and did not ensure newly hired nurses received the required onboarding training. These findings are set forth in the table below. The OIG rated this indicator ***inadequate***.

Compliance Testing Results

Nonscored Results

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

Our testing period reviewed mortality reports completed both before and after the effective revision date of the CCHCS mortality review policy requirements. Prior to May 2022, we obtained CCHCS Death Review Committee (DRC) reporting data. Three unexpected (Level 1) deaths occurred during our review period. In our inspection, we found the DRC did not complete any death review reports promptly. The DRC finished one report 55 days late and submitted it to the institution's CEO 48 days late. The remaining two death reports were overdue at the time of the OIG's inspection. Effective

May 2022, we obtained CCHCS Mortality Case Review reporting data. At the time of our inspection, for two patients, we found no evidence in the submitted documentation of the Preliminary Mortality Report having been completed. These reports were overdue at the time of the OIG's inspection (MIT 15.998).

Compliance Testing Results

Table 21. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	This is a nonscored test. Please refer to the discussion in this indicator.			
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	0	12	0	0
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	4	0	0	100%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	2	1	0	66.7%
Did the responses to medical grievances address all of the patients' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial patient death reports to the CCHCS Mortality Case Review Unit on time? (15.103)	3	2	0	60.0%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	6	3	1	66.7%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	8	2	0	80.0%
Did the providers maintain valid state medical licenses? (15.106)	14	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates, and did the pharmacy maintain valid Automated Drug Delivery System (ADDS) licenses? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? Effective 05/2022: Did the Headquarters Mortality Case Review process mortality review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 3 for CCHCS-provided staffing information.			
Overall percentage (MIT 15): 74.9%				

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

Recommendations

The OIG offers no recommendations for this indicator.

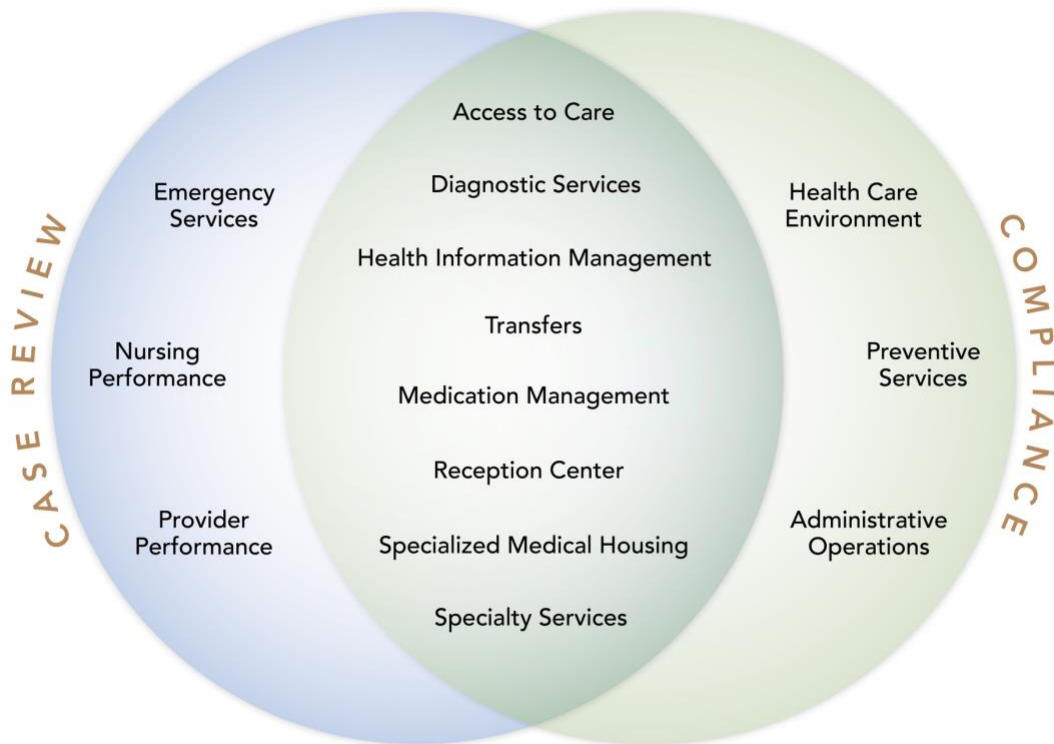
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Appendix A: Methodology

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

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

Figure A-1. Inspection Indicator Review Distribution for WSP



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

Case Reviews

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

Table A-1. Case Review Definitions

<p>Case, Sample, or Patient</p>	<p>The medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.</p>
<p>Comprehensive Case Review</p>	<p>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.</p>
<p>Focused Case Review</p>	<p>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.</p>
<p>Event</p>	<p>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.</p>
<p>Case Review Deficiency</p>	<p>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.</p>
<p>Adverse Event</p>	<p>An event that caused harm to the patient.</p>

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

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

Case Review Sampling Methodology

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

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

Case Review Testing Methodology

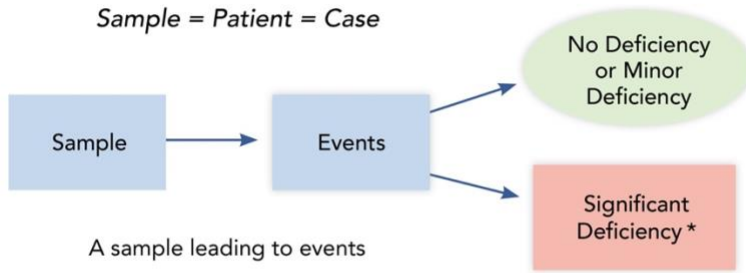
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review **events**. Our clinicians also record medical errors, which we refer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

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

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

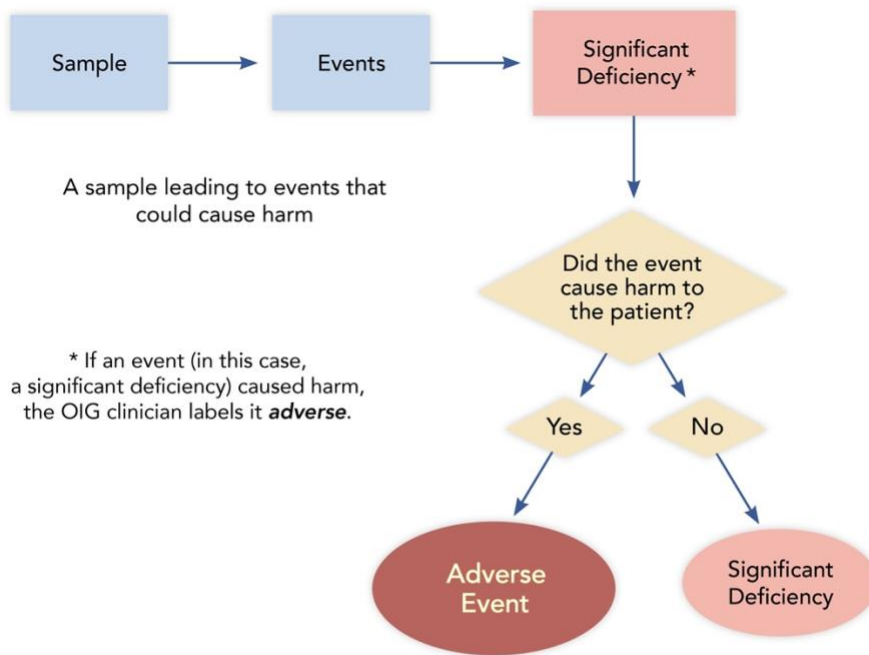
Figure A-2. Case Review Testing

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



Deficiencies

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



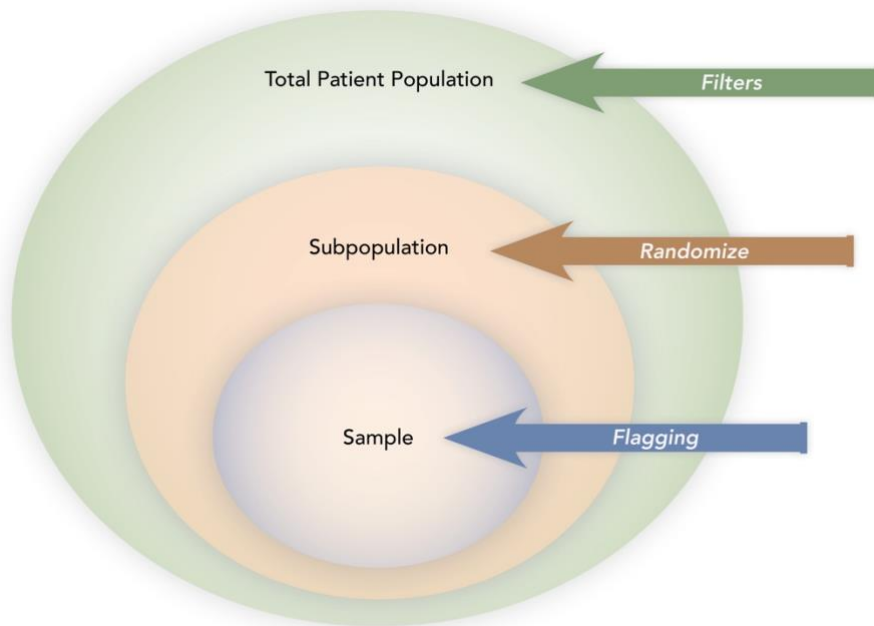
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

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

Figure A-3. Compliance Sampling Methodology



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

Compliance Testing Methodology

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

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

Scoring Methodology

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

Indicator Ratings and the Overall Medical Quality Rating

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

Appendix B. Case Review Data

Table B–1. WSP Case Review Sample Sets

Sample Set	Total
Anticoagulation	1
CTC/OHU	3
Death Review/Sentinel Events	2
Diabetes	3
Emergency Services – CPR	3
Emergency Services – Non-CPR	2
High Risk	6
Hospitalization	3
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	21
Reception Center Transfers	3
Specialty Services	1
	54

Table B–2. WSP Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	5
Anticoagulation	2
Arthritis/Degenerative Joint Disease	2
Asthma	7
Cancer	5
Cardiovascular Disease	8
Chronic Kidney Disease	4
Chronic Pain	14
Cirrhosis/End-Stage Liver Disease	6
Coccidioidomycosis	1
COPD	1
COVID-19	4
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	12
Gastroesophageal Reflux Disease	3
Hepatitis C	19
HIV	2
Hyperlipidemia	15
Hypertension	26
Mental Health	24
Migraine Headaches	3
Seizure Disorder	1
Sleep Apnea	1
Substance Abuse	24
Thyroid Disease	3
	193

Table B–3. WSP Case Review Events by Program

Diagnosis	Total
Diagnostic Services	196
Emergency Care	36
Hospitalization	11
Intrasystem Transfers In	5
Intrasystem Transfers Out	6
Not Specified	3
Outpatient Care	395
Reception Center Care	24
Specialized Medical Housing	69
Specialty Services	180
	925

Table B–4. WSP Case Review Sample Summary

Clinician	Total
MD Reviews Detailed	18
MD Reviews Focused	5
RN Reviews Detailed	13
RN Reviews Focused	36
Total Reviews	72
Total Unique Cases	54
Overlapping Reviews (MD & RN)	18

Appendix C: Compliance Sampling Methodology

Wasco State Prison

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	<ul style="list-style-type: none"> Chronic care conditions (at least one condition per patient—any risk level) Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	<ul style="list-style-type: none"> See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	35	Clinic Appointment List	<ul style="list-style-type: none"> Clinic (each clinic tested) Appointment date (2–9 months) Randomize
MIT 1.007	Returns From Community Hospital	19	OIG Q: 4.005	<ul style="list-style-type: none"> See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	<ul style="list-style-type: none"> See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	<ul style="list-style-type: none"> Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	<ul style="list-style-type: none"> Appointment date (90 days–9 months) Randomize Abnormal
MITs 2.004–006	Laboratory	10	Quest	<ul style="list-style-type: none"> Appt. date (90 days–9 months) Order name (CBC or CMPs only) Randomize Abnormal
MITs 2.007–009	Laboratory STAT	10	Quest	<ul style="list-style-type: none"> Appt. date (90 days–9 months) Order name (CBC or CMPs only) Randomize Abnormal
MITs 2.010–012	Pathology	10	InterQual	<ul style="list-style-type: none"> Appt. date (90 days–9 months) Service (pathology related) Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Health Information Management (Medical Records)</i>				
MIT 4.001	Health Care Services Request Forms	35	OIG Qs: 1.004	<ul style="list-style-type: none"> • Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	<ul style="list-style-type: none"> • Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	19	OIG Q: 4.005	<ul style="list-style-type: none"> • Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested incarcerated person	<ul style="list-style-type: none"> • Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	19	CADDIS off-site admissions	<ul style="list-style-type: none"> • Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
<i>Health Care Environment</i>				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	12	OIG inspector on-site review	<ul style="list-style-type: none"> • Identify and inspect all on-site clinical areas
<i>Transfers</i>				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	<ul style="list-style-type: none"> • Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	5	OIG inspector on-site review	<ul style="list-style-type: none"> • R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Pharmacy and Medication Management</i>				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	<ul style="list-style-type: none"> • See Access to Care • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	<ul style="list-style-type: none"> • Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	19	OIG Q: 4.005	<ul style="list-style-type: none"> • See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	20	OIG Q: 12.001	<ul style="list-style-type: none"> • See Reception Center
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	<ul style="list-style-type: none"> • Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	20	Medication error reports	<ul style="list-style-type: none"> • All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	10	On-site active medication listing	<ul style="list-style-type: none"> • KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	<ul style="list-style-type: none"> • Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	<ul style="list-style-type: none"> • Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	25	Maxor	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Date of birth (45 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	25	Cocci transfer status report	<ul style="list-style-type: none"> • 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
<i>Reception Center</i>				
MITs 12.001–007	RC	20	SOMS	<ul style="list-style-type: none"> • Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
<i>Specialized Medical Housing</i>				
MITs 13.001–003	Specialized Health Care Housing Unit	10	CADDIS	<ul style="list-style-type: none"> • Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	<ul style="list-style-type: none"> • Specialized Health Care Housing • Review by location
<i>Specialty Services</i>				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	<ul style="list-style-type: none"> • Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	<ul style="list-style-type: none"> • Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	<ul style="list-style-type: none"> • Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Specialty Services (continued)</i>				
MIT 14.010	Specialty Services Arrivals	13	Specialty Services Arrivals	<ul style="list-style-type: none"> Arrived from (other departmental institution) Date of transfer (3–9 months) Randomize
MITs 14.011–012	Denials	0	InterQual	<ul style="list-style-type: none"> Review date (3–9 months) Randomize
		N/A	IUMC/MAR Meeting Minutes	<ul style="list-style-type: none"> Meeting date (9 months) Denial upheld Randomize
<i>Administrative Operations</i>				
MIT 15.001	Adverse/sentinel events	0	Adverse/sentinel events report	<ul style="list-style-type: none"> Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	<ul style="list-style-type: none"> Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	<ul style="list-style-type: none"> Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	<ul style="list-style-type: none"> Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	<ul style="list-style-type: none"> Most recent full quarter Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	<ul style="list-style-type: none"> Medical grievances closed (6 months)
MIT 15.103	Death Reports	5	Institution-list of deaths in prior 12 months	<ul style="list-style-type: none"> Most recent 10 deaths Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	<ul style="list-style-type: none"> On duty one or more years Nurse administers medications Randomize
MIT 15.105	Provider Annual Evaluation Packets	10	On-site provider evaluation files	<ul style="list-style-type: none"> All required performance evaluation documents
MIT 15.106	Provider Licenses	14	Current provider listing (at start of inspection)	<ul style="list-style-type: none"> Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	<ul style="list-style-type: none"> All staff Providers (ACLS) Nursing (BLS/CPR) Custody (CPR/BLS)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Administrative Operations (continued)</i>				
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	<ul style="list-style-type: none"> All required licenses and certifications
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	<ul style="list-style-type: none"> All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	<ul style="list-style-type: none"> New employees (hired within last 12 months)
MIT 15.998	CCHCS Mortality Case Review	5	OIG summary log: deaths	<ul style="list-style-type: none"> Between 35 business days & 12 months prior California Correctional Health Care Services mortality reviews

California Correctional Health Care Services' Response

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March 25, 2024

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

Dear Ms. Singh:

California Correctional Health Care Services (CCHCS) has reviewed the draft Medical Inspection Report for Wasco State Prison (WSP) conducted by the Office of the Inspector General (OIG) from July 2022 to December 2022. During this timeframe, 8,392 primary care provider (PCP) encounters, not including Triage and Treatment Area visits, were completed. In contrast, the OIG inspection reviewed approximately 1% or 120 PCP encounters, which are not indicative of the quality of care delivered to the patient population at WSP.

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

Sincerely,



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

- cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
- Clark Kelso, Receiver
Directors, CCHCS
- Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
- Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
- Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
- Annette Lambert, Deputy Director, Quality Management, CCHCS
- Robin Hart, Associate Director, Risk Management Branch, CCHCS
- Regional Executives, Region III, CCHCS
- Chief Executive Officer, WSP
- Heather Pool, Chief Assistant Inspector General, OIG
- Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
- Amanda Elhardt, Report Coordinator, OIG



CALIFORNIA CORRECTIONAL
 HEALTH CARE SERVICES

P.O. Box 588500
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June 19, 2024, OIG Response to March 25, 2024, Letter Regarding WSP Report

STATE of CALIFORNIA
OIG OFFICE of the
 INSPECTOR GENERAL

Independent Prison Oversight

Amarik K. Singh, Inspector General
 Neil Robertson, Chief Deputy Inspector General

Regional Offices

Sacramento
 Bakersfield
 Rancho Cucamonga

June 19, 2024

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

Dear Ms. Goulidy:

OIG RESPONSE TO MARCH 25, 2024, CCHCS LETTER REGARDING WSP REPORT

The Office of the Inspector General (OIG) received your March 25, 2024, Response Letter to the OIG's Cycle 7 Draft Medical Inspection Report for Wasco State Prison (WSP). Following the dispute period, CCHCS did not dispute any of the OIG's findings in the WSP inspection report. However, similar to your February 13, 2024, Response Letter regarding Valley State Prison (VSP), you generally noted 8,392 primary care provider (PCP) encounters were completed during the time period of the WSP medical inspection from July 2022 to December 2022. You reiterated the opinion that, since the OIG reviewed only 120 PCP encounters, the OIG findings "are not indicative of the quality of care delivered to the patient population at WSP."

The OIG again respectfully disagrees with the assertion that its case review sampling is not sufficient for the OIG to reach findings indicative of the quality of care that WSP's health care system is providing to the incarcerated population. In contrast, both the Mathematics and Statistics Department of the California State University, Sacramento (CSUS) and all stakeholders, including CCHCS, approved the current retrospective case sampling methodology as an appropriate process for MIU clinicians to accurately assess the quality of medical care each institution is providing. As such, the OIG stands behind both its methodology and the undisputed findings in the Cycle 7 Draft Medical Inspection Report for WSP.

As previously noted, CSUS issued a report titled "Office of the Inspector General Medical Inspections Unit Retrospective Case Review Sample Size Considerations," in which Michelle Norris, Ph.D., of the CSUS Mathematics and Statistics Department opined, "The MIU has carefully described the rationale for the selection of patients for case review where the targeted

Gavin Newsom, Governor

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Ms. DeAnna Gouldy, Deputy Director
 June 19, 2024
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patients are typically patients who use the medical care component under study most frequently or have the most serious medical conditions. This is a purposeful sample designed to yield the maximum amount of information for the number of inmate-patients sampled.” In the report, Dr. Norris further clarified, “In the Retrospective Case Review study, the principle of saturation means that clinicians should conduct as many case reviews as are necessary to capture the important deficiencies in the medical care system,” and ultimately concluded, “[T]he [OIG’s] method seems quite appropriate to the goal of identifying deficiencies in the overall medical care system.”

On another note, the OIG finds this contention confusing in light of representations the Department made two weeks earlier to the federal court in its Joint Case Management Conference Statement in *Plata v. Newsom*, case 4:01-cv-01351-JST, Doc. 3895, filed on March 11, 2024, for the March 18, 2024, case management conference (Joint Statement). Specifically, the Joint Statement defended the quality of VSP’s care, despite the OIG VSP report’s overall rating of inadequate, by differentiating between the medical inspection’s case review component (subjective quality measure) and compliance component (objective technical adherence to the Department’s own Health Care Department Operations Manual). The Joint Statement expressly states, “Of the 10 indicators assessed during the case review portion of the inspection, 8 were rated as adequate or proficient, and only 2 were inadequate. [Citation removed.] This is significant because it demonstrates that the quality of medical care being provided at Valley State Prison is, at a minimum, adequate.” (*Id.* at p. 34, ln. 23 through p. 35, ln. 3., *emphasis added*). In contrast to the representations made in your March 11, 2024, court filing, your February 13, 2024, response to our VSP report and your March 25, 2024, response to our WSP report insist our sample size is not large enough to reach any conclusions regarding the quality of care being delivered to the patient population. However, these statements in the Joint Statement suggest CCHCS believes the OIG’s case review sample size is sufficient to demonstrate the medical care being provided at VSP is adequate.


For these reasons, the OIG again disagrees with your assertion. As detailed in our February 16, 2024, response to your February 13, 2024, letter regarding our Cycle 7 VSP inspection report, the case review aspect of the OIG medical inspection process was designed in 2014 with collaboration and input from each of our stakeholders, including CCHCS, and with guidance from the CSUS Mathematics and Statistics Department. Moreover, CCHCS’s own recent reliance on the MIU Case Review methodology in its Joint Statement further reinforces the validity of the OIG’s current methodology for assessing quality of care.

However, after considering the benefits of establishing a single overall rating for each institution, on April 19, 2024, the OIG communicated to CCHCS and the department that we elected to update our reporting format to include individual ratings for each institution: one assessing the clinical quality of care provided at the institution and another assessing the institution’s compliance with the department’s own policies. Providing the individual ratings will increase the transparency of the OIG’s findings regarding the quality of medical care and policy compliance at each institution. This bifurcated ratings format has now been implemented, retroactive to the first institution of Cycle 7, and this new format is reflected in the final WSP published report.

Ms. DeAnna Gouldy, Deputy Director
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Additionally, as previously discussed in our February 16, 2024, response, the OIG has continuously invited comments each quarter on the current inspection methodology, which has remained consistent since Cycle 5. The legitimacy of the sample size for conducting comprehensive retrospective case reviews has never been raised prior to your February 13, 2024, Cycle 7 VSP response letter. Should you have support for your assertion that our sample size is insufficient, I encourage you to present it so we can evaluate its legitimacy. I would also like to renew our longstanding invitation to discuss any concerns you have with our methodology at your earliest convenience.

Sincerely,


Amarik Singh (Jun 19, 2024 16:28 PDT)

Amarik Singh
Inspector General
Office of the Inspector General

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Federal Receiver
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Shaun Spillane, Chief Counsel, OIG

Cycle 7
Medical Inspection Report
for
Wasco State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
June 2024

OIG