Amarik K. Singh, *Inspector General*

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

February 2025

Cycle 7

Medical Inspection Report

Avenal State Prison

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Contents

Illustrations

Tables

Figures

Photographs

Introduction

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

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

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

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

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

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

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

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

As we did during Cycle 6, our office continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 7 inspection of Avenal 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 April 2023 to September 2023.[4]

[4] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include emergency cardiopulmonary resuscitation reviews for January 2023 and death reviews between December 2022 and April 2023.

Summary: Ratings and Scores

We completed the Cycle 7 inspection of Avenal State Prison (ASP) in March 2024. OIG inspectors monitored the institution's delivery of medical care that occurred between April 2023 and September 2023.

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

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

OIG clinicians (a team of physicians and nurse consultants) reviewed 46 cases, which contained 610 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 March 2024 to verify their initial findings. OIG physicians rated the quality of care for 20 comprehensive case reviews. Of these 20 cases, our physicians rated zero ***proficient***, 19 ***adequate***, and one ***inadequate***.

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 379 patient records and 1,081 data points, and we used the data to answer 90 policy questions. In addition, we observed ASP's processes during an on-site inspection in November 2023.

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

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

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

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

		Ratings: Proficient / Adequate / Inadequate		Scoring Ranges: 100%–85.0% / 84.9%–75.0% / 74.9%–0		
		Case Review		Compliance		
MIT Number	Health Care Indicators	Cycle 7	Change Since Cycle 6*	Cycle 7	Cycle 6	Change Since Cycle 6*
1	Access to Care	Proficient	↑	83.3%	82.4%	=
2	Diagnostic Services	Proficient	↑	60.0%	57.5%	=
3	Emergency Services	Adequate	=	N/A	N/A	N/A
4	Health Information Management	Adequate	=	87.3%	86.0%	=
5	Health Care Environment†	N/A	N/A	56.6%	70.0%	=
6	Transfers	Adequate	=	74.5%	70.8%	=
7	Medication Management	Adequate	=	55.9%	64.0%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	87.6%	71.6%	↑↑
10	Nursing Performance	Adequate	=	N/A	N/A	N/A
11	Provider Performance	Adequate	=	N/A	N/A	N/A
12	Reception Center	N/A	N/A	N/A	N/A	N/A
13	Specialized Medical Housing	Adequate	=	41.1%	70.0%	=
14	Specialty Services	Adequate	=	70.7%	79.2%	↓
15	Administrative Operations†	N/A	N/A	71.5%	80.8%	↓

* 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 causes 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 ASP during the Cycle 7 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to ASP. Of these 10 indicators, OIG clinicians rated two ***proficient***, eight ***adequate***, and none ***inadequate***. OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, none were ***proficient***, 19 were ***adequate***, and one was ***inadequate***. In the 610 events reviewed, we identified 128 deficiencies, 22 of which OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at ASP:

- The institution provided excellent overall access to providers, nurses, and diagnostic services.
- ASP nurses often delivered good care for OHU, newly arrived, and hospital return patients.
- ASP nurses provided good emergency care, frequently performing good patient assessments, intervention, and documentation as well as responding promptly to emergencies.

Our clinicians found the following weaknesses at ASP:

- Providers did not always perform thorough subjective or objective assessments and needed improvement in sending complete patient test result notification letters.
- Nurses intermittently completed transfer-out requirements for patients.
- Outpatient clinic nurse assessments and interventions needed improvement.

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

Compliance Testing Results

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

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

- Staff performed well in offering immunizations and providing preventive services for their patients, such as influenza vaccinations, annual testing for tuberculosis, and colorectal cancer screenings.
- Staff performed well in providing TB medications and timely monitoring patients taking TB medications.
- Staff performed well in scanning initial health care screening forms, community hospital discharge reports, and specialist reports.
- Nursing staff processed sick call request forms, performed face-to-face evaluations, and completed nurse-to-provider referrals within required time frames. In addition, ASP housing units contained adequate supplies of health care request forms.

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

- Nursing staff performed poorly in completing nursing assessments of patients admitted to the specialized medical housing unit within required time frames.
- Staff frequently failed to maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients admitted to specialized medical housing unit. In addition, ASP maintained poor medication continuity for patients who had a temporary layover at ASP.
- Providers often did not communicate results of diagnostic services timely. Most patient letters communicating these results were missing the date of the diagnostic service, the date of results, and whether the results were within normal limits.
- Health care staff did not follow hand hygiene precautions before or after patient encounters.
- Nurses did not regularly inspect emergency response bags.

Institution-Specific Metrics

Avenal State Prison (ASP), located in the city of Avenal, in Kings County, opened in 1987. ASP is designated as a low- to medium-security institution and currently provides housing for both general population and sensitive needs incarcerated people. The

institution operates seven clinics in which staff handle nonurgent requests for medical services, including six facility clinics and one specialty clinic. ASP also conducts patient screenings in its receiving and release clinic (R&R), treats patients requiring urgent or emergent care in its triage and treatment area (TTA), and houses patients who require assistance with activities of daily living in its outpatient housing unit (OHU). California Correctional Health Care Services (CCHCS) has designated ASP as a *basic care institution*. Basic care institutions are located in rural areas, away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients. Basic care institutions can provide limited specialty medical services and consultations for a patient population that is generally healthy.[7]

As of July 18, 2024, the department reports on its public tracker that 67 percent of ASP's incarcerated population is fully vaccinated for COVID-19 while 63 percent of ASP's staff is fully vaccinated for COVID-19.

In November 2023, the Health Care Services Master Registry showed that ASP had a total population of 4,620. A breakdown of the medical risk levels of the ASP population as determined by the department is set forth in Table 2 below.[8]

Table 2. ASP Master Registry Data as of November 2023

Medical Risk Level	Number of Patients	Percentage*
High 1	0	0
High 2	14	0.3%
Medium	1,815	39.3%
Low	2,791	60.4%
Total	**4,620**	**100.0%**

* Percentages may not total 100% due to rounding.

Source: Data for the population medical risk levels were obtained from the CCHCS Master Registry dated 11-13-23.

[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, ASP had no vacant executive leadership positions, 2.6 primary care provider vacancies, 2.2 nursing supervisor vacancies, and 16.5 nursing staff vacancies.

Table 3. ASP Health Care Staffing Resources as of November 2023

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	4.0	11.0	11.7	95.6	122.3
Filled by Civil Service	4.0	8.4	9.5	79.1	101.0
Vacant	0	2.6	2.2	16.5	21.3
Percentage Filled by Civil Service	100%	76.4%	81.2%	82.7%	82.6%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	0	0	3.0	3.0
Percentage Filled by Registry	0	0	0	3.1%	2.5%
Total Filled Positions	4.0	8.4	9.5	82.1	104.0
Total Percentage Filled	**100%**	**76.4%**	**81.2%**	**85.9%**	**85.0%**
Appointments in Last 12 Months	1.0	3.0	1.0	21.5	26.5
Redirected Staff	0	0	0	0	0
Staff on Extended Leave ‡	0	0	0	3.0	3.0
Adjusted Total: Filled Positions	**4.0**	**8.4**	**9.5**	**79.1**	**101.0**
Adjusted Total: Percentage Filled	**100%**	**76.4%**	**81.2%**	**82.7%**	**82.6%**

* Executive Leadership includes the Chief Physician and Surgeon.

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

‡ In Authorized Positions.

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

Source: Cycle 7 medical inspection preinspection questionnaire received on November 13, 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 ASP's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. Currently, only two HEDIS measures are available for review: **poor HbA1c control**, which measures the percentage of diabetic patients who have poor blood sugar control, and **colorectal cancer screening** rates for patients ages 45 to 75. 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)—ASP's percentage of patients with poor HbA1c control was significantly lower, indicating very good performance on this measure.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include these data for informational purposes. ASP had a 52 percent influenza immunization rate for adults 18 to 64 years old. Data for the influenza immunization rate for adults 65 years of age and older was not available.[9] The pneumococcal vaccination rate was also not available.[10]

Cancer Screening

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—ASP's colorectal cancer screening rate of 60 percent was higher than California Medi-Cal but

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

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

lower than both Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal).

Table 4. ASP Results Compared With State HEDIS Scores

HEDIS Measure	ASP Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	94%	–	–	–
Poor HbA1c Control (> 9.0%) ‡,§	**2%**	36%	31%	22%
HbA1c Control (< 8.0%) ‡	95%	–	–	–
Blood Pressure Control (< 140/90) ‡	89%	–	–	–
Eye Examinations	84%	–	–	–
Influenza – Adults (18–64)	52%	–	–	–
Influenza – Adults (65+)	N/A	–	–	–
Pneumococcal – Adults (65+)	N/A	–	–	–
Colorectal Cancer Screening	60%	37%	68%	**70%**

Notes and Sources

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

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

Diagnostic Services

- The department should develop and implement strategies to ensure providers create patient letters that contain all elements required by CCHCS policy when they endorse test results.

Health Care Environment

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

- Nursing leadership should determine the root cause(s) for staff not ensuring the EMRBs are inventoried or stocked appropriately and should implement necessary remedial measures.

- ASP leadership should determine the root cause(s) for staff not following adequate protocols for managing and storing bulk medical supplies and should implement necessary remedial measures.

Transfers

- Nursing leadership should determine the challenges preventing nurses from thoroughly completing the initial health screening process, including documenting a complete set of vital signs, answering all questions, and documenting an explanation for all "yes" answers before the patient is transferred to the housing unit. Leadership should implement remedial measures as appropriate.

- Nursing leadership should determine the challenges to ensuring nursing staff complete screenings of patients transferring to another institution, including documenting or communicating pending specialty appointments, and should implement remedial measures as appropriate.

- Nursing leadership and custody staff should collaboratively strategize on whether their processes require amendments to ensure nurses evaluate and screen all patients before they transfer out of the institution. Leadership should implement remedial measures as appropriate.

Medication Management

- The institution should develop and implement measures to ensure staff timely make available and administer medications to chronic care and hospital discharge patients, and staff document administering medications for layover patients in the electronic health record system (EHRS) as described in CCHCS policy and procedures.

Nursing Performance

- Nursing leadership should determine the challenges to nurses completing thorough patient assessments for face-to-face encounters and providing appropriate interventions and should implement remedial measures as appropriate.

Specialized Medical Housing

- Nursing and pharmacy leadership should determine the root cause of challenges to patients receiving all ordered medications within required time frames and should implement remedial measures as appropriate.

- Nursing leadership should also determine the challenges to staff completing timely initial RN assessments upon patient admission to specialized medical housing and should implement remedial measures as appropriate.

Specialty Services

- Medical leadership should determine the challenges to timely providing specialty appointments and should implement remedial measures as appropriate.

- Medical leadership should determine the challenges to ensuring specialty reports are received, scanned, and endorsed in a timely manner and should implement remedial measures as appropriate.

Access to Care

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Proficient	***Adequate* (83.3%)**

Case review found ASP offered excellent access to care. Providers generally evaluated patients within the required time frame for primary care appointments, sick-call referrals, and follow-ups for post-specialty, post-hospitalization, and post-transfer appointments. Likewise, clinic nursing had no delays with sick call and nurse follow-up appointments. Both providers and nurses timely assessed specialized medical housing patients. Considering all factors, the OIG rated the case review component of this indicator ***proficient***.

ASP's performance in compliance testing was satisfactory. Access to providers was very good for newly transferred patients as well as for patients who returned to ASP following hospitalizations or specialty services appointments. Providers also performed satisfactorily in timely evaluating patients with chronic care conditions. Nurses frequently reviewed patient sick call requests within the required time frame. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 120 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events requiring the institution to generate appointments. We identified four deficiencies relating to **Access to Care**, none of which were significant.[11]

Access to Care Providers

ASP provided variable access to clinic providers. Compliance testing showed chronic care face-to-face follow-up appointments frequently occurred timely (MIT 1.001, 84.0 %). Although compliance testing revealed only half the sick call follow-up provider appointments occurred timely (MIT 1.006, 50.0%), compliance testing had only two applicable samples to evaluate. Case review found routine provider and follow-up

[11] Deficiencies occurred in cases 8, 13, and 20, none of which were significant.

provider appointments generally occurred timely. We identified three provider access deficiencies, none of which were significant.[12]

Access to Specialized Medical Housing Providers

ASP provided excellent access to specialized medical housing providers. Compliance testing showed providers always completed history and physical (H&P) examinations (MIT 13.002, 100%) timely. Similarly, case review identified no deficiencies related to specialized medical housing provider access.

Access to Clinic Nurses

ASP also provided excellent access to clinic nurses. Compliance testing showed registered nurses always reviewed patient requests for service within required time frames (MIT 1.003, 100%), and they frequently assessed patients within one business day after reviewing a sick call request (MIT 1.004, 90.0%). Our clinicians assessed 45 nursing sick call requests and identified no deficiencies related to clinic nurse access.

Access to Specialty Services

ASP's performance in referrals to specialty services varied. Compliance testing showed a satisfactory completion rate of high-priority specialty services (MIT 14.001, 80.0%). However, completion of medium-priority specialty services was poor (MIT 14.004, 46.7%), and completion of routine-priority specialty services needed improvement (MIT 14.007, 73.3%). In contrast, specialist follow-up appointments generally occurred timely for high-priority (MIT 14.003, 90.9%) and routine-priority specialty appointments (MIT 14.009, 85.7%) and always occurred timely for medium-priority specialty appointments (MIT 14.006, 100%). Case review clinicians found specialty appointments almost always occurred within requested time frames; we identified only one deficiency, which was not significant.[13]

Follow-Up After Specialty Services

Compliance testing revealed most provider appointments after specialty services occurred within required time frames (MIT 1.008, 79.1%). OIG clinicians identified no deficiencies related to provider appointments after specialty services.

Follow-Up After Hospitalization

Providers usually evaluated patients after hospitalizations timely. Compliance testing showed the institution performed satisfactorily in timely providing provider follow-up appointments following hospitalization (MIT 1.007, 80.0%). Case review identified no deficiencies in this category.

[12] Provider access deficiencies occurred in cases 8, 13, and 20, none of which were significant.

[13] A deficiency occurred in case 8. This deficiency was not significant.

Follow-Up After Urgent or Emergent Care (TTA)

Providers generally evaluated their patients following a triage and treatment area (TTA) event as medically indicated. OIG clinicians reviewed 18 TTA events and identified no delays in provider follow-up.

Follow-Up After Transferring Into ASP

Access to care for patients who had recently transferred into ASP was similar for both compliance testing and case review. Compliance testing showed the institution offered very good access to intake appointments for newly arrived patients (MIT 1.002, 91.7%). Case review did not find any deficiencies in this area; however, we only reviewed three cases in which patients transferred into ASP from another institution, so the sample was small.

Clinician On-Site Inspection

OIG clinicians attended all the morning huddles, which included those for patient care teams and staff. Either all or some members of the executive management team attended the huddles. ASP had six main clinics: A, B, C, D, E, and F. Clinics A and B, C and D, and E and F were co-located as pairs, and their staff conducted their morning huddles together. At the huddles, office technicians from each clinic reported they scheduled about 10 to 12 appointments for each primary care provider per day.

On the first day of the on-site inspection, OIG clinicians attended the huddle for Clinics A and B. After this huddle, the patient care team conducted a patient population management meeting. The chief medical executive (CME) and the care coordinator ran this meeting with input from the patient care team, the chief executive officer (CEO), the chief physician and surgeon (CP&S), and the chief nurse executive (CNE). The attendees pointed to an influx of patients as well as provider vacancies as driving the backlogs. Even so, they also noted a downward trend in provider backlogs over the previous six months.

In addition to its main clinics, ASP operated an OHU, a TTA, and specialty clinics. The specialty clinics included optometry, audiology, orthotics, gastroenterology (colonoscopy and endoscopy), and physical therapy.

Compliance On-Site Inspection

Five of six housing units randomly tested at the time of inspection had access to health care services request forms (CDCR form 7362) (MIT 1.101, 83.3 %). In one housing unit, custody officers did not have a system in place for reordering the forms. Custody officers reported relying on medical staff to replenish the forms in the housing unit.

Compliance Score Results

Table 5. Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001)	21	4	0	84.0%
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)	22	2	1	91.7%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	30	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004)	27	3	0	90.0%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005)	11	1	18	91.7%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006)	1	1	28	50.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007)	4	1	0	80.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	34	9	2	79.1%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	5	1	0	83.3%
				Overall percentage (MIT 1): **83.3%**

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

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

Table 6. Other Tests Related to Access to Care

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003)	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days (prior to 07/2022) or five working days (effective 07/2022)? (12.004)	N/A	N/A	N/A	N/A
Was a written history and physical examination completed within the required time frame? (13.002)	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)	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	10	1	4	90.9%
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)	7	8	0	46.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	8	0	7	100%
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)	11	4	0	73.3%
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	1	8	85.7%

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

Recommendations

The OIG offers no recommendations for this indicator.

Diagnostic Services

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

Ratings and Results Overview

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

In this indicator, case review found ASP performed excellently in diagnostic services. We found ASP staff always timely completed diagnostic testing. Providers timely and appropriately reviewed test results. As a result, the OIG rated the case review component of this indicator ***proficient***.

ASP's overall compliance testing scored low for this indicator. Staff performed very well in completing radiology and laboratory tests, and providers frequently endorsed diagnostic results timely. However, ASP staff needed to improve in retrieving pathology reports timely. Furthermore, providers rarely generated complete patient test result notification letters with all required elements. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 77 diagnostic related events and found 31 deficiencies related to health information management, one of which was significant.[14]

For health information management, we consider test reports that were never retrieved or reviewed to be as severe a problem as tests that were never performed. We discuss this further in the **Health Information Management** indicator.

Test Completion

ASP staff performed very well in completing radiology services (MIT 2.001, 90.0%) and satisfactorily in completing laboratory services (MIT 2.004, 80.0%) within required time frames. Compliance testing did not have any STAT laboratory tests in the samples to be evaluated (MIT 2.007, N/A). Case review found no deficiencies related to test completion.

Health Information Management

Staff retrieved laboratory and diagnostic results promptly and sent them to providers for review. Compliance testing showed providers frequently endorsed both radiology (MIT

[14] Deficiencies occurred in cases 4, 10–16, 18, 19, 21, and 44. A significant deficiency occurred in case 12.

2.002, 90.0%) and laboratory (MIT 2.005, 90.0%) results timely. However, compliance testing showed ASP had a mixed performance in retrieving and reviewing pathology reports as well as timely and properly communicating the results. While providers always reviewed and endorsed pathology reports (MIT 2.011, 100%), staff needed improvement in retrieving pathology reports (MIT 2.010, 70.0%), and providers never properly communicated pathology results with complete test result notification letters within specified time frames (MIT 2.012, zero). Similarly, case review identified 29 deficiencies related to incomplete, late, or missing results letters, and three deficiencies related to late or missing provider endorsements.[15] We discuss and consider these letter deficiencies further in the **Health Information Management** indicator.

Clinician On-Site Inspection

OIG clinicians met with providers, the correctional health services administrator (CHSA), and the senior laboratory assistant, who reported being fully staffed with no vacancies for the laboratory and radiology staff during the review period. Although ASP did not have an on-site laboratory, providers reported no difficulty in obtaining laboratory services and generally did not order STAT laboratory tests. Instead, providers often sent patients to a higher level of care when patients clinically required STAT laboratory tests.

The CHSA reported general X-ray, magnetic resonance imaging (MRI), computerized tomography (CT), and ultrasound (US) examinations as available on-site imaging services. In addition, the CHSA reported completing low-dose lung cancer screening CT scans was challenging due to patient refusals.

[15] Deficiencies occurred in cases 4, 9–16, 18, 19, 21, and 44. A significant deficiency occurred in case 12.

Compliance Score Results

Table 7. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001)	9	1	0	90.0%
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)	2	8	0	20.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	9	1	0	90.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	0	10	0	0
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	N/A	N/A	N/A	N/A
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	N/A	N/A	N/A	N/A
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	7	3	0	70.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
				Overall percentage (MIT 2): **60.0%**

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

Recommendations

- The department should develop and implement strategies to ensure providers create patient letters that contain all elements required by CCHCS policy when they endorse test results.

Emergency Services

In this indicator, OIG clinicians evaluated the quality of emergency medical care. Our clinicians reviewed emergency medical services by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardiopulmonary resuscitation (CPR) quality, 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 solely through case review.

Ratings and Results Overview

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

Similar to Cycle 6, case review determined ASP delivered satisfactory emergency services. ASP providers and nurses provided good emergency care. We found nursing staff responded immediately to emergencies and frequently performed good patient assessments, interventions, and documentation. In addition, EMRRC reviewed emergency events as required, identified issues, and provided staff training. Overall, the OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 18 urgent and emergent events and found eight emergency care deficiencies, two of which were significant.[16]

Emergency Medical Response

ASP staff responded promptly to emergencies throughout the institution. Our clinicians reviewed 13 emergency medical events requiring responses from first medical responders.[17] First medical responders frequently performed thorough assessments and documentation. They mostly intervened as required. The following examples were exceptions:

- In case 2, OIG clinicians identified a delay in care. In July 2023, the patient arrived at the prior D Yard clinic, which staff referred to as the "old" clinic, at 7:30 a.m., complaining of severe left lower abdominal pain and vomiting. The LVN referred the patient to the D Yard clinic nurse. The patient arrived at the new D Yard clinic at 8:04 a.m., over 30 minutes later, and the clinic RN assessed the patient and referred the patient to the TTA for further care. At 10:11 a.m., over two hours later, the patient arrived in the TTA, and the TTA

[16] Urgent and emergent events occurred in cases 1–4, 12–16, and 18–21. Deficiencies occurred in cases 1–4, 12 and 13. Significant deficiencies occurred in case 2.

[17] First medical responder events occurred in cases 1–4, 12–14, and 19–21.

provider evaluated the patient at 10:23 a.m. At 11:00 a.m., over three and a half hours after the patient's initial report of symptoms, the patient was transferred out to a higher level of care via ambulance.

- In case 2, ASP staff activated a medical alarm for a patient with abdominal pain. However, the LVN first responder did not assess the patient's level of pain. In addition, the nurse used an inappropriate mode of transportation to transfer the patient. The patient with abdominal pain walked from the housing unit to the clinic and then from the clinic to the TTA, instead of being transported via wheelchair or gurney.

During our on-site inspection, nursing staff agreed with the above deficiencies and provided staff training regarding the timely transfer of patients from the clinic to the TTA and the use of the appropriate mode of transportation for patients experiencing severe pain.

Cardiopulmonary Resuscitation Quality

OIG clinicians reviewed two cases in which staff initiated CPR.[18] Custody and nursing staff initiated CPR without delay and notified emergency medical services and TTA staff as required. In both cases, nurses applied the AED promptly, administered Narcan, and continued CPR until EMS arrived. We did not identify any significant deficiencies related to CPR events.

Provider Performance

ASP providers performed well in urgent and emergent situations, and in after-hours care. Providers usually made accurate diagnoses, completed documentation, and made appropriate triage decisions. Our clinicians identified three deficiencies related to emergency care, none of which were significant.[19]

Nursing Performance

Overall, TTA nurses performed well during emergency events. They frequently completed thorough patient assessments, provided appropriate and timely interventions during emergencies, and notified the provider as required. We identified one significant deficiency as detailed below:

- In case 2, staff activated a medical alarm for a patient with abdominal pain. The first medical responder and the clinic nurse assessed the patient. However, when the patient arrived in the TTA, the TTA nurse did not perform a patient assessment.

Nursing Documentation

TTA nurses and first medical responders often thoroughly documented emergency events, including event timelines. While case review identified some deficiencies, the

[18] CPR events occurred in cases 3 and 4.

[19] Emergency deficiencies occurred in cases 1 and 13.

deficiencies did not affect overall patient care.[20] Examples of missing nursing documentation included medication administration, patient response to Narcan, the time the patient left the TTA, and the nursing protocol used.

Emergency Medical Response Review Committee

Our clinicians reviewed nine EMRRC cases and found the EMRRC met monthly and reviewed emergency response care within required time frames.[21] Required staff performed timely clinical reviews, frequently identified opportunities for improvement, and provided staff training. In contrast, compliance testing showed the EMRRC event checklists were often incomplete, and in a few cases, the institution did not review the emergency event within the required time frame (MIT 15.003, 25.0%).

Clinician On-Site Inspection

TTA staff reported nursing morale was good, and they worked well with custody staff. They did not have any issues with supplies, equipment, or pharmacy. We also interviewed the supervising registered nurse (SRN) who was covering for this area. The SRN reported TTA staff had good teamwork. They had monthly staff meetings during which they provided needed staff training and addressed any new concerns. The SRN expressed having great, very supportive administrative leadership.

At the time of our inspection, the TTA had two beds and two emergency response vehicles. The TTA was staffed with two nurses on each shift. The second shift had a medical assistant assigned to the TTA. One provider was assigned to the TTA with on-call provider coverage for nonbusiness hours. Providers also performed special procedures, such as wound care and toenail removals in the TTA.

At ASP, the medication LVNs are the first responders to emergencies. They gather information and notify TTA staff if TTA nursing response is needed.

[20] TTA nursing documentation deficiencies occurred in cases 2–4 and 12.

[21] Cases 1–4, 12, 14, 16, and 19 had EMRRC events.

Recommendations

We offer no specific recommendations for this indicator.

Health Information Management

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Proficient* (87.3%)**

Case review found ASP performed sufficiently in health information management (HIM). HIM staff almost always timely retrieved and appropriately processed medical records. While we identified a pattern of incomplete or delayed patient notification letters, we found providers often reviewed diagnostic results timely. After reviewing these factors, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed ASP performed very well in this indicator. Staff always scanned patient health care request forms. They performed exceptionally in scanning, labeling, and filing medical documents in the appropriate patient file. Although staff retrieved most hospital records, they needed improvement in timely scanning specialty reports. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***proficient***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 610 events and found 37 deficiencies related to health information management, three of which were significant.[22]

Hospital Discharge Reports

Compliance testing showed ASP staff often timely retrieved and scanned hospital records into the EHRS (MIT 4.003, 80.0%). In addition, hospital reports always contained key elements, and ASP providers always reviewed them timely (MIT 4.005, 100%). OIG clinicians reviewed 16 off-site emergency department and hospital encounters and found one deficiency, which was significant as shown below:

- In case 13, ASP staff scanned the patient's 52-page hospital report into the EHRS. However, they did not forward this report to the ASP provider for review.

[22] Deficiencies occurred in cases 4, 9–16, 18–21, 44, and 46. Significant deficiencies occurred in cases 12, 13, and 46.

Specialty Reports

ASP had a mixed performance in managing specialty reports. Compliance testing showed staff needed improvement in retrieval of specialty reports (MIT 4.002, 56.7%) and provider endorsement of high-priority specialty reports (MIT 14.002, 66.7%). Furthermore, compliance testing revealed poor performance with provider endorsement of medium-priority (MIT 14.005, 46.7%) and routine-priority (MIT 14.008, 42.9%) specialty reports.

OIG clinicians reviewed 36 specialty reports and identified five deficiencies, one of which was significant as follows:[23]

- In case 46, the maxillofacial surgery dental specialist evaluated the patient at an off-site follow-up appointment. However, the ASP HIM staff did not obtain this specialist's report.

We also discuss these findings in the **Specialty Services** indicator.

Diagnostic Reports

ASP also had a mixed performance in diagnostic reports management. Compliance showed providers always reviewed and endorsed pathology reports timely (MIT 2.011, 100%). However, providers performed poorly when communicating pathology results with patient letters (MIT 2.012, zero). Compliance testing did not have any STAT laboratory tests in the samples available for its evaluation (MIT 2.007, N/A).

Case review identified 32 deficiencies; 29 related to incomplete, late, or missing results letters, and three related to late or missing provider endorsements.[24] We identified only one significant deficiency as described below:

- In case 12, the hepatitis B laboratory results were available for review. However, the provider never reviewed the results.

Additional details are discussed in **Diagnostic Services** indicator.

Urgent and Emergent Records

OIG clinicians reviewed 18 emergency care events and found ASP nurses and providers documented these events adequately. Providers also recorded their emergency care sufficiently, including off-site telephone encounters. Case review identified only one deficiency related to provider documentation, which was not significant.[25] Please refer to the **Emergency Services** indicator for additional information regarding emergency care documentation.

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[23] Specialty health information management deficiencies occurred in cases 9, 19, 20, and 46. A significant deficiency occurred in case 46.

[24] Deficiencies occurred in cases 4, 9–16, 18, 19, 21, and 44. A significant deficiency occurred in case 12.

[25] A deficiency occurred in case 1, which was not significant.

Scanning Performance

Staff performed excellently with the scanning process. Compliance testing showed perfect scanning, labeling, and filing performance (MIT 4.004, 100%). OIG clinicians identified two deficiencies related to mislabeled, misfiled, or duplicate medical documents, neither of which was significant.[26]

Clinician On-Site Inspection

The OIG physician met with the correctional health services administrator (CHSA) and the medical records supervisor to discuss HIM processes. The medical records supervisor described the process of retrieving documents from on-site and off-site reports and routing them to providers for review. The medical records supervisor reported difficulty in obtaining reports from cardiology and neurology specialists and having access to the electronic health records database of only one hospital.

The medical records supervisor relayed the process of ensuring providers reviewed reports and results timely. HIM staff checked the message center in the EHRS daily. In addition, the supervisor reviewed a weekly audit of unsigned reports and results. The supervisor involved the chief medical executive (CME) and the chief physician and surgeon (CP&S) after the second or third day if no provider had endorsed the report or result. The supervisor stated providers had no issues with responding timely.

Last, the OIG physician discussed staffing with the CHSA and the medical records supervisor. They reported the HIM staff vacancies that were present during the case review period had been filled by the time of the OIG's inspection.

[26] Deficiencies occurred in cases 19 and 20, none of which were significant.

Compliance Score Results

Table 8. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	10	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	17	13	15	56.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	4	1	0	80.0%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	24	0	0	100.0%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	5	0	0	100.0%
				Overall percentage (MIT 4): **87.3%**

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

Table 9. Other Tests Related to Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	9	1	0	90.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	9	1	0	90.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	7	3	0	70.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	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)	10	5	0	66.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	7	8	0	46.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	6	8	1	42.9%

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

Recommendations

The OIG offers no recommendations for this indicator.

Health Care Environment

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

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (56.6%)**

Overall, ASP performed poorly with respect to its health care environment. We found disorganized medical supplies. In addition, medical supply storage areas contained unidentified or inaccurately labeled medical supplies. Several clinics did not meet the requirements for essential core medical equipment and supplies. Staff did not regularly sanitize or wash their hands during patient encounters. Emergency medical response bags (EMRB) contained expired medical supplies as well as compromised medical supply packaging and had not been properly inventoried. Based on the overall compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Patient Waiting Areas

We inspected only indoor waiting areas as ASP had no outdoor waiting areas. Health care and custody staff reported the existing waiting areas contained sufficient seating capacity (see Photo 1). During our inspection, we did not observe overcrowding in any of the clinics' indoor waiting areas.

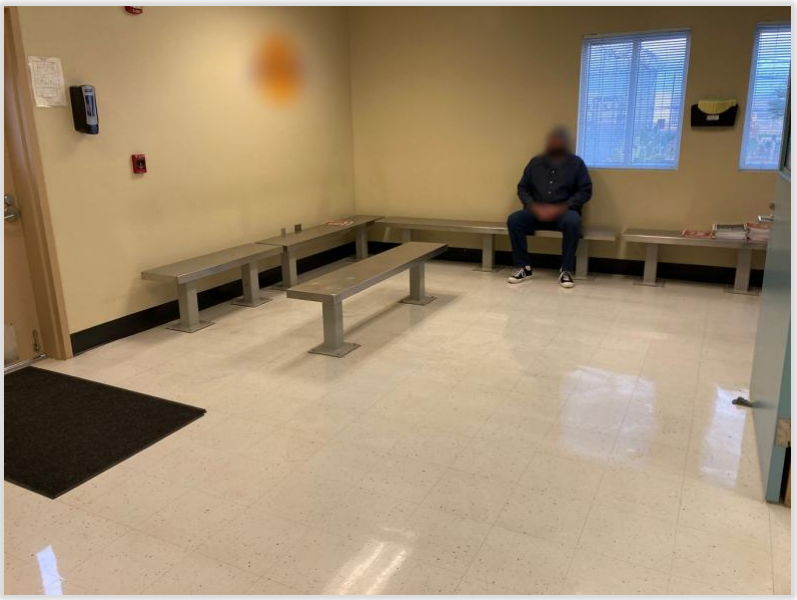

Photo 1. Indoor waiting area (photographed on 11-30-23).

Clinic Environment

Nine of 10 applicable clinic environments were sufficiently conducive to the practice of medical care. They provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 90.0%). In one clinic, the blood-draw station was within close proximity to the patient waiting area, which hindered auditory privacy.

Of the 10 clinics we observed, nine contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 90.0%). The remaining clinic had an examination chair with a torn vinyl cover.

Clinic Supplies

Three of the 10 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 30.0%). We found one or more of the following deficiencies in seven clinics: expired medical supplies; compromised medical supplies; unidentified, inaccurately labeled, or disorganized medical supplies (see Photo 2); or cleaning materials stored with medical supplies.

Photo 2. Disorganized medical supplies (photographed on 11-28-23.

Five of the 10 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 50.0%). The remaining five clinics lacked medical supplies. The missing items included lubricating jelly and tips for an otoscope. We found the Snellen eye chart was either placed at an improper distance or missing a clearly established and identified distance line. Moreover, ASP staff did not properly log the results of the defibrillator performance test or glucometer quality control test within the last 30 days.

We examined EMRBs to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only three of the eight EMRBs passed our test (MIT 5.111, 37.5%). We found one or more of the following deficiencies with five EMRBs: staff had not inventoried the EMRBs when the seal tags were replaced; EMRBs contained expired or compromised medical supplies (see Photo 3 and Photo 4, below); and staff failed to accurately log EMRB glucometer daily quality control performance results.

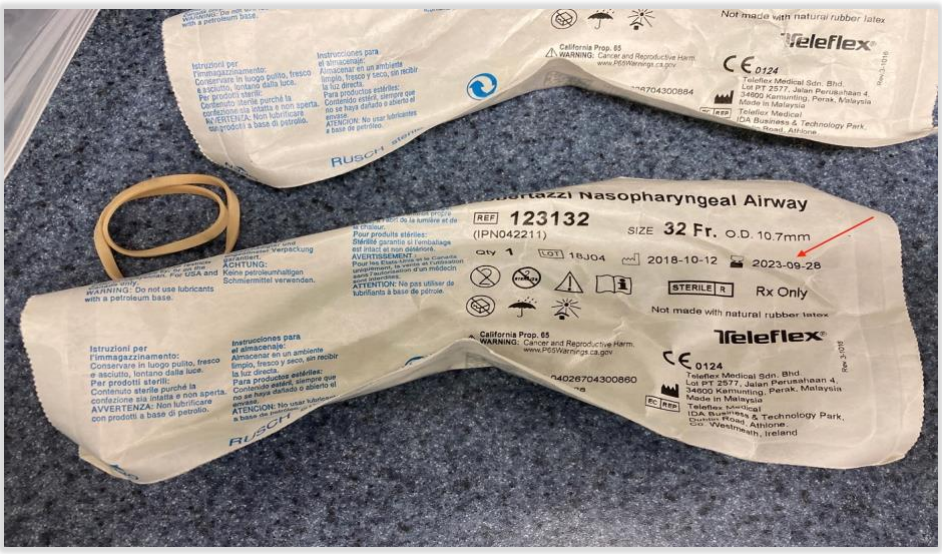

Photo 3. EMRB expired supply (photographed on 11-28-2023).

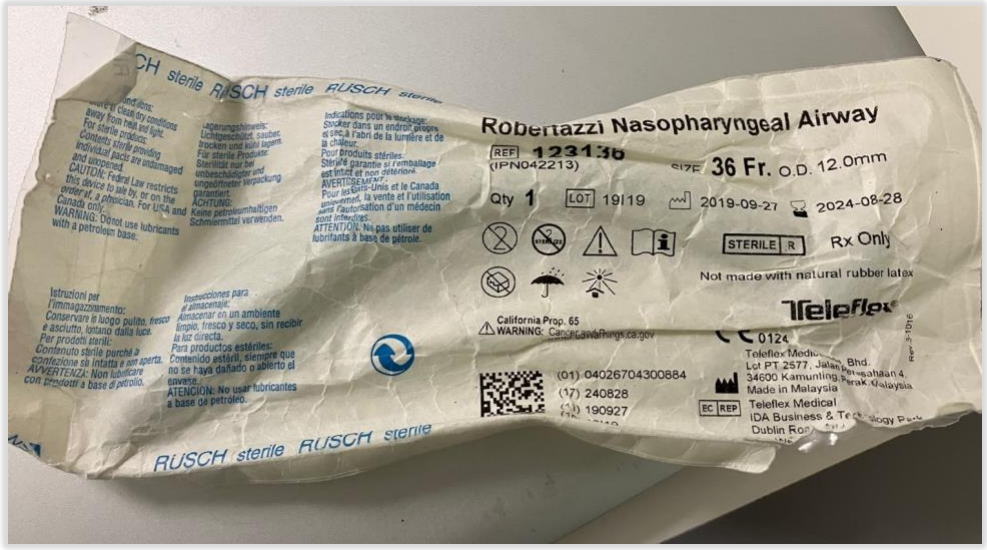

Photo 4. EMRB compromised supply (photographed on 11-30-23).

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). The warehouse manager did not monitor the temperature or maintain a temperature log for medical supplies with manufacturer temperature guidelines stored in the warehouse.

According to the CEO, the institution did not have any concerns about the medical supply process. Health care and warehouse managers expressed no concerns about the medical supply chain or their communication process with the existing system in place.

Infection Control and Sanitation

Staff appropriately, cleaned, sanitized, and disinfected seven of 10 clinics (MIT 5.101, 70.0%). In one clinic, staff did not maintain the cleaning logs. In the other two clinics, we found unsanitary health care areas.

Staff in four of seven applicable clinics properly sterilized or disinfected medical equipment (MIT 5.102, 57.1%). In three clinics, staff did not mention disinfecting the examination table as part of their daily start-up protocol.

We found operating sinks and hand hygiene supplies in the examination rooms in six of 10 clinics (MIT 5.103, 60.0%). The patient restrooms in four clinics lacked either antiseptic soap or disposable hand towels.

We observed patient encounters in eight clinics. In five clinics, clinicians did not wash their hands before or after examining their patients, after removing gloves, before performing a blood draw, or during subsequent regloving (MIT 5.104, 37.5%).

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

Physical Infrastructure

At the time of our medical inspection, the institution's administrative team reported no ongoing health care facility improvement program construction projects. Various areas had ceiling damage, including the OHU, R&R, and medical warehouse (see Photo 5 and Photo 6, next page). According to health care management and the plant operations manager, these damages did not hinder health care services. The plant operations manager reported the leaks had been repaired and the cosmetic repairs were ongoing (MIT 5.999).

Photo 5. Ceiling damage in the outpatient housing unit (photographed on 11-30-23).

Photo 6. Ceiling damage in the receiving and release area (photographed on 11-28-23).

Compliance On-Site Inspection and Discussion

In addition to the above findings, in one clinic, our compliance inspectors found a wound cleanser for single-patient use without a label, which had been prescribed for a specific patient. Staff reported the cleanser was utilized for multiple patients (see Photo 7 and Photo 8).

Photo 7. Wound cleanser (photographed on 11-28-23).

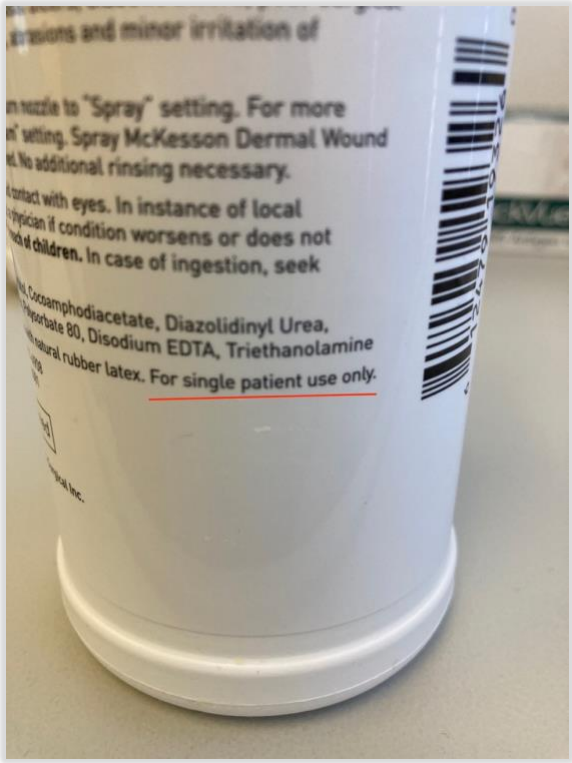

Photo 8. Wound cleanser (photographed on 11-28-23).

Compliance Score Results

Table 10. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	**No**	**N/A**	**Yes %**
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	7	3	0	70.0%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	4	3	3	57.1%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	6	4	0	60.0%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	3	5	2	37.5%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	10	0	0	100%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	3	7	0	30.0%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	5	5	0	50.0%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	9	1	1	90.0%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	9	1	0	90.0%
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)	3	5	2	37.5%
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): **56.6%**

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

Recommendations

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

- Nursing leadership should determine the root cause(s) for staff not ensuring the EMRBs are inventoried or stocked appropriately and should implement necessary remedial measures.

- ASP leadership should determine the root cause(s) for staff not following adequate protocols for managing and storing bulk medical supplies and should implement necessary remedial measures.

Transfers

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (74.5%)**

Case review found ASP performed well for the transfer-in process. Receiving and release (R&R) nurses completed initial health screenings thoroughly, ensured medication continuity, and scheduled nurse and provider follow-up appointments as required. ASP also performed very well for hospital returns. Nurses mostly completed good assessments, and the institution provided continuity of hospital recommended medications. The transfer-out process, however, needed improvement. Nursing only sometimes completed the required screening for patients transferring out of the institution. Factoring in all the information, the OIG rated the case review component of this indicator ***adequate.***

In compliance testing, ASP's performance was mixed for this indicator. ASP performed excellently in completing the assessment and disposition sections of the screening process. Staff also performed well in medication continuity for newly transferred patients arriving at ASP. Even so, ASP staff needed to improve in completing the initial health screening form. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 27 events in 17 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified eight deficiencies, three of which were significant.[27]

Transfers In

Case review analyzed four events in which patients transferred into the facility from other institutions. We identified one deficiency, which was not significant.[28]

Compliance testing showed patients received their medications without interruption most of the time (MIT 6.003, 82.4%). Case review similarly found patients arriving at ASP received medications without a break in continuity. Medication continuity for patients transferring from yard to yard within the institution was also sufficient (MIT 7.005, 84.0%).

OIG clinicians found the R&R nurses completed the initial health screening thoroughly, scheduled required nurse and provider follow-up appointments, and educated patients as required. R&R nurses almost always completed the assessment and disposition section of the initial health screening form (MIT 6.002, 91.7%). However, nurses performed poorly in completing the initial health screening thoroughly (MIT 6.001, 24.0%). The low score mostly resulted from incomplete vital signs and nurses not documenting an explanation when patients answered "yes" to the question asking whether they had ever been treated for mental illness.

Compliance testing showed providers nearly always evaluated patients who arrived at ASP within the required time frame (MIT 1.002, 91.7%). However, specialty services appointments for patients arriving at ASP only intermittently occurred within the required time frame (MIT 14.010, 50.0%). Specialty appointments at times either did not occur or were not scheduled timely.

Transfers Out

OIG clinicians reviewed seven transfer-out events and found four deficiencies, two of which were significant.[29] We found nurses intermittently ensured all transfer requirements were met. The following are examples of significant deficiencies:

- In case 25, the patient transferred out of ASP to Pleasant Valley State Prison. However, the nurse did not ensure the patient was medically cleared for transfer. When we discussed this case with nursing leadership, they informed us custody staff did not bring the patient to the R&R nurse for medical clearance prior to transfer.

[27] Deficiencies occurred in cases 4, 13, 23–25, 44, and 45. Significant deficiencies occurred in cases 13, 25, and 45.

[28] Transfer-in events occurred in cases 4, 13, and 22. A deficiency occurred in case 4.

[29] Transfer-out events occurred in cases 23–25, and 45. Deficiencies occurred in cases 23–25, and 45. Significant deficiencies occurred in cases 25 and 45.

- In case 45, the patient transferred out of ASP to Kern Valley State Prison. The nurse did not perform either a transfer screening or COVID-19 screening, did not ensure the patient's medications were not expiring within five days, and did not ensure all keep-on-person (KOP) medications were placed in the transfer packet.[30]

During our on-site inspection, the institution agreed with the above deficiencies and provided staff training. Compliance tested three relevant samples and determined staff always sent required medications, durable medical equipment (DME), and documents with the transfer packets in each sample (MIT 6.101, 100%).

Case review found opportunities for improvement in nurses documenting and communicating with the receiving institution about pending specialty appointments.[31]

Hospitalizations

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

Our clinicians reviewed 14 events in 11 cases in which patients returned from off-site hospitalizations or emergency room encounters. We identified three deficiencies, one of which was significant.[32]

Case review found ASP nurses performed excellently. Nurses almost always conducted thorough patient assessments when patients returned from the hospital. Patients frequently received provider follow-up appointments timely (MIT 1.007, 80.0%). In addition, providers always reviewed the hospital discharge documents within required time frames (MIT 4.005, 100%). Case review identified one significant deficiency related to reviewing hospital discharge documents. Please refer to the **Health Information Management** indicator for further details. Most of the time, ASP staff scanned hospital or emergency room summary reports into the EHRS and made them available timely (MIT 4.003, 80.0%).

Results for medication continuity differed between case review and compliance testing. Case review did not identify any deficiencies related to patients receiving hospital discharge medications timely. Compliance testing, however, revealed poor results (MIT 7.003, 20.0%). Please refer to the **Medication Management** indicator for further discussion.

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[30] KOP means "keep on person" and refers to medications that a patient can keep and self-administer according to the directions provided.

[31] Documentation and communication of pending specialty appointment deficiencies occurred in cases 23–25.

[32] Patients returned from a hospitalization or emergency room encounters occurred in cases 1, 12–16, 19, 21, and 44–46. Deficiencies occurred in cases 13 and 44. A significant deficiency occurred in case 13.

Clinician On-Site Inspection

During our on-site inspection, we interviewed the R&R nurse, who was knowledgeable about the transfer processes. The R&R staffing consisted of one RN assigned to the second watch and one to the third watch. Another RN was scheduled from 4:00 a.m. to 12:00 p.m. Staff informed us the number of patients arriving to and transferring out of ASP recently varied, with an average weekly rate of 60 to 70 patients arriving and 25 patients transferring out. Nursing staff reported one issue they encountered with patient transfers was missing DME and DME receipts. Nursing stated they had a basic supply of DME available in the R&R, which they provided to patients as needed. The R&R did not have an automated drug delivery system (ADDS) available.[33] However, the nurse reported the R&R could obtain medications from the TTA ADDS if needed. The nurse also stated the R&R had no problems with the pharmacy or equipment and reported good nursing morale as well as supportive administration.

Compliance On-Site Inspection

R&R nursing staff ensured all three patients transferring out of the institution had their required medications, transfer documents, and assigned DME (MIT 6.101, 100%).

[33] The automated drug delivery system (ADDS), also known as an automated dispensing cabinet, is used to provide drug security, and tracking for controlled substances to meet all federal and state requirements.

Compliance Score 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)	6	19	0	24.0%
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)	22	2	1	91.7%
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)	14	3	8	82.4%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	3	0	0	100%
				Overall percentage (MIT 6): **74.5%**

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

Table 12. Other Tests Related to Transfers

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	22	2	1	91.7%
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)	4	1	0	80.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	4	1	0	80.0%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	5	0	0	100%
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)	1	4	0	20.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	21	4	0	84.0%
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)	0	2	0	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)	5	5	0	50.0%

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

Recommendations

- Nursing leadership should determine the challenges preventing nurses from thoroughly completing the initial health screening process, including documenting a complete set of vital signs, answering all questions, and documenting an explanation for all "yes" answers before the patient is transferred to the housing unit. Leadership should implement remedial measures as appropriate.

- Nursing leadership should determine the challenges to ensuring nursing staff complete screenings of patients transferring to another institution, including documenting or communicating pending specialty appointments, and should implement remedial measures as appropriate.

- Nursing leadership and custody staff should collaboratively strategize on whether their processes require amendments to ensure nurses evaluate and screen all patients before they transfer out of the institution. Leadership should implement remedial measures as appropriate.

Medication Management

In this indicator, OIG inspectors evaluated the institution's performance in administering prescription medications on time and without interruption. The inspectors examined this process from the time a provider prescribed medication until the nurse administered the medication to the patient. In addition to examining medication administration, our compliance inspectors also tested many other processes, including medication handling, storage, error reporting, and other pharmacy processes.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (55.9%)**

Case review found ASP performed satisfactorily, similar to Cycle 6. ASP performed excellently with new medication prescriptions, chronic care medications, hospital discharge medications, specialized housing medications, and medication administration. Factoring in all the information, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed ASP needed improvement with this indicator. ASP scored low in providing patients with chronic care medications, community hospital discharge medications, and medications for patients temporarily housed at the institution. ASP needed further improvement in timely providing medications for patients admitted to the specialized medical housing unit and thoroughly documenting medication administration for layover patients in the EHRS. Based on the overall compliance score results, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 129 events in 27 cases related to medications and found nine medication deficiencies, four of which were significant.[34]

New Medication Prescriptions

Case review found ASP staff performed excellently with new prescription medications.[35] Patients received their newly ordered medications timely. Conversely, compliance testing revealed only 19 out of 25 patients received their medications within the required time frames (MIT 7.002, 76.0%).

[34] Deficiencies occurred in cases 6, 8, 16, 21, and 44–46. Significant deficiencies occurred in cases 6, 21, and 46.

[35] A new medication deficiency occurred in case 16.

Chronic Medication Continuity

During this review period, case review found ASP's performance was excellent for chronic medication continuity.[36] Out of 129 events reviewed, we identified only four deficiencies, three of which were significant as described below:

- In case 6, the patient did not receive his chronic medication, aspirin, during June, July, and August 2023. The order for the aspirin expired in June 2023 and was not renewed.

- In case 21, during June 2023, the patient did not receive his automatically refilled cholesterol medication. The medication documentation stated, "Not done; refill not requested," despite being ordered to refill automatically.

- In case 46, during the month of May 2023, the patient did not receive his chronic medication for high cholesterol.

In contrast, compliance testing revealed poor performance for chronic medication continuity (MIT 7.001, 33.3%). Results showed pharmacy staff were often not timely in filling and dispensing KOP medications as ordered.

Hospital Discharge Medications

ASP showed insufficient performance for patients receiving their discharge medications on return from an off-site hospitalization or emergency room encounter (MIT 7.003, 20.0%). The sample size for compliance testing consisted of five patients. One patient received medication timely. One patient received his blood thinning medication two days late. The other three patients received their prescribed medications less than two hours late.

Case review found better performance with hospital discharge medications. We reviewed 14 hospital or emergency room events and did not identify any delays in patients receiving their hospital discharge medications timely.

Specialized Medical Housing Medications

Patients received their medications without delay upon admission to the outpatient housing unit (OHU). In reviewing cases involving patients in the OHU, case review found four deficiencies related to medication management. One of these was significant[37] as explained below:

- In case 21, during September 2023, the patient did not receive his chronic care medication for high cholesterol.

Compliance testing showed OHU staff performed poorly for medication management (MIT 13.003, 44.4%). An analysis of the compliance results for the 10-patient sample set showed patients received their medications several minutes to one day late. Staff

[36] Patients did not receive their chronic care medications timely in cases 6, 8, 21, and 46.

[37] Deficiencies occurred in cases 21, 44, and 45. A significant deficiency occurred in case 21.

administered an ordered antibiotic and Tylenol one day late. Staff delayed less than three hours in administering the remaining medications.

Transfer Medications

OIG clinicians determined ASP's performance for transfer medications was excellent. Case review did not identify any medication deficiencies for patients transferring into or out of the institution. Compliance testing revealed satisfactory performance (MIT 6.003, 82.4%) for new arrival medications. When patients transferred within the institution, compliance testing showed good performance (MIT 7.005, 84.0%). Patients mostly received their medications timely. For patients transferring out of the institution, ASP always included required medications and documents (MIT 6.101, 100%). In two samples for patients who were on layover and temporarily housed at ASP, compliance testing revealed nurses documented on the wrong institution medication administration record (MAR) summary (MIT 7.006, zero).

Medication Administration

Compliance testing showed nurses performed well in administering tuberculosis (TB) medications (MIT 9.001, 88.0%) and always monitored patients on TB medications as required (MIT 9.002, 100%). We did not identify any problems with medication administration.

Clinician On-Site Inspection

While on site, we interviewed the pharmacist and medication nurses for Yards A and D. The nurses were knowledgeable about various processes, including KOP medications, patients transferring to another institution and within the institution, and patient noncompliance with medications. The nurses reported each yard has two licensed vocational nurses (LVNs) assigned on the second watch and one LVN on the third watch, except for Yard A, which has two LVNs assigned on the third watch. The medication LVNs reported they receive medications timely from the pharmacy.

As LVNs do not carry radios, custody staff notifies the LVNs for medical emergencies. The second watch LVN staff informed us LVNs were the first medical responders for medical emergencies in their assigned yards, and they request TTA nurses or call 9-1-1 as needed. During clinic hours, clinic providers either evaluate patients or refer them to the TTA for further evaluation.

Medication LVNs reported they worked well with custody staff, found their administration to be supportive, and believed nursing morale was good.

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in seven of eight clinic and medication line locations (MIT 7.101, 87.5%). In one location, narcotic medications were not properly and securely stored as required by CCHCS policy.

ASP appropriately stored and secured nonnarcotic medications in four of eight clinic and medication line locations (MIT 7.102, 50.0%). In four locations, we observed one or more of the following deficiencies: nurses did not maintain unissued medication in its original

labeled packaging; the treatment cart log had incomplete daily security check entries; and the medication storge area was unsanitary.

Staff kept medications protected from physical, chemical, and temperature contamination in four of the eight clinic and medication line locations (MIT 7.103, 50.0%). In three locations, staff did not consistently record the room and refrigerator temperatures. In the remaining location, staff did not store internal and external medications separately.

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

Nurses exercised proper hand hygiene and contamination control protocols in four of six applicable locations (MIT 7.105, 66.7%). In two locations, some nurses neglected to wash or sanitize their hands when required. These occurrences included before each subsequent regloving and when gloves were compromised.

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

Staff in five of six applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 83.3%). In one location, the medication nurse did not reliably observe patients while they swallowed direct observation therapy medications.

Pharmacy Protocols

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

The institution did not properly store refrigerated or frozen medications in the pharmacy. We found expired refrigerated medications. As a result, the institution scored zero for this test (MIT 7.110).

The pharmacist in charge (PIC) did not thoroughly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC or designee did not complete the medication area inspection checklists (CDCR Form 7477) in one location. In addition, the PIC or designee did not show evidence that a narcotic discrepancy was investigated. These errors resulted in a score of zero for this test (MIT 7.111).

We examined nine medication error reports. For two reports, the PIC was not able to provide a completed pharmacy error follow-up form. For the remaining seven reports, the PIC did not document the reason why neither the patient nor the provider was notified of the error. As a result, ASP received a score of zero for this test (MIT 7.112).

Nonscored Tests

In addition to testing the institution's self-reported medication errors, our inspectors also follow 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 ASP, the OIG did not find any applicable medication errors (MIT 7.998).

ASP did not have restricted housing units; therefore, we did not determine whether patients had immediate access to their prescribed rescue medications (MIT 7.999).

Compliance Score Results

Table 13. Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001)	6	12	7	33.3%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	19	6	0	76.0%
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)	1	4	0	20.0%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004)	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	21	4	0	84.0%
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)	0	2	0	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)	7	1	2	87.5%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	4	4	2	50.0%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	4	4	2	50.0%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	8	0	2	100%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	4	2	4	66.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	6	0	4	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	5	1	4	83.3%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	0	9	0	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): **55.9%**

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

Table 14. Other Tests Related to Medication Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	14	3	8	82.4%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	3	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)	25	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	5	1	44.4%

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

Recommendations

- The institution should develop and implement measures to ensure staff timely make available and administer medications to chronic care and hospital discharge patients, and staff document administering medications for layover patients in the electronic health record system (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	Compliance Rating and Score
Not Applicable	***Proficient* (87.6%)**

ASP performed very well in preventive services. Staff performed well to excellently in administering and monitoring patients on 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. In addition, ASP almost always timely transferred patients at the highest risk for coccidioidomycosis. However, ASP only occasionally offered required immunizations to chronic care patients. These findings are set forth in the table on the next page. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***proficient***.

Compliance Score Results

Table 15. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	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)	25	0	0	100%
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)	3	5	17	37.5%
Are patients at the highest risk of coccidioidomycosis (Valley Fever) infection transferred out of the facility in a timely manner? (9.009)	24	1	0	96.0%
				Overall percentage (MIT 9): **87.6%**

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

Recommendations

The OIG offers no recommendations for this indicator.

Nursing Performance

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

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

Ratings and Results Overview

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

ASP nurses provided good nursing care, which was similar to Cycle 6 findings. Nurses mostly performed good assessments, intervened timely, and generally documented well. However, we identified an opportunity for improvement in the outpatient clinic area for nursing assessments and interventions. Factoring in all the information, the OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 169 nursing encounters in 44 cases and identified 36 nursing performance deficiencies, seven of which were significant.[38]

Outpatient Nursing Assessment and Interventions

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

Seventy-eight nursing encounters occurred in the outpatient setting, 44 of which were sick call requests. In these encounters, our clinicians identified 19 deficiencies, two of

[38] We reviewed nursing events in cases 1-4, 6, and 8–48. Deficiencies occurred in cases 2–4, 9, 10, 12, 13, 21, 23–26, 31, 37, 38, 40, 42–45. Significant deficiencies occurred in cases 2, 10, 12, 25, and 45.

which were significant.[39] Clinic nurses mostly triaged sick calls appropriately, timely evaluated patients, and performed good patient assessments. They also generally intervened appropriately and scheduled timely provider follow-up appointments. However, nursing assessments and interventions showed room for improvement. Case review found a pattern of missing components for patient assessments and inappropriate interventions.[40] The following are examples:

- In case 12, the clinic nurse assessed the patient during a scheduled follow-up for a wound evaluation. In this encounter, the patient reported he had started stuttering three days ago, but the nurse did not notify a provider. The nurse ordered a provider follow-up within seven days. However, the nurse should have consulted with a provider the same day. The stuttering was a new symptom onset and could have been related to a neurologic event, such as a stroke.

- In case 13, the clinic nurse assessed the patient for hives, redness, and swelling affecting his lower extremities. However, the nurse did not listen to the patient's lung sounds to assess for severe allergic reaction, which could have led to respiratory distress.

- In case 40, the clinic nurse assessed the patient for a persistent cough, a sore throat, and pain with swallowing. However, the nurse did not assess the patient's throat for further abnormalities.

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. Although outpatient clinic nurses mostly documented well, we identified a pattern of missing documentation.[41] The following are examples:

- In case 12, the clinic nurse assessed the patient for complaints of pain in both feet. The nurse documented a provider follow-up within 14 days. However, the nurse did not place an order for the provider follow-up.

- In case 43, the clinic nurse assessed the patient for chest pain, performed an EKG, and used the nursing protocol for chest wall pain.[42] However, the nurse did not place an order for the EKG.

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[39] We reviewed nursing sick call events in cases 4, 8–15, 18–20, and 26–43. Deficiencies occurred in case 2, 4, 9, 10, 12, 13, 26, 31, 37, 38, 40, 42, and 43. Significant deficiencies occurred in case 12.

[40] Incomplete nursing assessments occurred in cases 12, 13, 31, 37, 38, 40, and 41. Clinic nurses did not intervene appropriately in cases 2 and 12.

[41] Outpatient documentation deficiencies occurred in cases 4, 9, 10, 12, 26, 42, and 43.

[42] An EKG is an electrocardiogram. This non-invasive test measures and records the electrical impulses from the heart and is used to help diagnose heart problems.

Wound Care

We reviewed four cases involving wound care orders. Nurses frequently performed wound care as ordered.[43]

Emergency Services

We reviewed 18 urgent or emergent events. Overall, nurses responded promptly to urgent and emergent events, performed good assessments, mostly intervened as required, and documented well. Please refer to the **Emergency Services** indicator for further discussion.

Hospital Returns

We reviewed 14 events involving patient returns from off-site hospitals or emergency rooms. ASP nurses frequently performed good nursing assessments and documented well, which we detailed further in the **Transfers** indicator.

Transfers

We reviewed 11 events involving transfer-in and transfer-out processes. ASP nurses evaluated patients appropriately and initiated provider appointments within required time frames. However, when patients transferred out of the institution, nurses did not always ensure all transfer requirements were met. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

We reviewed 25 nursing events. OHU nurses performed well with patient assessments, communicated with the provider as required, and provided good documentation. For details, please refer to the **Specialized Medical Housing** indicator.

Specialty Services

OIG clinicians reviewed 28 events in which patients returned from off-site specialty appointments.[44] ASP nurses generally performed well. They frequently performed good assessments, reviewed specialty recommendations, and scheduled provider follow-up appointments as required. We identified three deficiencies, one of which was significant. Please refer to the **Specialty Services** indicator for further discussion.

Medication Management

OIG clinicians examined 129 events involving medication management. ASP performed well in this area. We identified nine deficiencies, four of which were significant. For further details, please refer to the **Medication Management** indicator.

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[43] Wound care occurred in cases 4, 13, 16, 20, and 26. A deficiency occurred in case 26.

[44] Specialty services nursing encounters occurred in cases 1, 9, 10, 15, 17–21, and 44–46. Deficiencies occurred in cases 10 and 44. A significant deficiency occurred in case 10.

Clinician On-Site Inspection

We inspected various areas including the TTA, the OHU, outpatient clinics, R&R, and medication areas. Clinical staff in each area were knowledgeable about processes pertaining to their areas. We attended well-organized huddles. Nursing and medical staff were familiar with their patients, and all staff participated in discussions regarding patient care. Medication nurses also attended morning huddles and relayed medication concerns to providers. In addition, we interviewed nurses, supervisors, and nursing leadership. Staff reported nursing morale was generally good, they felt supported by their supervisors and nursing leadership, and they had good relationships with custody staff.

Recommendations

- Nursing leadership should determine the challenges to nurses completing thorough patient assessments for face-to-face encounters and providing appropriate interventions and should implement remedial measures as appropriate.

Provider Performance

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

Ratings and Results Overview

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

Similar to Cycle 6, ASP providers continued to deliver good care in this cycle. Providers usually made proper assessments, ordered appropriate follow-up appointments, and referred patients to specialists as medically indicated. They referred patients to a higher level of care when necessary and managed chronic medical conditions effectively. Although we identified a pattern of incomplete patient notification letters, these deficiencies were not significant. Overall, the OIG rated this indicator ***adequate***.

Case Review Results

OIG clinicians reviewed 106 medical provider encounters and identified 40 deficiencies, seven of which were significant.[45] In addition, our clinicians examined the quality of care in 20 comprehensive case reviews. Of these 20 cases, we found 19 ***adequate*** and one ***inadequate***.[46]

Outpatient Assessment and Decision-Making

Providers generally made appropriate assessments and sound decisions for their patients. Most of the time, they took good histories, formulated differential diagnoses, ordered appropriate tests, provided care with the correct diagnosis, and referred patients to proper specialists when needed. However, case review identified 32 deficiencies related to an incorrect diagnosis, insufficient assessments, not ordering appropriate follow-up, and poor decision-making.[47] Six significant deficiencies are described below:

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[45] Deficiencies occurred in cases 1, 2, 4–7, 9, 10, 12, 13, 16–21, and 26. Significant deficiencies occurred in cases 2, 6, 9, 10, 13, 18, and 20.

[46] We rated case 13 ***inadequate***.

[47] The provider did not make a correct diagnosis in case 17. Providers performed insufficient examinations in cases 1, 4, 7, 9, 10, 12, 13, 16, and 18–21. Providers did not order appropriate follow-up in cases 5 and 13. Providers made questionable or poor decisions in cases 2, 13, and 17. Significant deficiencies occurred in cases 2, 9, 19, and 20.

- In case 2, the provider evaluated the patient at a follow-up appointment after the patient's emergency room encounter. The patient's emergency room laboratory tests showed an abnormally elevated kidney function. However, the provider did not order a recheck of the patient's kidney function laboratory test to ensure continued improvement.

- In case 9, the provider evaluated the patient at a follow-up appointment to discuss the patient's lung CT scan results. However, the provider did not perform a subjective and objective assessment and did not review vital signs.

- In case 10, the provider evaluated the patient at a chronic care appointment for abnormal laboratory tests results follow-up. The patient had a history of pancytopenia and had a pending appointment with the hematology specialist.[48] However, the provider did not perform a subjective examination to inquire about signs of bleeding and did not complete an objective examination of the patient. In addition, the provider did not review the patient's vital signs.

- In case 13, the provider evaluated the patient at a chronic care and nurse co-consultation appointment for the patient's, "persistent right foot pain and swelling secondary to abscess." The provider documented the patient as having, "significant swelling and area of erythema approximately 7 to 8 cm with a large central bulla and straight incision line."[49] The patient reported having self-performed the incision on the affected area. Despite the significance of these findings and the risk for severe infection, the provider did not order an appointment for a close follow-up, review vital signs, or review medications.[50]

- In case 18, the nurse co-consulted with the provider about the patient's complaints of dizziness, headache, and hot flashes. The nurse ordered an episodic care appointment to occur that same day with the provider. However, the provider only reviewed orthostatic vital signs and did not otherwise perform an objective assessment of the patient to further evaluate these complaints.

- In case 20, the provider evaluated the patient to follow up on the patient's appointment with an orthopedic specialist. The specialist recommended the patient have a cervical spine MRI to evaluate for cervical radiculopathy.[51] However, the provider did not perform a subjective or objective examination to evaluate for cervical radiculopathy and did not consider ordering the MRI.

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[48] Pancytopenia is a medical condition in where all types of blood cells are low, including white blood cells, red blood cells, and platelets. A hematology specialist evaluates and treats disorders of the blood.

[49] Erythema is redness of the skin caused by dilation of the capillary blood vessels. A bulla is a blister or sac containing fluid.

[50] The risk of infection is increased when a patient attempts to make an incision without proper medical training, sanitized equipment, and sterile environment.

[51] Cervical radiculopathy is a medical condition in which a pinched nerve in the neck causes tingling, pain, numbness, or weakness in the arm or hand.

Outpatient Review of Records

Providers usually reviewed medical records carefully. Our clinicians identified only one deficiency involving a specialty report, which was not significant.[52]

Emergency Care

Providers made appropriate triage decisions when patients arrived at the TTA for emergency treatment. However, although providers were available for consultation with TTA nursing staff, they did not always document progress notes, order appropriate follow-up timely, or perform an adequate physical examination. Our clinicians identified three deficiencies related to emergency care, none of which were significant.[53]

Chronic Care

Providers usually performed well in managing chronic medical conditions, such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular diseases. We identified four deficiencies involving chronic care.[54] The following deficiency was a significant example:

- In case 6, the provider evaluated the patient at a chronic care appointment and documented the patient's elevated diabetic test result. The provider decreased the patient's metformin total daily dosage and stopped the patient's glipizide prescription.[55] Due to the patient's uncontrolled diabetes, these medication changes increased the risk of worsening the overall blood sugar level, affecting its control.

Specialized Medical Housing

Providers appropriately completed OHU admission H&P examinations thoroughly and timely. They also evaluated patients at clinically appropriate intervals and made appropriate assessments, sound decisions, and regular follow-up appointments. We found four minor deficiencies related to incomplete examinations.[56]

Specialty Services

Providers appropriately referred patients for specialty consultations when needed. When specialists made recommendations, providers followed recommendations appropriately and communicated with the specialists as needed. We found no deficiencies related to the untimely review of specialty reports.

We discuss providers' specialty performance further in the **Specialty Services** indicator.

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[52] The deficiency occurred in case 8, which was not significant.

[53] A deficiency in emergency care documentation occurred in case 1. A deficiency about not ordering appropriate follow-up occurred in case 13. A deficiency about not performing an adequate physical examination occurred in case 13.

[54] Deficiencies occurred in cases 1, 4, 6. A significant deficiency occurred in case 6.

[55] Metformin and glipizide are diabetic medications used to treat diabetes and reduce blood sugar.

[56] The deficiencies occurred in case 21.

Documentation Quality

Documentation is important because it shows the provider's thought process during clinical decision-making. When contacted by nurses, providers frequently documented the interactions. Our clinicians found only three undocumented interactions.[57] In these three undocumented interactions, nurses co-consulted with providers.

Patient Notification Letters

Providers needed improvement in relaying diagnostic test results to their patients as they did not send patient notification letters or sent incomplete patient notification letters. These deficiencies are discussed in the **Diagnostic Services** indicator.

Provider Continuity

Generally, the institution offered good provider continuity. Providers were assigned to specific clinics and to the OHU to ensure continuity of care.

Clinician On-Site Inspection

The OIG physician met with the CME, the CP&S, and providers. The CME and the CP&S reported no problems retaining providers and were in the process of hiring more providers. We asked the CME and the CP&S about providing care at the institution, and they identified three challenges. First, they described ASP as being located far from hospitals and specialists. Second, since ASP was a reception center, they explained the population was in flux, with patients being admitted to the institution and then soon paroling. Third, the CME and the CP&S identified the ISUDT program as a factor that contributed to increasing the overall work burden.[58]

All providers reported high morale and easy access to their CME and CP&S to be able to voice any concerns. Multiple providers shared the opinion that leadership emphasized the importance of family and work-life balance. ASP had instituted the four 10-hour days work week schedule, and providers covered for one another during regularly scheduled days off.

[57] Documentation deficiencies occurred in cases 1, 12, and 26, none of which were significant.

[58] ISUDT is the Integrated Substance Use Disorder Treatment program.

Recommendations

The OIG offers no recommendations for this indicator.

Specialized Medical Housing

In this indicator, OIG inspectors evaluated the quality of care in the specialized medical housing units. We evaluated the performance of the medical staff in assessing, monitoring, and intervening for medically complex patients requiring close medical supervision. Our inspectors also evaluated the timeliness and quality of provider and nursing intake assessments and care plans. We assessed staff members' performance in responding promptly when patients' conditions deteriorated and looked for good communication when staff consulted with one another while providing continuity of care. At the time of our inspection, ASP's specialized medical housing consisted of an outpatient housing unit (OHU).

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (41.1%)**

Case review findings showed ASP performed better in this cycle, compared with Cycle 6, for medical care of patients in specialized medical housing. Nursing performance improved as well. OHU nurses frequently completed thorough patient assessments, notified providers as required, and created good documentation. Providers performed well and delivered good patient care. When patients were admitted to the OHU, patients received medications without interruption. Factoring in all the information, OIG rated the case review component of this indicator ***adequate***.

In compliance testing, ASP performed poorly in this indicator. Although, staff timely completed H&P examinations, staff needed to improve in completing admission assessments and in administering medications to newly admitted patients. Due to a nonfunctional call light system, nursing staff needed to conduct and document 30-minute patient safety rounds; however, staff did not document entries timely in the safety rounding log for the call system. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 73 OHU events including 24 provider events and 25 nursing events. Due to the frequency of nursing and provider contacts in specialized medical housing, we bundled up to two weeks of patient care into a single event. We identified 11 deficiencies, one of which was significant.[59]

Provider Performance

One provider was assigned to the OHU. This provider delivered good care and generally performed thorough H&P examinations, evaluations, made sound medical plans, and

[59] OHU events occurred in cases 14, 15, 18, 19, 21, 44–46. Deficiencies occurred in cases 21, 44, and 45. A significant deficiency occurred in case 21.

reviewed test results and consultations timely. Case review identified four minor deficiencies related to performing an incomplete physical examination, none of which were significant.[60]

Nursing Performance

Case review found OHU nurses performed sufficiently. We reviewed 25 nursing events and identified three deficiencies related to nursing performance, none of which were significant. Two deficiencies related to missing components of an assessment, and one related to not obtaining a patient's weight upon admission.[61] OHU nurses frequently completed thorough patient assessments, notified the provider as required, and performed good documentation. OHU nurses conducted rounds on patients as required and ensured patient safety.

Case review found OHU nurses performed initial patient assessments timely. Compliance testing, however, revealed most initial assessments were not completed timely (MIT 13.001, 20.0%). They were completed the following day.

Medication Administration

Case review did not identify any deficiencies in administering medications for patients newly admitted to the OHU.[62] Upon admission, patients received their medications without a break in continuity. Compliance testing, however, found patients newly admitted to the OHU only occasionally received their medications timely (MIT 13.003, 44.4%). Examples of medications administered up to one day late included an antiviral medication and an antibiotic.

Case review identified four deficiencies related to medication management in the OHU, one of which was significant.[63] Please refer to the **Medication Management** indicator for further discussion.

Clinician On-Site Inspection

While on site, we toured the OHU and interviewed nursing staff and the SRN. The OHU had 28 beds and was staffed with an RN, a CNA, and an MA on the second watch. The first and third watches had an LVN. In addition, the third watch had a CNA assigned. The OHU had a designated provider. The average patient census in the OHU was 11 to 12. During our inspection, the OHU housed one patient. The provider and the RN made daily patient rounds in the OHU.

The CEO informed us a new nurse call system was to be installed in the OHU. The CEO expressed hope of a possible renovation to add a medication room in the OHU. At the time of our inspection, the OHU nurses conducted rounds on patients every 30 minutes.

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[60] Deficiencies occurred in case 21 four times, none of which were significant.

[61] Nursing performance deficiencies occurred in cases 21, 44, and 45.

[62] We reviewed patients newly admitted to the OHU in cases 15, 21, 45, and 46.

[63] OHU medication management deficiencies occurred in cases 21, 44, and 45. A significant deficiency occurred in case 21.

Nursing staff reported they had no issues with supplies, equipment, or pharmacy. Nurses and the OHU SRN reported a good rapport with custody staff and found their administrative staff to be supportive and approachable.

Compliance On-Site Inspection and Discussion

During the on-site inspection, the OHU did not have an operational call light communication system in place (MIT 13.101, N/A). Although the institution had a local operating procedure in an event the call light system was inoperable, staff in the OHU did not perform safety checks timely for all patients admitted into the OHU (MIT 13.102, zero).

Compliance Score Results

Table 16. 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)	2	8	0	20.0%
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	5	1	44.4%
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101)	0	0	1	N/A
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	1	0	0
				Overall percentage (MIT 13): **41.1%**

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

Recommendations

- Nursing and pharmacy leadership should determine the root cause of challenges to patients receiving all ordered medications within required time frames and should implement remedial measures as appropriate.

- Nursing leadership should also determine the challenges to staff completing timely initial RN assessments upon patient admission to specialized medical housing and should implement remedial measures as appropriate.

Specialty Services

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (70.7%)**

Case review found ASP performed very well in specialty services. Staff usually provided specialty services within required time frames. Providers also generally evaluated patients for follow-up appointments without delay, and specialty-return nursing care was usually appropriate. However, OIG clinicians identified deficiencies with nursing performance and health information management. Overall, the OIG rated the case review component of this indicator ***adequate***.

In this cycle, compliance testing showed ASP needed improvement in specialty services compared with Cycle 6. Access to specialists ranged from excellent to poor, depending on the appointment priority. Preapproved specialty referrals for newly arrived patients occasionally occurred within recommended time frames. In addition, both retrieval of specialty reports and timely provider endorsements needed significant improvements. Based on the overall compliance score results, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 72 events related to specialty services, which included 36 specialty consultations and procedures and 28 nursing encounters. OIG clinicians identified 10 deficiencies in this category, two of which were significant.[64]

Access to Specialty Services

ASP's performance in this area was mixed. Compliance testing showed the institution performed satisfactorily in completing most high-priority (MIT 14.001, 80.0%) specialty appointments within required time frames. However, completion of specialty appointments ordered as medium-priority was poor (MIT 14.004, 46.7%), and routine-priority appointment work needed improvement (MIT 14.007, 73.3%). In addition, compliance testing revealed transfer continuity of specialty services was also poor (MIT

[64] Deficiencies occurred in cases 8–10, 13, 19, 20, 44, and 46. Significant deficiencies occurred in cases 10 and 46.

14.010, 50.0%). Case review identified only one deficiency related to timely specialty appointment completion, which was not significant.[65]

Provider Performance

Compliance testing showed ASP completed timely provider follow-up appointments after specialty consultations (MIT 1.008, 79.1%). Case review found providers generally ordered appropriate specialty consultations and followed specialty recommendations. We identified no deficiencies related to provider follow-up after specialty services.

Nursing Performance

ASP nurses performed well in assessing patients who returned to the facility from specialty off-site appointments. We identified two deficiencies related to nursing assessment, neither of which was significant.[66] We identified one significant deficiency related to ordering a provider follow-up appointment:

- In case 10, the patient returned from an urgent off-site abdominal ultrasound appointment. The nurse did not order a five-day provider follow-up for the high-priority off-site appointment.

We discuss this further in the **Nursing Performance** indicator.

Health Information Management

Compliance testing revealed providers struggled with timely review of specialty reports for routine-priority (MIT 14.008, 42.9%), medium-priority (MIT 14.005, 46.7%), and high-priority (MIT 14.002, 66.7%) specialty services. Similarly, ASP staff only intermittently scanned specialty reports into the EHRS in a timely manner (MIT 4.002, 56.7%).

OIG clinicians identified five deficiencies of different types, such as not sending one patient a test result notification letter, not timely retrieving or scanning two specialty reports into the EHRS, not properly labeling one report, and not properly scanning one specialty report.[67] Only one of these deficiencies was significant.[68]

We discuss this further in the **Health Information Management** indicator.

Clinician On-Site Inspection

We discussed specialty processes with the supervising registered nurse (SRN) for specialty services. The SRN described the process for timely completing specialty appointments. Staff routinely reviewed the specialty services dashboard and discussed any issues each day. If staff were unable to secure a specific specialty appointment, such as telemedicine, they would then attempt to secure an off-site face-to-face specialty appointment. The SRN described challenges to obtaining telemedicine urology and

[65] A deficiency occurred in case 8 and was not significant.

[66] Two deficiencies occurred in case 44, neither of which was significant.

[67] Specialty health information management deficiencies occurred in cases 9, 19, 20, and 46.

[68] A significant deficiency occurred in case 46.

neurology as well as off-site ENT specialty services.[69] The SRN also identified ASP's remote location as a reason for off-site specialty access difficulties. When the specialty report did not return with the patient, the off-site nurse would then follow-up with the specialist within 24 to 48 hours. Afterward, if the nurse was still unable to obtain the report, the nurse would reach out to the HIM department for assistance.

The specialty services department was staffed with one on-site, one telemedicine, and one off-site nurse, each of whom cross-trained in one another's duties. When any of these nurses were not available, the appeals and utilization management nurses provided coverage.

[69] An ENT specialist is an Ear, Nose, and Throat specialist.

Compliance Score Results

Table 17. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	12	3	0	80.0%
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)	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	10	1	4	90.9%
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)	7	8	0	46.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	7	8	0	46.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	8	0	7	100%
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)	11	4	0	73.3%
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)	6	8	1	42.9%
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	1	8	85.7%
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)	5	5	0	50.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	15	5	0	75.0%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	18	2	0	90.0%
			Overall percentage (MIT 14): **70.7%**	

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

Table 18. Other Tests Related to Specialty Services

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	34	9	2	79.1%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	17	13	15	56.7%

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

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

Recommendations

- Medical leadership should determine the challenges to timely providing specialty appointments and should implement remedial measures as appropriate.

- Medical leadership should determine the challenges to ensuring specialty reports are received, scanned, and endorsed in a timely manner and should implement remedial measures as appropriate.

Administrative Operations

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

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (71.5%)**

ASP's performance was mixed in this indicator. While ASP scored well in some applicable tests, it needed improvement in several areas. The Emergency Medical Response Review Committee (EMRRC) intermittently completed the required checklists and reviewed the cases within required time frames. In addition, the institution conducted medical emergency response drills with incomplete documentation, missing required emergency response drill forms, and without participation of custody staff. Physician managers sporadically completed probationary and annual performance appraisals in a timely manner. Last, nursing managers did not ensure all newly hired nurses received the required onboarding. These findings are set forth in the table on the next page. Based on the overall compliance score results, the OIG rated the compliance component of this indicator ***inadequate***.

Compliance Testing Results

Nonscored Results

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

We obtained CCHCS mortality case review reporting data. In our inspection, for one patient, we found no evidence in the submitted documentation the preliminary mortality report had been completed. The report was overdue at the time of OIG's inspection (MIT 15.998).

Compliance Score Results

Table 19. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	This is a nonscored test. Please refer to the discussion in this indicator.			
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	3	9	0	25.0%
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)	N/A	N/A	N/A	N/A
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the patients' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial patient death reports to the CCHCS Mortality Case Review Unit on time? (15.103)	1	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	3	6	0	33.3%
Did the providers maintain valid state medical licenses? (15.106)	16	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)	5	0	2	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): **71.5%**

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

Recommendations

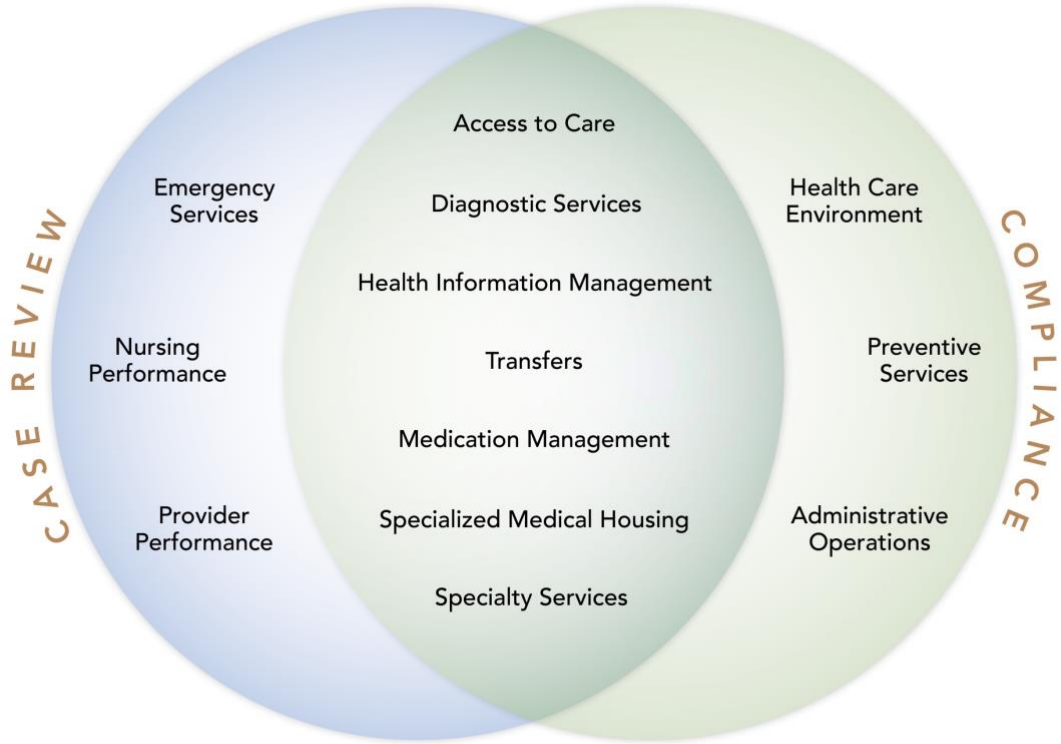
The OIG offers no recommendations for this indicator.

Appendix A: Methodology

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

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

Figure A–1. Inspection Indicator Review Distribution for ASP



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

Case Reviews

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

Table A–1. Case Review Definitions

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

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

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

Case Review Sampling Methodology

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

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

Case Review Testing Methodology

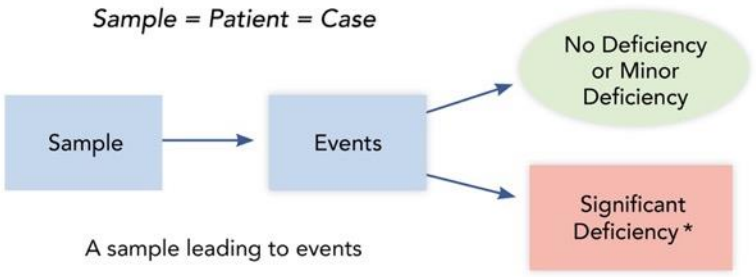
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

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

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

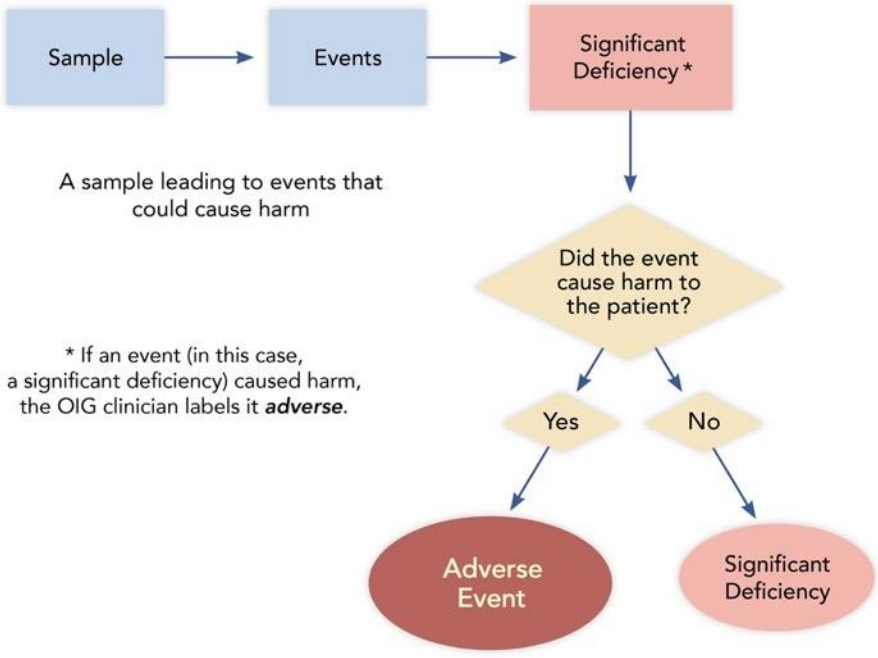
Figure A–2. Case Review Testing

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



Deficiencies

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



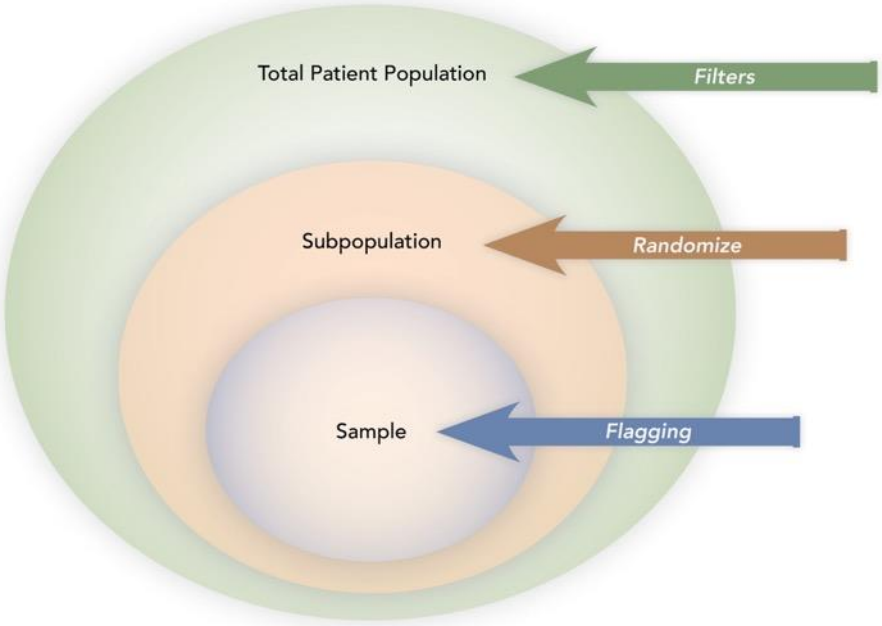
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

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

Figure A–3. Compliance Sampling Methodology



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

Compliance Testing Methodology

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

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

Scoring Methodology

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

Indicator Ratings and the Overall Medical Quality Rating

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

Appendix B: Case Review Data

Table B–1. ASP Case Review Sample Sets

Sample Set	Total
CTC/OHU	3
Death Review/Sentinel Events	1
Diabetes	3
Emergency Services – CPR	1
Emergency Services – Non-CPR	2
High Risk	4
Hospitalization	5
Intrasystem Transfers In	1
Intrasystem Transfers Out	3
RN Sick Call	18
Specialty Services	5
	46

Table B–2. ASP Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	1
Arthritis/Degenerative Joint Disease	3
Asthma	4
COPD	2
COVID-19	3
Cancer	1
Cardiovascular Disease	2
Chronic Kidney Disease	1
Coccidioidomycosis	1
Diabetes	5
Gastroesophageal Reflux Disease	6
Hepatitis C	7
Hyperlipidemia	16
Hypertension	11
Mental Health	21
Sleep Apnea	2
Substance Abuse	10
Thyroid Disease	1
	97

Table B–3. ASP Case Review Events by Program

Diagnosis	Total
Diagnostic Services	83
Emergency Care	29
Hospitalization	27
Intrasystem Transfers In	4
Intrasystem Transfers Out	7
Outpatient Care	306
Specialized Medical Housing	73
Specialty Services	81
	610

Table B–4. ASP Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	20
MD Reviews Focused	3
RN Reviews Detailed	12
RN Reviews Focused	27
Total Reviews	62
Total Unique Cases	46
Overlapping Reviews (MD & RN)	16

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Appendix C: Compliance Sampling Methodology

Avenal State Prison

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	5	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC, BMP, or CMPs only • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	0	Quest	• Appt. date (90 days–9 months) • Order name (CBC, BMP, or CMPs only • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology-related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	5	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested incarcerated person	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	5	CADDIS off-site admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	10	OIG inspector on-site review	• Identify and inspect all on-site clinical areas
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	3	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	• See Access to Care • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	5	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See Reception Center
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	2	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	9	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	N/A at this institution	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–007	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–003	Specialized Health Care Housing Unit	10	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	1	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care / addiction medication, narcotic treatment program, and transgender services • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Specialty Services (continued)				
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize
MIT 14.010	Specialty Services Arrivals	10	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	20	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	0	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	N/A at this institution	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	1	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations (continued)				
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	9	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	16	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff • Providers (ACLS) • Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	CCHCS Mortality Case Review	1	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services mortality reviews

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California Correctional Health Care Services' Response

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February 4, 2025

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

Dear Ms. Singh:

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

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

Sincerely,

DocuSigned by:
DeAnna Gouldy
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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
Jeff Macomber, Secretary, CDCR
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Robin Hart, Associate Director, Risk Management Branch, CCHCS
Regional Executives, Region III, CCHCS
Chief Executive Officer, ASP
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
Elk Grove, CA 95758

Cycle 7

Medical Inspection Report

for

Avenal State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

STATE *of* CALIFORNIA
February 2025

OIG