Amarik K. Singh, *Inspector General*

Neil Robertson, *Chief Deputy Inspector General*

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

July 2023

Cycle 6
Medical Inspection Report

Ironwood State Prison

Electronic copies of reports published by the Office of the Inspector General are available free in portable document format (PDF) on our website.

We also offer an online subscription service.
For information on how to subscribe,
visit **www.oig.ca.gov**.

For questions concerning the contents of this report,
please contact Shaun Spillane, Public Information Officer,
at 916-288-4233.

Contents

Illustrations

Tables

Figures

Photographs

Cover: Rod of Asclepius courtesy of Thomas Shafee

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 6, the OIG continues to apply the same assessment methodologies used in Cycle 5, including clinical case review and compliance testing. These methods provide an accurate assessment of how the institution's health care systems function regarding patients with the highest medical risk who tend to access services at the highest rate. This information helps to assess the performance of the institution in providing sustainable, adequate care.[3]

We continue to review institutional care using 15 indicators, as in prior cycles. Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the *medical inspection tool* (MIT).[4] We determine a total compliance score for each applicable indicator and consider the MIT scores in the overall conclusion of the institution's performance. In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff.

In reviewing the cases, our clinicians examine whether providers used sound medical judgment in the course of caring for a patient. In the event we find errors, we determine whether such errors were clinically significant or led to a significantly increased risk of harm to the patient.[5] At the same time, our clinicians examine whether the institution's medical system mitigated the error. The OIG rates the indicators as ***proficient***, ***adequate***, or ***inadequate***.

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

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

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

[4] The department regularly updates its policies. The OIG updates our policy-compliance testing to reflect the department's updates and changes.

[5] If we learn of a patient needing immediate care, we notify the institution's chief executive officer.

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

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

We completed our sixth inspection of ISP, and this report presents our assessment of the health care provided at this institution during the inspection period from January 2022 to June 2022.[6] The data obtained for ISP and the on-site inspections occurred during the COVID-19 pandemic.[7]

Ironwood State Prison (ISP) is located in Blythe, in eastern Riverside County. The institution houses minimum, medium, and close-custody incarcerated people. Patients are seen in the receiving and release area (R&R) on arrival at ISP. ISP has multiple medical clinics where staff handle requests for routine medical services. ISP treats patients needing urgent or emergent care in its triage and treatment area (TTA), and those requiring additional daily care or accommodations in its outpatient housing unit (OHU), and provides specialty services in a specialty clinic. ISP has been designated a *basic care prison*. Basic institutions are in rural areas, away from tertiary care centers and specialty care providers whose services would likely be used by higher-risk patients. Basic institutions can provide limited specialty medical services and consultation for a generally healthy patient population.

[6] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between July 2021 and February 2022, and transfer reviews between September 2021 and May 2022.

[7] As of May 23, 2023, the department reports on its public tracker that 72% of ISP's incarcerated population is fully vaccinated while 68% of ISP's staff is fully vaccinated: http://www.cdcr.ca.gov/covid19/population-status-tracking/.

Summary

We completed the Cycle 6 inspection of ISP in December 2022. OIG inspectors monitored the institution's delivery of medical care that occurred between January 2022 and June 2022.

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

Table 1. ISP Summary Table

Ratings: *Proficient* | *Adequate* | *Inadequate*

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

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

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

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

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 308 patient records and 991 data points, and used the data to answer 86 policy questions. In addition, we observed ISP processes during an on-site inspection in September 2022. Table 2 below lists ISP's average scores from Cycles 4, 5, and 6.

Table 2. ISP Policy Compliance Scores

Scoring Ranges

100%–85.0%	84.9%–75.0%	74.9%–0

Medical Inspection Tool (MIT)	Policy Compliance Category	Average Score		
		Cycle 4	Cycle 5	Cycle 6
1	Access to Care	78.0%	83.1%	83.8%
2	Diagnostic Services	85.6%	80.0%	73.3%
4	Health Information Management	64.6%	87.2%	96.4%
5	Health Care Environment	80.6%	82.8%	42.9%
6	Transfers	96.7%	75.0%	86.1%
7	Medication Management	70.9%	81.1%	38.9%
8	Prenatal and Postpartum Care	*N/A*	*N/A*	*N/A*
9	Preventive Services	76.7%	67.7%	78.3%
12	Reception Center	*N/A*	*N/A*	*N/A*
13	Specialized Medical Housing	82.5%	86.7%	55.6%
14	Specialty Services	87.2%	79.8%	72.3%
15	Administrative Operations	53.9%*	68.9%	65.7%

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

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

The OIG clinicians (a team of physicians and nurse consultants) reviewed 48 cases, which contained 867 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in December 2022 to verify their initial findings. The OIG physicians rated the quality of care for 20 comprehensive case reviews. Of these 20 cases, our physicians rated 19 ***adequate*** and one ***inadequate***. Our physicians found no adverse deficiencies during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 13 health care indicators.[8] Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our OIG clinicians acknowledged institutional structures that catch and resolve mistakes which may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable for this institution in the ISP Summary Table.

In August 2022, the Health Care Services Master Registry showed that ISP had a total population of 2,552. A breakdown of the medical risk level of the ISP population as determined by the department is set forth in Table 3 below.[9]

Table 3. ISP Master Registry Data as of August 2022

Medical Risk Level	Number of Patients	Percentage*
High 1	15	0.6%
High 2	60	2.4%
Medium	357	14.0%
Low	2,120	83.1%
Total	**2,552**	**100.0%**

* Percentages may not total 100% due to rounding.

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 8-12-22.

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

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

Based on staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, ISP had one vacant executive leadership position, no primary care provider vacancies, 0.7 nursing supervisor vacancies, and 12.2 nursing staff vacancies.

Table 4. ISP Health Care Staffing Resources as of July 2022

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	1.0	11.7	61.8	79.5
Filled by Civil Service	4.0	1.0	10.0	51.0	66.0
Vacant	1.0	0	0.7	12.2	13.9
Percentage Filled by Civil Service	80.0%	100%	85.5%	82.5%	83.0%
Filled by Telemedicine	0	3.0	0	0	3.0
Percentage Filled by Telemedicine	0	300.0	0	0	3.8
Filled by Registry	0	0	0	11.0	11.0
Percentage Filled by Registry	0	0	0	17.8%	13.8%
Total Filled Positions	4.0	4.0	10.0	62.0	80.0
Total Percentage Filled	**80.0%**	**400.0%**	**85.5%**	**100.3%**	**100.6%**
Appointments in Last 12 Months	1.0	0	1.0	13.0	15.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	0	0	2.0	2.0
Adjusted Total: Filled Positions	**4.0**	**4.0**	**10.0**	**60.0**	**78.0**
Adjusted Total: Percentage Filled	**80.0%**	**400.0%**	**85.5%**	**97.1%**	**98.1%**

* 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 6 medical inspection preinspection questionnaire received on August 12, 2022, from California Correctional Health Care Services.

Medical Inspection Results

Deficiencies Identified During Case Review

Deficiencies are medical errors that increase the risk of patient harm. Deficiencies can be minor or significant, depending on the severity of the deficiency. An *adverse event* occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[10] The OIG did not find any adverse events at ISP during the Cycle 6 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to ISP. Of these 10 indicators, OIG clinicians rated three ***proficient*** and seven ***adequate***. The OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 19 were ***adequate***, and one was ***inadequate***. In the 867 events reviewed, there were 112 deficiencies, 10 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at ISP:

- ISP performed well in ensuring that patients saw their providers timely for sick call follow-up appointments, after specialty services, after hospitalizations, and after urgent or emergent care.
- Nurses generally performed good assessments, interventions, and documentation.

Our clinicians found the following weaknesses at ISP:

- Patients did not always receive their new medications timely.
- When communicating test results with patients, the providers did not always include all the elements required in the patient results notification letters.

Compliance Testing Results

Our compliance inspectors assessed 10 of the 13 indicators applicable to ISP. Of these 10 indicators, our compliance inspectors rated two ***proficient***, two ***adequate*** and six ***inadequate***. We tested policy compliance in **Health Care Environment**,

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

Preventive Services, and **Administrative Operations** as these indicators do not have a case review component.

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

- Medical staff performed well in scanning requests for health care services forms, specialty services and community hospital discharge reports into patients' electronic medical records within required time frames.

- ISP performed well with the transfer system including appropriately completing assessment and disposition of the initial health screening forms and delivering patients' previously ordered medications without interruption. Furthermore, patients who transferred out of ISP had the required documents, medications, and durable medical equipment.

- Nursing staff processed sick call request forms and performed timely face-to face evaluations. ISP housing units contained adequate supplies of health care services request forms.

- The institution performed satisfactorily in offering immunizations and providing preventive services for patients, such as influenza vaccinations, annual testing for tuberculosis (TB), and colorectal cancer screenings.

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

- The institution's pharmacy staff performed poorly in handling refrigerated and nonrefrigerated medications. At the time of our inspection, they also did not follow security protocols in the main pharmacy, which would have included properly accounting for narcotic medications in medication areas, following medication error reporting protocols, and securing the pharmacy door.

- Health care staff did not follow hand hygiene precautions before or after patient encounters.

- Providers performed poorly in communicating diagnostic test results to patients. Most patient letters communicating these results were missing the date of diagnostic service, the date of the results, and whether the results were within normal limits.

- ISP did not perform well in ensuring that preapproved specialty services were provided timely for patients upon arrival. Furthermore, appointments for patients with high-priority and medium-priority specialty services were not provided within the required time frames.

Population-Based Metrics

In addition to our own compliance testing and case reviews, as noted above, the OIG presents selected measures from the Healthcare Effectiveness Data and Information Set (HEDIS) for comparison purposes. The HEDIS is a set of standardized quantitative performance measures designed by the National Committee for Quality Assurance to ensure that the public has the data it needs to compare the performance of health care plans. Because the Veterans Administration no longer publishes its individual HEDIS scores, we removed them from our comparison for Cycle 6. 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 for one diabetic measure to use in conducting our analysis, and we present that here for comparison.

HEDIS Results

We used population-based metrics in considering ISP's performance to assess the macroscopic view of the institution's health care delivery. We list the applicable HEDIS measures in Table 5.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—ISP performed better in the one diabetic measure that has statewide comparative data: poor HbA1c control.

Immunizations

Statewide comparative data were also not available for immunization measures; however, we include these data for informational purposes. ISP had a 60 percent influenza immunization rate for adults 18 to 64 years old and a 69 percent influenza immunization rate for adults 65 years of age and older.[11] The pneumococcal vaccine rate was 92 percent.[12]

Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. ISP had an 80 percent colorectal cancer screening rate.

---

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

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

Table 5. ISP Results Compared With State HEDIS Scores

HEDIS Measure	ISP Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	97%	–	–	–
Poor HbA1c Control (>9.0%)‡,§	**5%**	42%	34%	23%
HbA1c Control (<8.0%)‡	86%	–	–	–
Blood Pressure Control (<140/90)‡	93%	–	–	–
Eye Examinations	67%	–	–	–
Influenza–Adults (18–64)	60%	–	–	–
Influenza–Adults (65+)	69%	–	–	–
Pneumococcal–Adults (65+)	92%	–	–	–
Colorectal Cancer Screening	80%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in September 2022 by reviewing medical records from a sample of ISP'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, 2020–June 30, 2021 (published April 2022); **https://www.dhcs.ca.gov/dataandstats/reports/Documents/EQRTechRpt-Vol1.pdf**.

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

Diagnostic Services

- The department should consider developing an electronic solution to ensure that providers create patient letters at the time of endorsement and that the patient results letter automatically populates accurately with all required elements per CCHCS policy.

Health Care Environment

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.

- Executive leadership should consider performing random spot checks to ensure that medical supply storage areas, located outside the clinics, store medical supplies adequately.

- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) logs to ensure that the EMRBs are regularly inventoried and kept sealed.

Medication Management

- The institution should consider developing and implementing measures to ensure that staff make available and administer medications to patients in a timely manner and that staff document their activities in the medication administration record (MAR) as prescribed in CCHCS policy and procedures.

Specialty Services

- Medical leadership should determine the root cause(s) of challenges to the provision of timely specialty services with high-priority referrals and their subsequent high-priority specialty follow-up appointments, and should implement remedial measures as appropriate.

- Medical and nursing leadership should ensure that newly arrived patients receive their previously scheduled specialty appointments within the required time frame.

Access to Care

In this indicator, OIG inspectors evaluated the institution's performance in providing patients with timely clinical appointments. Our inspectors reviewed the 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.

Overall Rating
Adequate

Case Review Rating
Proficient

Compliance Score
***Adequate* (83.8%)**

Results Overview

ISP provided good access to care. OIG clinicians found that, in general, appointments were completed timely including appointments with clinic providers and nurses. Improvements were needed for chronic care follow-up appointments with providers and high-priority specialty appointments. After reviewing ISP's performance in both case review and compliance, we rated this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 192 provider, nursing, urgent or emergent care, specialty, and hospital events that required the institution to generate appointments. We identified five access-to-care deficiencies, one of which was significant.[13]

Access to Clinic Providers

Access to clinic providers is an integral part of patient care in health care delivery. ISP did not perform well in providing chronic care follow-up appointments with clinic providers. Compliance testing found chronic care face-to-face follow-up appointments only occurred timely about half the time (MIT 1.001, 52.0%); however, nurse-to-provider follow-up appointments occurred often (MIT 1.005, 80.0%), and sick call follow-up appointments occurred timely (MIT 1.006, 100%). Due to movement restrictions related to the COVID-19 pandemic, OIG clinicians considered most cases of provider chart reviews of nonurgent, low-risk, or medium-risk chronic care appointments to be an acceptable alternative to face-to-face or telephonic visits.

OIG clinicians reviewed 77 clinic provider encounters and identified one deficiency as follows:[14]

- In case 43, the sick call nurse evaluated a patient complaining of right-toe pain and bruising, co-consulted with the primary care

[13] Deficiencies occurred twice in case 12, and once in cases 2, 20, and 43. A significant deficiency occurred in case 12.

[14] A deficiency occurred in case 43.

provider (PCP), and scheduled a follow-up PCP appointment within one week. However, the patient saw his PCP one day late.

Access to Specialized Medical Housing Providers

ISP had a mixed performance in providing access to outpatient housing unit (OHU) providers. Compliance testing showed ISP did not perform well in completing written history and physical examinations of patients admitted to the OHU within the required time frame (MIT 13.002, 66.7%). Our clinicians did not identify any deficiencies regarding patients' access to OHU providers.

Access to Clinic Nurses

ISP performed well in providing access to nursing sick calls and provider-to-nurse referrals. Compliance testing found that all nursing sick call requests were reviewed on the same day they were received (MIT 1.003, 100%), and nurses often completed face-to-face visits within one day after the sick call requests were reviewed (MIT 1.004, 86.7%). Our clinicians assessed 41 nursing sick call triage nursing encounters and did not identify any deficiencies related to clinic nurse access.

Access to Specialty Services

ISP had a mixed performance in access to specialty services. Compliance testing found that initial high-priority and medium-priority specialty appointments did not always occur within the required time frame (MIT 14.001, 60.0% and MIT 14.004, 73.3%); however, initial routine-priority specialty appointments occurred timely (MIT 14.007, 100%). The institution also had variable results with follow-up specialty appointments. Compliance testing found subsequent high-priority and medium-priority follow-up specialty appointments did not always occur within the required time frame (MIT 14.003, 42.9% and MIT 14.006, 66.7%); however, subsequent routine-priority specialty service appointments often occurred within the required time frame (MIT 14.009, 87.5%). Our clinicians assessed 67 specialty service events and identified four deficiencies.[15] The following is an example:

- In case 12, the provider ordered a urology specialty appointment with routine priority. However, the urology appointment occurred 62 days late.

We discuss access to specialty services further in the **Specialty Services** indicator.

Follow-Up After Specialty Services

ISP performed well in ensuring patients saw their providers within the required time frame after specialty appointments. Compliance testing showed that 86.5

[15] Deficiencies occurred twice in case 12, and once in cases 2 and 20.

percent of provider appointments after specialty services occurred within the required time frame (MIT 1.008). OIG clinicians did not identify any missed or delayed appointments with their providers.

Follow-Up After Hospitalization

ISP performed well in ensuring that patients saw their providers within the required time frames after hospitalizations. Compliance testing found that 89.5 percent of provider appointments after hospitalization occurred within the required time frame (MIT 1.007). The OIG clinicians reviewed 12 hospital returns and did not identify any missed or delayed appointments.

Follow-Up After Urgent or Emergent Care (TTA)

Providers generally saw their patients following a triage and treatment area (TTA) event as requested. OIG clinicians assessed three TTA events and did not identify any delayed or missed provider follow-up appointments.

Follow-Up After Transferring Into the Institution

Access to care for patients who had recently transferred into the institution was mixed. Compliance testing showed poor access for intake appointments of newly arrived patients (MIT 1.002, 60.0%). OIG clinicians assessed five transfer-in cases and did not find any deficiencies in this area.

Clinician On-Site Inspection

ISP has five main clinics: A Yard, B Yard, C Yard, D Yard, and E Yard. Each clinic has one medical provider to care for the patients seen in it. Medical leadership reported that during the review period, the outpatient housing unit (OHU) had been closed for construction since March 29, 2022.

The OIG clinicians attended morning huddles and a provider meeting, which were well attended. Medical leadership reported that each clinic was scheduling 12 appointments per day for each provider with one slot held open for same-day appointments. The office technician reported there was a backlog of five patient appointments with providers at the time of our inspection. The technician expressed that there were challenges in obtaining off-site specialty appointments. Medical leadership reported that the institution had one provider vacancy and even with the additional pay differential being offered, it was challenging to recruit a provider due to the institution's remote location. Medical leadership stated that one provider from nearby Chuckawalla Valley State Prison was assigned to help with after-hours on-call service on a rotation basis with ISP providers and there were telemedicine providers for the clinics.

Compliance On-Site Inspection

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

Compliance Testing Results

Table 6. Access to Care

	Scored Answer			
Compliance Questions	**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) *	13	12	0	52.0%
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) *	15	10	0	60.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	30	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004) *	26	4	0	86.7%
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) *	4	1	25	80.0%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006) *	3	0	27	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	17	2	0	89.5%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	32	5	3	86.5%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	6	0	0	100%
				Overall percentage (MIT 1): **83.8%**

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

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

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

Table 7. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003) *	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	N/A	N/A	N/A	N/A
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	2	1	0	66.7%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	N/A	N/A	3	N/A
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	6	4	0	60.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	3	4	3	42.9%
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) *	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	4	2	9	66.7%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	15	0	0	100%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	7	1	7	87.5%

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

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

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

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

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Inadequate **(73.3%)**

Results Overview

ISP had a mixed performance in diagnostic services. Staff completed laboratory and radiology testing within appropriate time frames. Staff retrieved and providers endorsed these results timely. However, the area of communicating test results could benefit from improvement. After factoring in both case review and compliance performances, we rated this indicator ***adequate.***

Case Review and Compliance Testing Results

We reviewed 307 diagnostic events and found 62 deficiencies, none of which were significant.[16] Of these 62 deficiencies, we found 61 related to health information management and one related to the patient care environment.[17]

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

ISP's performance was excellent in completing radiology services and laboratory services within required time frames (MIT 2.001, 100% and MIT 2.004, 80.0%). OIG clinicians reviewed seven radiology tests and 276 laboratory tests, and did not find any deficiencies in test completion. There were no STAT laboratory tests in the case review samples.

Health Information Management

ISP staff retrieved laboratory and diagnostic results promptly and sent them to providers for review. Compliance testing showed that providers always endorsed both radiology and laboratory results timely (MIT 2.002, 100% and MIT 2.005, 100%).

---

[16] Deficiencies occurred nine times in case 12, seven times in case 15, five times in cases 2, 6, and 21, four times in cases 9, 11, and 20, thrice 14 and 18, twice in cases 5, 7, 8, and 13, and once in cases 1, 10, 16, 17, and 19.

[17] A deficiency related to the patient care environment occurred in case 10.

OIG clinicians identified 61 deficiencies, and 60 of these 61 deficiencies were related to patient test results notification letters. Of these 60 deficiencies, 54 deficiencies were due to missing elements in the letters.[18] We identified one deficiency with a late provider endorsement of test results.[19] The following are examples:

- In case 15, the provider reviewed and endorsed laboratory test results three days late.
- In case 20, the provider reviewed on-site computed tomography (CT) chest results and created a patient notification letter.[20] However, the letter did not indicate whether the results were within normal limits.

Patient Care Environment

We identified one deficiency in which the date on the patient's electrocardiogram (EKG) did not match the date documented in the nurse's note.[21]

Clinician On-Site Inspection

OIG clinicians met with laboratory and radiology staff. ISP provides on-site mobile CT, magnetic resonance imaging (MRI), and ultrasound imaging services as well as general on-site X-ray services.[22] The senior radiologic technologist reported that ISP was understaffed with a vacant technologist staff position, and the senior radiologic technologist had to cover both ISP and the nearby institution, Chuckawalla Valley State Prison. The senior laboratory technician stated that ISP provides clinical laboratory services that are supported by a regional clinical laboratory specialist through daily email communications and telephonic support. An external laboratory vendor provides laboratory and pathology diagnostic services for the institution. Once the laboratory sample is collected by laboratory staff, the vendor processes the specimen and transmits laboratory results directly to the patient's electronic health record for the patient care teams to review. The laboratory technician mentioned that any critical laboratory results are communicated through TTA staff directly by vendor via phone and fax.

[18] Deficiencies occurred nine times in case 12, six times in case 15, five times in cases 2 and 6, four times in cases 9, 11 and 21, thrice in cases 14 and 20, twice in cases 5, 7, 8, and 13, and once in cases 16, 17, and 18.

[19] Deficiencies occurred in case 15.

[20] A CT is a type of imaging scan.

[21] This deficiency occurred in case 10.

[22] An MRI is a type of imaging scan.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	10	0	0	100%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	5	5	0	50.0%
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) *	10	0	0	100%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	2	8	0	20.0%
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) *	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	9	1	0	90.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	2	8	0	20.0%
				Overall percentage (MIT 2): **73.3%**

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

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

Recommendations

- The department should consider developing an electronic solution to ensure that providers create patient letters at the time of endorsement and that the patient results letter automatically populates accurately with all required elements per CCHCS policy.

Emergency Services

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

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

Results Overview

ISP performed satisfactorily in providing emergency services. Staff responded promptly to emergent events, and providers delivered good care. In general, nurses performed good assessments and provided appropriate documentation for patients. However, the emergency medical response review committee (EMRRC) did not review cases timely, and the EMRRC checklists were not completed thoroughly. Overall, the OIG rated this indicator ***adequate.***

Case Review Results

We reviewed 15 urgent and emergent events and found two deficiencies, both of which were significant.[23]

Emergency Medical Response

ISP custody and health care staff responded promptly to emergencies throughout the institution. They initiated cardiopulmonary resuscitation (CPR), activated emergency medical services, and notified TTA staff timely.

Provider Performance

Providers made appropriate decisions for patients who arrived at the TTA for emergency treatment. On-call providers were available for consultations and documented their telephone calls with nurses.

Nursing Performance

Nurses generally provided good nursing assessments and interventions. However, the following case showed room for improvement.

- In case 1, the patient was found unresponsive in his housing unit, and CPR was initiated by custody staff. The nurse arrived on the

[23] Significant deficiencies occurred twice in case 1.

scene and did not apply the automated external defibrillator (AED) until the patient was at the TTA. The nurse should have applied the AED at the scene to determine if the patient had a shockable heart rhythm.

Nursing Documentation

Nurses documented well as it related to their findings, timelines, and sequence of events.

Emergency Medical Response Review Committee

Our clinicians found that the EMRRC met monthly to review emergency response cases. However, there was one significant deficiency identified. The supervising registered nurse (RN) did not identify that the nurse delayed applying the AED to a patient with a CPR in progress in case 1.

Compliance testing found the initial reviews were not completed timely and the EMRRC checklists were incomplete (MIT 15.003, 8.3%). This is discussed further in the **Administrative Operations** indicator.

Clinician On-Site Inspection

The institution's TTA had two medical beds to provide emergency care. The nurses reported there were two nurses staffed on each shift. There was an assigned TTA provider during regular business hours; otherwise, providers were assigned on-call and were available by telephone. Nurses also reported having a good rapport with custody staff.

OIG clinicians met with nursing leadership to discuss the case review findings. Nursing leadership reported that all nursing staff had completed the new emergency response training program from April 2022 to June 2022. While the OIG clinicians were on-site, ISP medical, nursing, and custody staff were participating in a large-scale incident drill as a part of the final training under the Emergency Medical Response Program.

Recommendations

- The OIG offers no recommendations for this indicator.

Health Information Management

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

Overall Rating
Proficient

Case Review Rating
Adequate

Compliance Score
Proficient **(96.4%)**

Results Overview

ISP staff's performance was excellent in health information management. Staff performed well in retrieving and scanning hospital discharge records, diagnostic tests, and pathology reports. We identified a pattern in which providers did not always communicate test results with patient notification letters containing all required elements; however, this did not significantly affect patients' care. After reviewing all performance aspects, the OIG rated this indicator ***proficient.***

Case Review and Compliance Results

Hospital Discharge Reports

Staff performed well in timely retrieving and scanning hospital discharge documents into patients' electronic health records (MIT 4.003, 94.7%). Most of the hospital discharge reports contained physician discharge summaries, and providers reviewed these reports timely (MIT 4.005, 94.7%). The OIG clinicians reviewed 12 off-site emergency department and hospital visits, and did not identify any deficiencies.

Specialty Reports

For the most part, ISP performed well in retrieving and reviewing specialty reports. Compliance testing showed that the vast majority of specialty reports were scanned into the electronic health record system within required time frames (MIT 4.002, 96.7%). On the other hand, staff did not perform well in retrieving and reviewing high-priority specialty service consultant reports timely (MIT 14.002, 70.0%). They performed better in retrieving and reviewing medium-priority and routine specialty service consult reports timely (MIT 14.005, 80.0% and MIT 14.008, 80.0%). Our clinicians reviewed 46 specialty reports and identified three deficiencies, one of which was significant.[24] The following is an example:

[24] Deficiencies occurred in cases 8, 13, and 20. A significant deficiency occurred in case 13.

- In case 13, the patient had an off-site bone density scan. The provider notified and discussed the results with the patient 20 days after the results were available. At the on-site inspection, the institution agreed with this deficiency.

We discuss specialty reports further in the **Specialty Services** Indicator.

Diagnostic Reports

ISP performed well in retrieving and endorsing diagnostic reports timely. Compliance testing showed providers always endorsed radiology and laboratory reports within required time frames (MIT 2.002, 100% and MIT 2.005, 100%). Staff always received the final pathology study within the required time frame (MIT 2.010, 100%). Providers often reviewed and endorsed pathology reports within required time frames (MIT 2.011, 90.0%), but infrequently communicated results of the pathology study to patients (MIT 2.012, 20.0%). Our clinicians identified 61 deficiencies, none of which were significant.[25] Most deficiencies (55 out of 61 deficiencies) were related to incomplete patient test results notification letters. The following is an example:

- In case 6, the provider endorsed the laboratory test results and sent a patient notification letter. However, the letter did not include whether the results were within normal limits.

Compliance testing and clinical review did not have any STAT laboratory tests in the testing or review samples.

The **Diagnostic Services** indicator provides more details on ISP's diagnostic services performance.

Urgent and Emergent Records

OIG clinicians reviewed 15 emergency care events and found that providers and nurses recorded these events well. The providers also recorded their emergency care sufficiently, including off-site telephone encounters. OIG clinicians did not find any deficiencies in nursing or provider documentation. The **Emergency Services** indicator provides additional details.

Scanning Performance

ISP staff performed well with the scanning process. Compliance testing found that staff properly scanned and labeled medical files (MIT 4.004, 95.8%). OIG clinicians identified two deficiencies related to mislabeled medical documents.[26] The following is an example:

---

[25] Deficiencies occurred nine times in case 12, six times in case 15, five times in cases 2, 6, 20, and 21, four times in cases 9 and 11, three times in cases 14 and 18, twice in cases 5, 7, 8, and 13, and once in cases 1, 16, 17, and 19.

[26] Deficiencies occurred in cases 5 and 20.

- In case 20, the radiologist's report was scanned into the electronic health record system and mislabeled as "7362-Non Symptomatic."

Clinician On-Site Inspection

Our clinicians discussed health information management processes with the ISP medical leadership, medical records supervisor, office technicians, and providers. We discussed with medical leadership the required elements in the patient notification letter when providers communicate diagnostic results with patients and how to explore various options for producing these letters, such as utilizing electronic letter templates. The medical records supervisor reported that there was one vacancy, but that the institution had not been able to hire a suitable applicant.

Compliance Testing Results

Table 9. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	10	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	29	1	10	96.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	18	1	0	94.7%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	23	1	0	95.8%
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) *	18	1	0	94.7%
Overall percentage (MIT 4): **96.4%**				

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

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

Table 10. Other Tests Related to Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	10	0	0	100%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008) *	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	9	1	0	90.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	2	8	0	20.0%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	7	3	0	70.0%
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) *	12	3	0	80.0%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	12	3	0	80.0%

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

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

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, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(42.9%)

Results Overview

Compliance Testing Results

In this cycle, multiple aspects of ISP's health care environment needed improvement: medical supply storage areas in the clinics contained expired medical supplies; medical supplies stored in the warehouse were not kept in a monitored and recorded temperature-controlled location; emergency medical response bags' (EMRB) inventory logs were not performed, and staff did not verify that the bags' compartments were sealed and intact; several clinics did not meet the requirements for stocking essential core medical equipment and supplies; and staff did not regularly sanitize their hands before and after patient encounters. These factors resulted in an ***inadequate*** rating for this indicator.

Outdoor Waiting Areas

The institution had no waiting areas that require patients to be outdoors.

Indoor Waiting Areas

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

Photo 1. Indoor waiting area (photographed on 9-12-22).

Clinic Environment

All clinic environments were sufficiently conducive to medical care; they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 100%).

Of the nine clinics we observed, five contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 55.6%).

Photo 2. Individual module in the TTA (photographed on 9-14-22).

The remaining four clinics had one or more of the following deficiencies: an examination room lacked visual privacy for conducting clinical examinations (see Photo 3, left), physical therapy exercise foam was torn and damaged, an examination room had unlabeled supplies, and clinics had unsecured confidential medical records (see Photos 4 and 5, next page).

Photo 3. An examination room did not provide visual privacy during patient examinations (photographed on 9-14-22).

Photo 4. Staff threw confidential medical records into the regular trash bin rather than shredding them (photographed on 9-13-22).

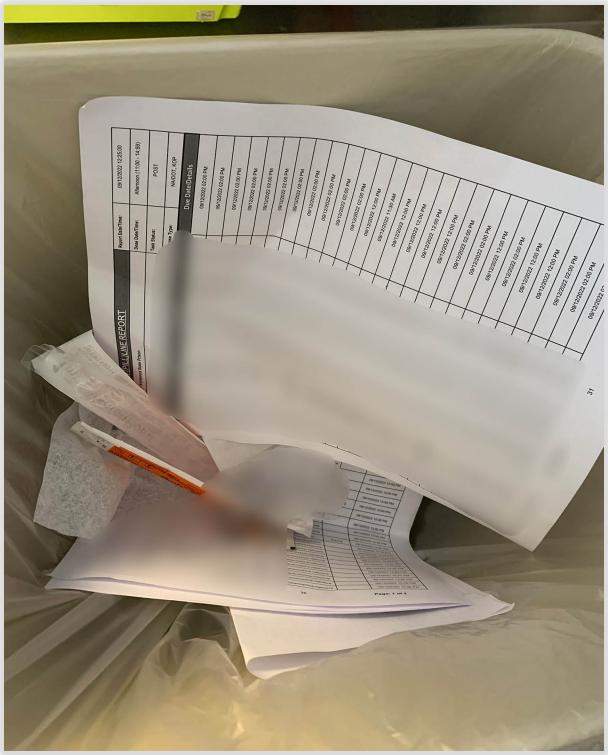


Photo 5. Staff threw confidential medical records into the regular trash bin rather than shredding them (photographed on 9-12-22).

Clinic Supplies

None of the nine clinics followed adequate medical supply storage and management protocols (MIT 5.107, zero). We found one or more of the following deficiencies in all nine clinics: expired medical supplies (see Photo 6), unidentified medical supplies, compromised medical supply packaging, disorganized medical supply cabinet or drawer, and staff members' personal items and food stored with medical supplies (see Photo 7).

Photo 6. Expired medical supply dated February 28, 2022 (photographed on 9-14-22).

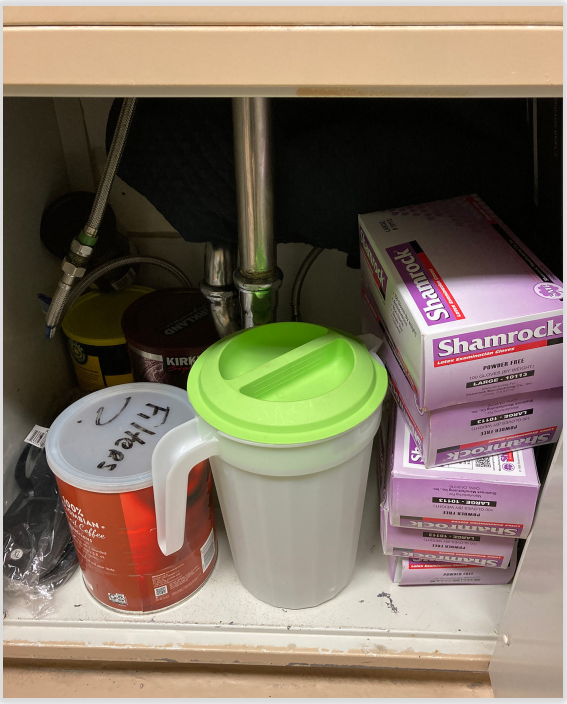


Photo 7. Staff members' personal food items were stored with medical supplies (photographed on 9-14-22).

None of the nine clinics met requirements for essential core medical equipment and supplies (MIT 5.108, zero). All nine clinics lacked medical supplies or had nonfunctional equipment. The missing items included disposable paper for an examination table and lubricating jelly. The Snellen eye chart was not mounted on the wall (see Photo 8), and several otoscopes and one thermometer that were nonfunctional. ISP staff either did not perform daily performance checks of the AED or did not complete defibrillator performance test log documentation within the last 30 days. In addition, several clinic daily glucometer quality control logs were either inaccurate or incomplete.

We examined emergency medical response bags (EMRBs) to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. None of the seven EMRBs passed our test (MIT 5.111, zero). We found one or more of the following deficiencies: staff failed to ensure the EMRBs' compartments were sealed and intact; staff did not inventory the EMRBs when the seal tags were replaced; and staff failed to log EMRB daily glucometer quality control results.

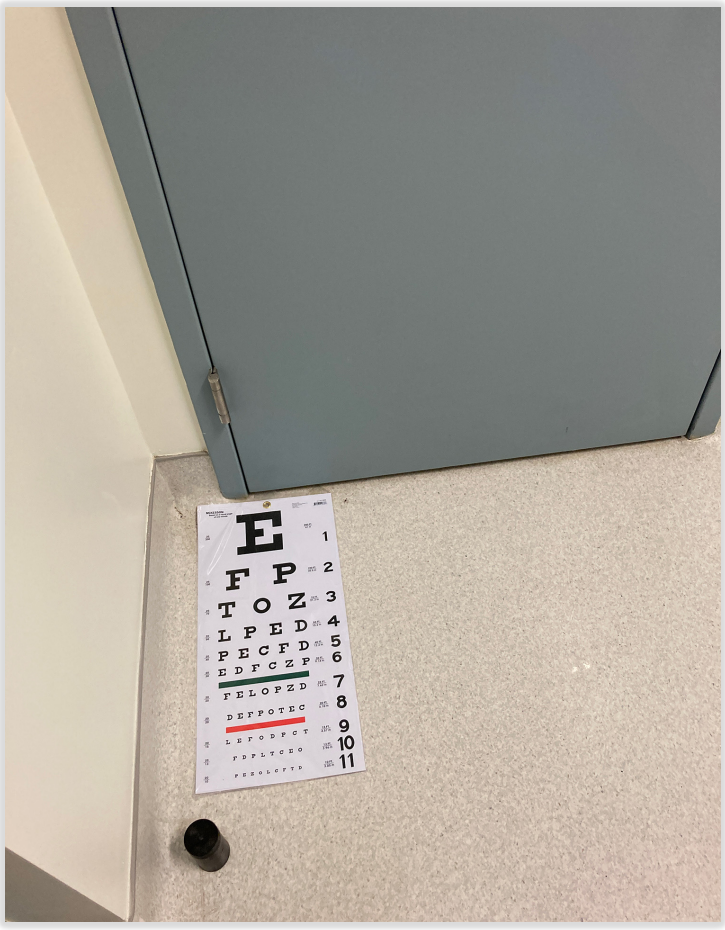


Photo 8. Snellen eye chart was not mounted on the wall at the time of inspection (photographed on 9-13-22).

Photo 9. Compromised medical supply packaging (photographed on 9-14-22).

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). We found compromised medical supply packaging (see Photo 9, left). In addition, the warehouse manager did not maintain a temperature log for medical supplies stored in the medical warehouse that provided manufacturers' temperature guidelines. As a result, several solutions had accumulated condensation (see Photo 10, below).

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

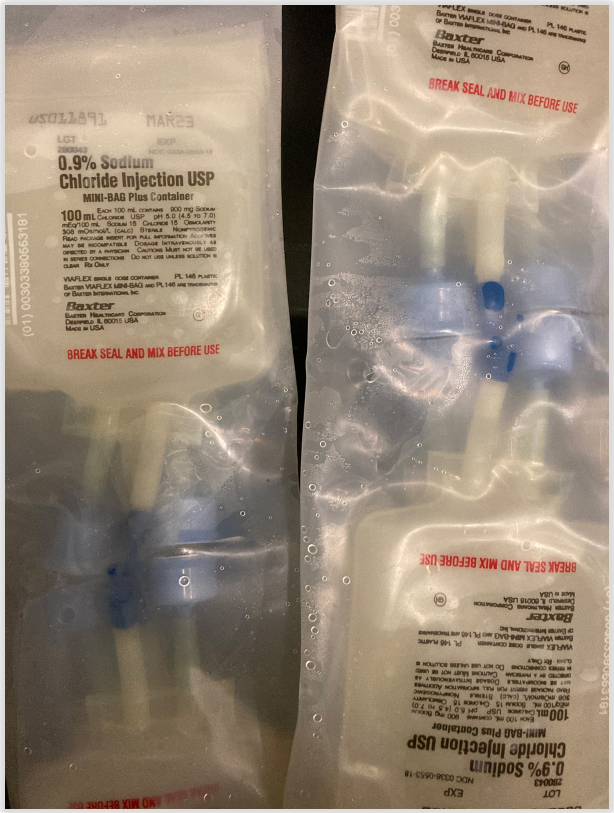


Photo 10. Several solutions stored in the medical warehouse had accumulated condensation (photographed on 9-14-22).

Infection Control and Sanitation

Staff appropriately cleaned, disinfected, and sanitized four of nine clinics (MIT 5.101, 44.4%). In five clinics, we found one or more of the following deficiencies: cleaning logs were not maintained, biohazardous waste was not emptied after each clinic day, a cabinet under the clinic sink was unsanitary, and a clinic floor was damaged and unsanitary.

Staff in seven of nine clinics (MIT 5.102, 77.8%) properly sterilized or disinfected medical equipment. In one clinic, examination table disposable paper was not removed and replaced in between patient encounters. In another clinic, we observed the clinician use the examination table without placing disposable paper on it during a patient encounter. In addition, the clinician did not disinfect the examination table before or after the patient encounter.

We found operating sinks and hand hygiene supplies in the examination rooms in eight of nine clinics (MIT 5.103, 88.9%). In one clinic, we found a nonfunctional sink in the patient restroom.

We observed patient encounters in six clinics. In five clinics, staff did not wash their hands before or after examining their patients, before applying gloves, or before performing blood draws (MIT 5.104, 16.7%).

Health care staff in eight of nine clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 88.9%). In one clinic, we found the sharps container was overly full.

Physical Infrastructure

ISP's health care management and plant operations manager reported an issue regarding the new environmental cooling system due to the incompatibility with the old buildings' air conditioning connection systems. The institution addressed the issues by minimizing the quantity of medications stored in the clinics and used portable air conditioners in the clinics. The project had begun in June 2018, and the institution had estimated the project would have been completed by December 2022. According to health care management, however, this issue did not hinder the provision of health care services (MIT 5.999).

Compliance Testing Results

Table 11. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	4	5	0	44.4%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	7	2	0	77.8%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	8	1	0	88.9%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	1	5	3	16.7%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	8	1	0	88.9%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	0	9	0	0
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	0	9	0	0
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	9	0	0	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	5	4	0	55.6%
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)	0	7	2	0
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): **42.9%**			

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

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

Recommendations

- Medical and nursing leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.

- Executive leadership should consider performing random spot checks to ensure that medical supply storage areas, located outside the clinics, store medical supplies adequately.

- Nursing leadership should direct each clinic nurse supervisor to review the monthly EMRB logs to ensure that EMRBs are regularly inventoried and kept sealed.

Transfers

In this indicator, OIG inspectors examined the transfer process for those patients who transferred into the institution as well as for those who transferred to other institutions. For newly arrived patients, our inspectors assessed the quality of health 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 administered 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 the receiving institution. For patients who returned from off-site hospitals or emergency rooms, inspectors reviewed whether staff appropriately implemented the recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

Overall Rating
Proficient

Case Review Rating
Proficient

Compliance Score
Proficient
(86.1%)

Results Overview

Compared with Cycle 5, ISP's transfer process showed improvement. Nurses performed good assessments and appropriately referred patients to the providers. Follow-up appointments occurred timely. Staff scanned and reviewed patient discharge documents within required time frames. Furthermore, nurses ensured that all required contents were inside the transfer packets. Staff provided excellent medication continuity for patients transferring into and out of the institution. However, hospital medication continuity showed room for improvement. Overall, the OIG rated this indicator ***proficient***.

Case Review and Compliance Testing Results

We reviewed 30 events in 16 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified one deficiency.[27]

Transfers In

Our clinicians found receiving nurses evaluated patients appropriately and requested provider appointments within required time frames in all cases reviewed. However, compliance testing found nurses did not complete the initial health screening forms thoroughly (MIT 6.001, 56.0%). Analysis of the compliance data revealed nursing staff did not always follow-up with additional questions when patients responded "Yes" to some of the screening questions.

[27] A deficiency occurred in case 2.

Compliance testing found only 60.0 percent of transfer-in patients received access to primary care providers within required time frames (MIT 1.002). In contrast, our clinicians found all patients were seen timely.

Compliance testing found good medication continuity for newly arrived patients (MIT 6.003, 88.2%). Our clinicians found all patients received their medications timely.

In general, when patients transferred into ISP with preapproved specialty appointments, compliance testing found appointments did not occur timely (MIT 14.010, 62.5%). Please refer to the **Specialty Services** indicator for more information.

Transfers Out

ISP's transfer-out process was excellent. Our clinicians found nurses performed face-to-face evaluations, completed the interfacility transfer information appropriately, and administered medications to patients prior to their transfers. Compliance on-site testing found transfer packets were complete (MIT 6.101, 100%).

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at a high risk for lapses in care quality. 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 transfer is necessary for good quality care. Any transfer lapse can result in serious consequences for these patients.

Compliance testing found patient discharge documents were scanned within required time frames (MIT 4.003, 94.7%), and providers reviewed the documents timely (MIT 4.005, 94.7%). Our clinicians found all discharge documents were scanned and reviewed timely. In addition, nurses performed good nursing assessments and provided accurate documentation.

Compliance testing found ISP provided timely follow-up appointments when patients returned from the hospital and emergency room (MIT 1.007, 89.5%). Our clinicians found all follow-up appointments occurred timely.

Compliance testing found ISP did not ensure medication continuity for its patients (MIT 7.003, 44.4%). Our clinicians found one medication deficiency:

- In case 2, the patient returned from the hospital with recommendations to continue taking antibiotics and a urine retention medication. The provider ordered the medications to start two days later, thus creating a lapse in medication continuity.

Clinician On-Site Inspection

During the on-site visit, the OIG clinicians toured the R&R area and met with nursing staff. The R&R nurse was knowledgeable about the transfer process. The R&R was staffed with one registered nurse on each shift and the nurses were responsible for both transfer-in and transfer-out processes. The R&R nurse reported the number of patients transferring into and out of ISP varied widely. The total anticipated patient counts for December 2022 were 42 patients arriving into ISP, and 32 patients transferring out of ISP. The nurse also reported having a good rapport with the supervising RN and custody staff.

Compliance Testing Results

Table 12. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	14	11	0	56.0%
For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	25	0	0	100%
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	15	2	8	88.2%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	4	0	0	100%
Overall percentage (MIT 6): **86.1%**				

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

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

Table 13. Other Tests Related to Transfers

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	15	10	0	60.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007) *	17	2	0	89.5%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	18	1	0	94.7%
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) *	18	1	0	94.7%
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) *	8	10	1	44.4%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	24	1	0	96.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	7	3	0	70.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	5	3	0	62.5%

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

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

Recommendations

The OIG offers no recommendations for this indicator.

Medication Management

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

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
Inadequate **(38.9%)**

Results Overview

ISP had a mixed performance in this indicator. ISP generally performed well for patients transferring into and out of the institution. However, in compliance testing, ISP had room for improvement in managing continuity of chronic medications, medications for patients laying over, and medications for patients who returned from the hospital. After considering all factors, we rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 120 events related to medications and found 12 medication deficiencies.

New Medication Prescriptions

Compliance testing found newly prescribed medications were available and administered within the required time frames (MIT 7.002, 84.0%). However, our clinicians found a pattern of deficiencies for newly ordered medications. The following are examples:

- In case 7, the patient received his diabetic medication four days late.
- In case 14, the patient did not receive his full doses of antibiotics for three days.

Chronic Medication Continuity

Compliance testing found patients did not always receive their chronic care medications within required time frames (MIT 7.001, 12.5%). Analysis of the compliance data found that most of the deficiencies occurred because the institution did not make the medications available one day prior to prescriptions' expiring. In contrast, our clinicians found most patients received their chronic care medications timely. However, the following cases showed room for improvement:

- In case 11, the patient received his asthma medication five days late.
- In case 14, the patient received his cholesterol medication 10 days late.

Hospital Discharge Medications

Compliance testing showed patients returning from off-site hospitals or emergency rooms did not always receive their medications within required time frames (MIT 7.003, 44.4%). Further analysis found most of these medications were antibiotics and blood pressure medications. In contrast, our clinicians found that all patients received their medications timely except for case 2. This case is further discussed in the **Transfers** indicator.

Specialized Medical Housing Medications

Compliance testing found patients did not always receive their medications within required time frames (MIT 13.004, 33.3%). In contrast, our clinicians found all patients received their medications timely. This is further discussed in the **Specialized Medical Housing** indicator.

Transfer Medications

Compliance testing showed patients often received their medications within required time frames (MIT 6.003, 88.2%). Patients transferring from one housing unit to another also frequently received their medications timely (MIT 7.005, 96.0%). However, patients laying over received their medication within required time frames 70.0 percent of the time (MIT 7.006). Our clinicians found that all patients transferring into and out of ISP received their medications timely.

Medication Administration

Compliance testing found nurses administered TB medications as prescribed (MIT 9.001, 100%). Our clinicians found all nurses administered medications properly.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians conducted interviews with medication nurses. We found the nurses were knowledgeable about the medication processes. The nurses attended clinic huddles and notified the providers of expiring medications and other medication-related issues. OIG clinicians also met with the pharmacist and nursing leadership to discuss case review findings. While the OIG clinicians were visiting on-site, ISP conducted the Emergency Medical Response Program large-scale incident drill. During this time, medication nurses administered medications at the housing units.

Compliance Testing Results

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 securely stored as required by CCHCS policy.

ISP appropriately stored and secured nonnarcotic medications in three of eight clinic and medication line locations (MIT 7.102, 37.5%). In five locations, we observed one or more of the following deficiencies: the medication storage cabinet was disorganized; the medication storage cabinet was unclean; the medication area lacked a clearly labeled designated area for medications that were to be returned to the pharmacy; and daily security check treatment cart log entries were incomplete.

Staff did not keep medications protected from physical, chemical, and temperature contamination in all seven clinic and medication line locations (MIT 7.103, zero). In seven locations, we found one or more of the following deficiencies: staff did not consistently record room and refrigerator temperatures; staff did not store oral and topical medications separately from one another; the medication refrigerator was unsanitary; and staff did not separate medications from disinfectants.

Staff appropriately stored valid, unexpired medications in six of the seven applicable medication line locations (MIT 7.104, 85.7%). In one location, nurses did not label a multiple-use medication as required by CCHCS policy.

Nurses exercised proper hand hygiene and contamination control protocols in two of seven locations (MIT 7.105, 28.6%). In five locations, some nurses neglected to wash or sanitize their hands before preparing medications, before administering medications, or before each subsequent regloving.

In six of seven medication preparation and administration areas, staff demonstrated appropriate administrative controls and protocols (MIT 7.106, 85.7%). In one location, nurses did not maintain unissued medication in its original labeled packaging.

Staff in two of seven medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 28.6%). In five locations, we observed one or more of the following deficiencies: medication nurses did not distribute medications to patients within time frames of one hour before or one hour after the normal distribution time; medication nurses did not reliably observe patients while they swallowed direct observation therapy medications; medication nurses did not consistently use a second form of identification before administering medications; medication nurses could not describe the medication error reporting process; and medication nurses did not follow proper administration of Suboxone medication as required by CCHCS policy.

Pharmacy Protocols

ISP did not follow general security, organization, and cleanliness management protocols in its main and remote pharmacies (MIT 7.108, zero). More specifically, the pharmacy doors were not kept locked to prevent unauthorized entry at the time of inspection.

In its main pharmacy, staff did not properly store nonrefrigerated medication. We found an unlabeled medication and a disorganized medication storage shelf at the time of inspection. As a result, ISP received a score of zero in this test (MIT 7.109).

The institution did not properly store refrigerated or frozen medications in the pharmacy. Pharmacy temperature logs were not maintained. As a result, the institution scored zero in this test (MIT 7.110).

The pharmacist-in-charge (PIC) did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the pharmacist present at the time of the medication-area inspection did not correctly complete a medication-area inspection checklist (CDCR Form 7477). In addition, in one location's CDCR Form 7477, there was no evidence that the PIC or pharmacy staff investigated the reported discrepancy of an unaccounted controlled substance in the Omnicell's return bin. These errors resulted in a score of zero in this test (MIT 7.111).

We examined seven medication error reports. For all seven reports, we found one or more of the following deficiencies: the PIC did not complete the medication follow-up form timely; the PIC did not document the reason why the patient and the provider were not notified of the error; the PIC did not document where the error occurred within the pharmacy process; the form had no documentation of the PIC's determination or findings regarding the error; and the PIC did not document the recommended changes to correct the errors from occurring in the future. As a result, ISP received a score of zero in this test (MIT 7.112).

Nonscored Tests

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

We interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Three of four applicable patients interviewed indicated they had access to their rescue medications. One patient reported not having the prescribed rescue inhaler and had reported that lack to medical staff for the past month and a half. We promptly notified the chief executive officer and the unit's nursing supervisor of this concern, and health care management immediately issued a replacement rescue inhaler to the patient (MIT 7.999).

Compliance Testing Results

Table 14. Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001) *	2	14	9	12.5%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	21	4	0	84.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	8	10	1	44.4%
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) *	24	1	0	96.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	7	3	0	70.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	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)	3	5	2	37.5%
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)	0	7	3	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)	6	1	3	85.7%
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)	2	5	3	28.6%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	6	1	3	85.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	2	5	3	28.6%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	0	7	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): **38.9%**			

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

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

Table 15. Other Tests Related to Medication Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	15	2	8	88.2%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	4	0	0	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	12	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	8	4	0	66.7%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	1	2	0	33.3%

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

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

Recommendations

- The institution should consider developing and implementing measures to ensure that staff make available and administer medications to patients in a timely manner and that staff document their activities in the MAR as prescribed 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 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, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Overall Rating
Adequate

Case Review Rating
(N/A)

Compliance Score
Adequate
(78.3%)

Results Overview

ISP staff performed well in administering TB medications as prescribed, screening patients annually for TB, offering patients an influenza vaccine for the most recent influenza season, and offering colorectal cancer screening for all patients ages 45 through 75. The institution faltered in monitoring patients who were taking prescribed TB medications and offering required immunizations to chronic care patients. These findings are set forth in the table on the next page. Overall, we rated this indicator ***adequate***.

Compliance Testing Results

Table 16. 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)	12	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) †	8	4	0	66.7%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	23	2	0	92.0%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	25	0	0	100%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	1	8	16	11.1%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
			Overall percentage (MIT 9): **78.3%**	

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

† In April 2020, after our review but before this report was published, CCHCS reported adding the symptom of *fatigue* into the electronic health record system (EHRS) PowerForm for tuberculosis (TB)-symptom monitoring.

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

Recommendations

The OIG offers no recommendations for this indicator.

Nursing Performance

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses (RNs), licensed vocational nurses (LVNs), psychiatric technicians (PTs), and certified nursing assistants (CNAs). Our clinicians evaluated nurses' 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 in many clinical settings and processes, including sick call, outpatient care, care coordination and management, emergency services, specialized medical housing, hospitalizations, transfers, specialty services, and medication management. The OIG assessed nursing care through case review only and performed no compliance testing for this indicator.

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

Results Overview

ISP nurses performed good nursing care. Generally, nurses performed sufficient assessments and documented records well. However, there was a case in the emergency care setting and a few cases in the outpatient setting that showed room for improvement. Considering all factors, the OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 169 nursing encounters in 47 cases. Of the nursing encounters we reviewed, 100 were in the outpatient setting. We identified 11 nursing performance deficiencies, two of which were significant.[28]

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. Nurses generally provided good nursing assessments and interventions.

Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook

[28] Deficiencies occurred in cases 6, 13, 16, 29, 30, 37, and 44. Significant deficiencies occurred twice in case 16.

changes in patients' conditions. For the most part, nurses documented well. However, we identified the following outpatient documentation deficiencies:

- In case 6, the patient had a low blood sugar level. The provider documented receiving a call from the nurse. However, the nurse did not document the event.

- In case 30, the patient complained of left shoulder pain. The nurse erroneously documented the patient had a bruise on the right upper arm instead of the left arm.

Nursing Sick Call

Our clinicians reviewed 41 sick call requests. The nurses often triaged patient sick requests appropriately and performed timely assessments on the same day in most cases. However, the following nursing assessments and interventions showed room for improvement:

- In case 16, the patient complained of severe tooth pain and facial swelling. The nurse saw the patient the same day and notified the dentist. The nurse wrote that the dentist was coming to the clinic in 30 minutes and would see the patient in an hour. However, the nurse discharged the patient to his housing unit, and the patient was not seen by the dentist that day. The following day, the nurse triaged a sick call request for the same patient, who was now complaining of fever, chills, difficulty breathing, facial pain, and swelling. The nurse did not make arrangements to have the patient seen emergently. The dentist saw the patient three hours later and sent the patient to the hospital. The patient was treated with intravenous antibiotics.

- In case 29, the patient complained of having diarrhea for nine days. The nurse did not assess for abdominal tenderness and did not assess mucous membranes for dehydration.

- In case 37, the patient complained of a bump that was located on his leg which caused pain when he worked out. The nurse did not assess for tone or sensation of the lower extremities.

Emergency Services

We reviewed 12 urgent or emergent cases and found nurses responded promptly to emergent events. In addition, nurses performed good assessments and documentation, which we discuss further in the **Emergency Services** indicator.

Hospital Returns

We reviewed eight cases that involved returns from off-site hospitals or emergency rooms. The nurses assessed patients appropriately and documented well, which we detailed further in the **Transfers** indicator.

Transfers

We reviewed eight cases involving transfer-in and transfer-out processes. The nurses evaluated the patients appropriately and requested provider appointments within the required time frames. Please refer to the **Transfers** indicator for further information.

Specialized Medical Housing

We reviewed four OHU cases. In general, nurses delivered good care, which is discussed further in the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed eight cases in which patients returned from off-site specialty appointments. Nurses performed good assessments, reviewed specialists' findings and recommendations, and communicated those results to the provider.

Medication Management

We reviewed 25 cases and found that all nurses administered patients' medication as prescribed. The **Medication Management** indicator provides further information.

Clinician On-Site Inspection

Our clinicians spoke with nurses in the TTA, R&R, specialty services, outpatient clinics, and medication areas. We attended well-organized clinic huddles. The clinic staff were familiar with their patient population. Clinic nurses reported a decline in sick call requests due to the COVID-19 pandemic as patients feared being tested for the disease or possibly having to be transferred. One sick call RN reported that previously, they had seen 12 to 15 patients a day. At the time of our visit, that those numbers had decreased to about six to eight patients a day. Another sick call nurse reported that, on average, 10 patients a day were seen. Clinic staff reported having no backlog for nursing appointments.

All staff interviewed reported having good morale among nurses and a sense of teamwork. In addition, they described having a good rapport with nursing leadership and custody staff. We observed leadership support when a supervising nurse stepped in to collect sick call slips and facilitated the morning huddle in the absence of the clinic RN. While on-site, we met with the chief nurse executive (CNE) and the director of nursing (DON) to discuss our case review findings. Nursing leadership presented the monthly sick call audits performed by supervising nurses and provided a sample of the tool they use for that purpose.

The CNE informed the OIG clinicians of some quality improvement projects that were in progress. Nursing leadership aimed to create a standardized training orientation with a mentor for newly hired nurses. In addition, ISP leadership was collaborating with the local hospitals to provide medication continuity for

substance abuse patients, thus reducing the risk of withdrawals when patients were hospitalized. The CNE also conveyed that the sick call audit process has changed from auditing 10 charts for every nurse, to 10 charts per month, per clinic. The CNE reported that the results of the audits are reviewed with nursing staff. The CNE also reported conducting leadership assessments for supervisory nurses and that the institution plans to implement supervisory training.

Recommendations

The OIG offers no recommendations for this indicator.

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.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

Results Overview

Compared with Cycle 5, ISP providers delivered acceptable care. Providers generally made appropriate evaluations, diagnosed medical conditions correctly, and managed chronic conditions effectively. They referred patients appropriately to specialists and for a higher level of care when needed. However, we found room for improvement in medical assessments and diabetic care. Overall, the OIG rated this indicator ***adequate***.

Case Review Results

OIG clinicians reviewed 96 medical provider encounters and identified 14 deficiencies related to provider performance, four of which were significant.[29] In addition, our clinicians examined the quality of care in 20 comprehensive case reviews. Of these 20 cases, 19 were adequate and one, inadequate.[30]

Assessment and Decision-Making

Providers generally made appropriate assessments and sound medical decisions for their patients. Most of the time, providers diagnosed medical conditions correctly, ordered appropriate tests, and referred their patients to specialists when needed. However, our clinicians identified 10 deficiencies related to poor medical assessment and decision-making, four of which were significant.[31] The following are examples:

- In case 8, the provider reviewed the patient's weekly blood sugar logs, which showed significant multiple low readings of blood sugar levels. However, the provider did not intervene or adjust the insulin dosage for the patient.

[29] Deficiencies occurred six times in case 8, three times in case 9, and once in cases 1, 5, 14, 19, and 20. All four significant deficiencies occurred in case 8.

[30] Case 8 was inadequate.

[31] Deficiencies occurred five times in case 8, twice in case 9, and once in cases 1, 19, and 20. Significant deficiencies occurred four times in case 8.

- Also in case 8, the provider assessed the patient for low blood sugar levels. The patient complained of sweating and fatigue with an abnormally low heart rate. However, the provider did not make a thorough assessment for the patient, and did not appropriately adjust medications for the frequent low blood sugar levels .

Review of Records

For patients returning from hospitalizations, providers performed well in reviewing medical records and addressing hospitalists' recommendations. Providers thoroughly reviewed the medication administration record (MAR) and reconciled patients' medications.

Emergency Care

Providers aptly managed patients in the TTA with urgent and emergent conditions. Providers made appropriate triage decisions when patients arrived at the TTA for emergency treatment. In addition, the providers were always available for consultation with the TTA nursing staff. We discuss these aspects further in the **Emergency Services** indicator.

Chronic Care

Providers generally managed their patients' chronic health conditions such as hypertension, asthma, hepatitis C infection, and cardiovascular disease, referring them to specialists when needed. However, our clinicians identified five deficiencies related to the care of patients with diabetes.[32] The following is an example:

- In case 8, nursing staff documented multiple significant hypoglycemic readings of blood sugar levels for the patient. Nurses notified providers multiple times. However, providers did not intervene or adjust the patient's insulin dosage appropriately and did not document appropriate progress notes in the patient's electronic health record.

Specialty Services

Providers appropriately referred patients to specialists when needed, reviewed specialty consultation reports timely, and followed recommendations adequately most of the time. We identified one deficiency; however, it was not significant.[33]

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

---

[32] Deficiencies with diabetic care occurred five times in case 8.

[33] A deficiency occurred in case 14.

Documentation Quality

Providers generally documented outpatient and TTA encounters on the same day of the encounter. Although most of the time providers correctly documented the encounter, providers did not always document on-call progress notes when required. Our clinicians identified two deficiencies in documentation quality.[34] The following is an example:

- In case 9, the provider performed a chart review for the patient. However, the provider documented the patient's blood pressure reading from a future date in the patient's electronic health record.

Provider Continuity

OIG clinicians did not find any deficiencies related to provider continuity.

Clinician On-Site Inspection

We observed morning huddles and a provider team meeting. The huddles and team meeting were well attended, and staff discussed pertinent patients' medical information. Staff reported assigning providers to specified clinics to ensure patients' continuity of care. At the time of our inspection, medical leadership reported that the institution was still in need of more providers. As a result, a provider from nearby Chuckawalla Valley State Prison and the chief physician and surgeon (CP&S) rotated as the physician-on-call for patient coverage. The CP&S gave us the meeting minutes for weekly provider meetings, which showed discussions concerning complex patient cases. The CP&S reviewed the specialty referrals with providers daily to ensure that providers ordered referrals appropriately. Providers expressed receiving support from medical leadership.

[34] Deficiencies occurred in cases 8 and 9.

Recommendations

The OIG offers no recommendations for this indicator.

Specialized Medical Housing

Overall Rating
Adequate

Case Review Rating
Proficient

Compliance Score
Inadequate **(55.6%)**

In this indicator, OIG inspectors evaluated the quality of care in the specialized medical housing units. We evaluated the performance of the medical staff in assessing, monitoring, and intervening for medically complex patients requiring close medical supervision. Our inspectors also evaluated the timeliness and quality of provider and nursing intake assessments and care plans. We assessed staff members' performance in responding promptly when patients' conditions deteriorated and looked for good communication when staff consulted with one another while providing continuity of care. Our clinicians also interpreted relevant compliance results and incorporated them into this indicator. At the time of our inspection, ISP's outpatient housing unit (OHU) had been inactive due to an ongoing health care facility improvement plan project.

Results Overview

Compared with Cycle 5, ISP improved in this indicator. Nurses performed good assessments and documented well; the providers delivered acceptable performance. However, compliance testing found there was room for improvement in providers' completion of history and physical examinations, nurses' initial assessments, and the administration of medications within required time frames. Considering all factors, we rated this indicator ***adequate.***

Case Review and Compliance Testing Results

We reviewed 14 provider events and 15 nursing events. Due to the frequency of nursing and provider contacts in specialized medical housing, we bundle up to two weeks of patient care into a single event. We identified two deficiencies.[35]

Provider Performance

Compliance testing showed providers did not complete admission history and physical examinations timely (MIT 13.002, 66.7%). Our clinicians found providers delivered good patient care. Providers followed up on their patients within the required time frames, made sound medical decisions, and documented well. We did not identify any deficiencies.

Nursing Performance

Compliance testing showed 66.7 percent of initial assessments occurred within required time frames (MIT 13.001). In general, our clinicians found that nurses performed good assessments and documented well. However, our clinicians identified the following two deficiencies:

[35] Deficiencies occurred in cases 46 and 47.

- In case 46, the patient had an elevated blood pressure. The nurse notified the provider who requested to recheck the patient's blood pressure during the following shift. The nurses did not recheck the patient's blood pressure.

- In case 47, the patient had a peripherally inserted central catheter (PICC) line.[36] The nurses did not measure the external length of the catheter. This is important for determining if, at some point, the catheter becomes dislodged.

Medication Administration

Compliance testing showed around a third of newly admitted patients received their medications within required time frames (MIT 13.004, 33.3%). Analyses of compliance data found that the pharmacy did not always dispense the medications as ordered; however, patients did not miss any scheduled medications. Our clinicians found that all patients received their medications timely.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians toured the OHU. Medical leadership reported that on March 29, 2022, the OHU was deactivated due to construction. In a discussion with the CNE, we were informed that once the OHU renovation has been completed and the unit is again operative, ISP will be given a 14-day notice to prepare staff for the unit's activation. We also learned the OHU will have 14 beds and five negative pressure rooms. While on-site, we met with nursing leadership to discuss our case review findings.

[36] A PICC line is a peripherally inserted central catheter, which is used to provide intravenous access and to administer fluids and medication.

Compliance Testing Results

Table 17. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Prior to 4/2019: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice? Effective 4/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001) *	2	1	0	66.7%
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	2	1	0	66.7%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	N/A	N/A	3	N/A
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	1	2	0	33.3%
For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells? (13.101) *	N/A	N/A	N/A	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) *	N/A	N/A	N/A	N/A
			Overall percentage (MIT 13): **55.6%**	

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

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

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

Recommendations

The OIG offers no recommendations for this indicator.

Specialty Services

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

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
***Inadequate* (72.3%)**

Results Overview

ISP had a mixed performance in this indicator. Staff generally completed specialty appointments within required time frames. Providers made appropriate referrals and offered follow-up care after specialty services. However, the institution did not ensure that all high-priority specialty appointments and transfer continuity of specialty appointments occurred timely. Considering compliance and case reviews, on balance, the OIG rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 82 events related to specialty services which included 59 off-site specialty consultations and procedures, five on-site specialty services, and 18 nursing encounters. There were seven deficiencies in this category, two of which were significant.[37]

Access to Specialty Services

Compliance testing showed that patients did not timely receive specialty services with high-priority referrals and transfer continuity of specialty services (MIT 14.001, 60.0% and MIT 14.010, 62.5%). Also, patients did not always timely receive specialty services with medium-priority referrals; however, they did receive specialty services with routine-priority referrals within the required time frame (MIT 14.004, 73.3% and MIT 14.007, 100%). OIG clinicians identified four deficiencies related to specialty appointments.[38] The following is an example:

- In case 12, the on-site optometrist assessed the patient for a foreign body in the right eye and recommended to follow-up in six days. However, the patient saw the optometrist 80 days later.

Provider Performance

In general, providers referred patients appropriately and followed the specialists' recommendations most of the time. Compliance testing showed that follow-up

[37] Deficiencies occurred three times in case 20, twice in case 12, and once in cases 8 and 13. Significant deficiencies occurred in cases 12 and 13.

[38] Deficiencies occurred twice in case 12 and once in cases 2 and 20. A significant deficiency occurred in case 12.

appointments with providers after specialty consultations often occurred within required time frames (MIT 1.008, 86.5%). OIG clinicians identified two deficiencies in which providers did not endorse specialists' reports timely.[39]

Nursing Performance

The specialty nurses reviewed specialty service requests and appropriately scheduled patients for specialty appointments. TTA nurses properly assessed patients after returning from specialty appointments, reviewed specialists' recommendations, and communicated them to the providers. OIG clinicians reviewed 18 nursing encounters related to specialty services and did not identify any deficiencies. This is discussed further in the **Nursing Performance** indicator.

Health Information Management

While providers did not always receive and review high-priority specialty reports within required time frames, most of the time, they often reviewed medium- and routine-priority specialty reports within required time frames (MIT 14.002, 70.0%, MIT 14.005, 80.0% and MIT 14.008, 80.0%). Staff nearly always scanned specialty reports into the EHRS within the required time frame (MIT 4.002, 96.7%). OIG clinicians identified two deficiencies related to delays in retrieving and scanning in the report, one deficiency related to mislabeling the report, and one deficiency related to the provider not sending the patient results notification letter.[40] The following is an example:

- In case 8, the endocrinologist assessed the patient for consultation. However, the consultation report was scanned into the EHRS one day late.

Clinician On-Site Inspection

We discussed specialty referral management with medical and nursing leadership, providers, specialty nurses, and the utilization management nurse. Medical leadership reported implementing daily referral for service (RFS) meetings during which providers review specialty referrals for appropriateness. Nursing staff reported that they reviewed specialty requests, contact specialists for available appointments, and schedule the appointments. However, they reported a lack of available local specialists in the area, so they utilized telemedicine for specialty services when needed. ISP offered on-site specialty services including audiology, optometry, physical therapy, orthotics, and mobile imaging for MRI and CT scans.

[39] Delayed endorsement deficiencies occurred in cases 13 and 20.

[40] Deficiencies occurred in cases 8 and 20.

Compliance Testing Results

Table 18. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	6	4	0	60.0%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	7	3	0	70.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	3	4	3	42.9%
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) *	11	4	0	73.3%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	4	2	9	66.7%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	15	0	0	100%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	7	1	7	87.5%
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	3	0	62.5%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	N/A	N/A	N/A	N/A
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 14): **72.3%**

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

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

Table 19. Other Tests Related to Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	32	5	3	86.5%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	29	1	10	96.7%

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

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

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

Recommendations

- Medical leadership should determine the root cause(s) of challenges to the timely provision of specialty services with high-priority referrals and their subsequent high-priority specialty follow-up appointments, and should implement remedial measures as appropriate.

- Medical and nursing leadership should ensure that newly arrived patients receive their previously scheduled specialty appointments within the required time frame.

Administrative Operations

Overall Rating
Inadequate

Case Review Rating
N/A

Compliance Score
***Inadequate* (65.7%)**

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 the 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, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

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

Results Overview

ISP's performance was mixed in this indicator as the institution scored well in some applicable tests. However, the institution needed to improve in several areas. The Emergency Medical Response Review Committee (EMRRC) did not always complete the required checklists. In addition, the institution conducted medical emergency response drills with incomplete documentation. Physician managers did not always complete annual appraisals in a timely manner. The nurse educator did not ensure that newly hired nurses received the required onboarding training. These findings are set forth in the table on the next page. Overall, we rated this indicator ***inadequate***.

Compliance Testing Results

Nonscored Results

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

We obtained CCHCS Death Review Committee (DRC) reporting data. There was only one death reported during our review period; therefore, this test is not applicable (MIT 15.998).

Compliance Testing Results

Table 20. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001) *	N/A	N/A	N/A	N/A
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	1	11	0	8.3%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	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 inmates' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103)	1	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	8	2	0	80.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	0	2	0	0
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)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information.			
	Overall percentage (MIT 15): **65.7%**			

* Effective March 2021, this test was for informational purposes only.

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

Recommendations

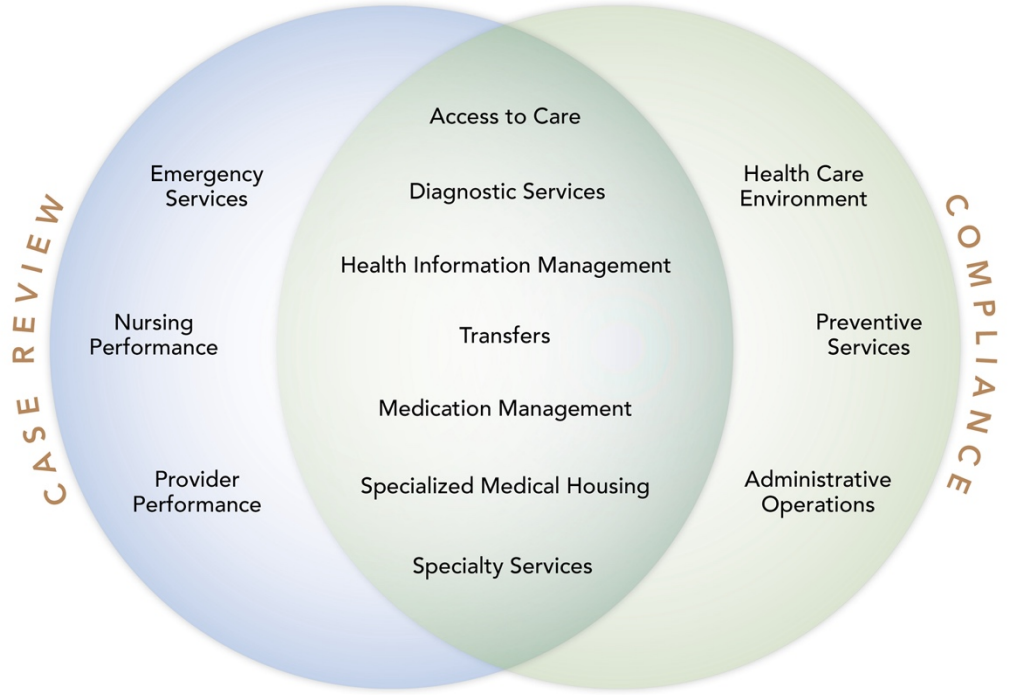
The OIG offers no recommendations for this indicator.

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 ISP



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

Case Reviews

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

Table A–1. Case Review Definitions

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

The OIG eliminates case review selection bias by sampling using a rigid methodology. No case reviewer selects the samples he or she reviews. Because the case reviewers are excluded from sample selection, there is no possibility of selection bias. Instead, 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

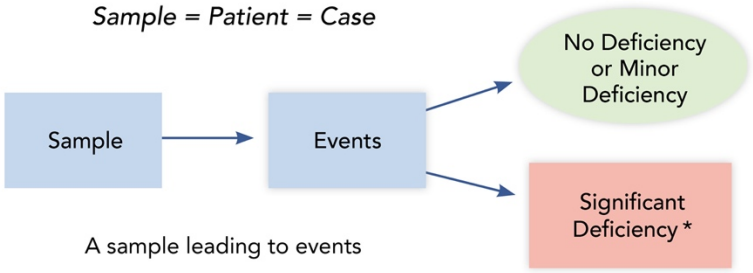
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

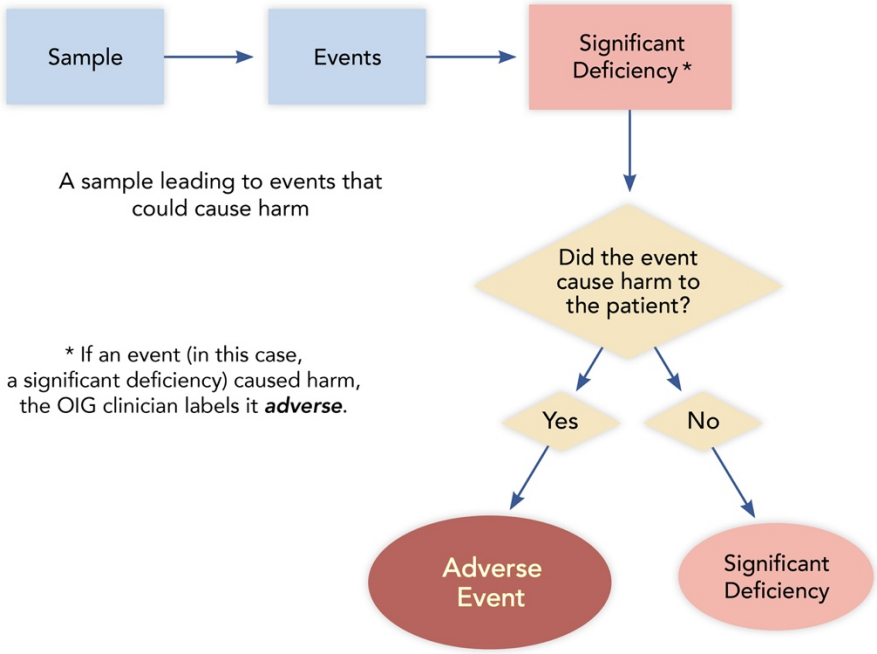
Figure A–2. Case Review Testing

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***.



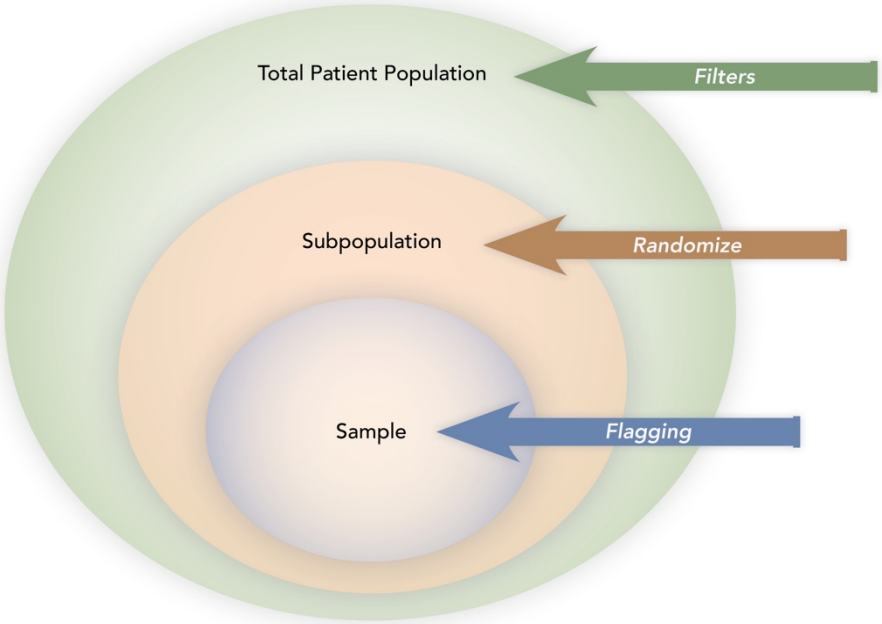
Source: The Office of the Inspector General medical inspection analysis.

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

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

Appendix B. Case Review Data

Table B–1. ISP Case Review Sample Sets

Sample Set	Total
OHU	3
Death Review/Sentinel Events	1
Diabetes	4
Emergency Services – CPR	1
Emergency Services – Non-CPR	2
High Risk	5
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	18
Specialty Services	4
	48

Table B–2. ISP Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	1
Arthritis/Degenerative Joint Disease	3
Asthma	4
COPD	1
COVID-19	5
Cardiovascular Disease	2
Chronic Pain	5
Cirrhosis/End-Stage Liver Disease	3
Coccidioidomycosis	2
Diabetes	7
Gastroesophageal Reflux Disease	4
Gastrointestinal Bleed	1
Hepatitis C	8
Hyperlipidemia	16
Hypertension	14
Mental Health	3
Migraine Headaches	1
Seizure Disorder	4
Sickle Cell Anemia	1
Substance Abuse	11
Thyroid Disease	1
	97

Table B–3. ISP Case Review Events by Program

Diagnosis	Total
Diagnostic Services	311
Emergency Care	26
Hospitalization	19
Intrasystem Transfers In	8
Intrasystem Transfers Out	3
Outpatient Care	368
Specialized Medical Housing	42
Specialty Services	90
	867

Table B–4. ISP Case Review Sample Summary

	Total
MD Reviews Detailed	20
MD Reviews Focused	0
RN Reviews Detailed	16
RN Reviews Focused	25
Total Reviews	61
Total Unique Cases	48
Overlapping Reviews (MD & RN)	13

Appendix C. Compliance Sampling Methodology

IRONWOOD 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	19	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	40	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	0	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 Ips for MIT 1.004
MIT 4.002	Specialty Documents	40	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 Ips for each question
MIT 4.003	Hospital Discharge Documents	19	OIG Q: 4.005	• Community hospital discharge documents • First 20 Ips selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	19	CADDIS Off-site Admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	9	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	4	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	19	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See Reception Center
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	10	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	7	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	3	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	12	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out Ips tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (45 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. Prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. Prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–008	Reception Center	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–004	Specialized Health Care Housing Unit	3	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	10	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize

MIT 14.010	Specialty Services Arrivals	8	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	0	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.001	Adverse/sentinel events (ASE)	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
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	2	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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	Death Review Committee	0	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services death reviews

This page left blank for reproduction purposes.

California Correctional Health Care Services' Response

DocuSign Envelope ID: 70AAA059-368F-4A0E-B852-29C8CE4534FE

June 30, 2023

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

Dear Ms. Singh:

The Office of the Receiver has reviewed the draft Medical Inspection Report for Ironwood State Prison (ISP) by the Office of the Inspector General (OIG) from January 2022 to June 2022. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 896-6780.

Sincerely,

DocuSigned by:
DeAnna Gouldy
3B7F6B95AC0A4D1...
DeAnna Gouldy
Deputy Director
Policy and Risk Management Services
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
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 IV, CCHCS
Chief Executive Officer, ISP
Luu Nguyen, Chief Assistant Inspector General (A), OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
David Lavorico, Staff Services Manager I (A), OIG

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

Cycle 6

Medical Inspection Report

for

Ironwood State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
July 2023

OIG