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# OIG | OFFICE of the INSPECTOR GENERAL

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Independent Prison Oversight

December 2023

## Cycle 7 *Medical Inspection Report*

California State Prison  
Los Angeles County



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## Introduction

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

In Cycle 7, the OIG continues to apply the same assessment methodologies used in Cycle 6, 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.<sup>3</sup>

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).<sup>4</sup> 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.<sup>5</sup> At the same time, our clinicians examine whether the institution's medical system mitigated the error.

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 individual or system errors. The review assesses the institution's medical care on both individual and system levels. The OIG rates the indicators ***proficient, adequate, or inadequate***.

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

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

<sup>3</sup> 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.

<sup>4</sup> The department regularly updates its policies. The OIG updates its policy-compliance testing to reflect the department's updates and changes.

<sup>5</sup> If we learn of a patient needing immediate care, we notify the institution's chief executive officer.

As we did during Cycle 6, our office continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 7 inspection of California State Prison, Los Angeles County, the institution had not been delegated back to the department by the receiver. We completed our seventh inspection of the institution, and this report presents our assessment of the health care provided at this institution during the inspection period from May 2022 to October 2022.<sup>6</sup>

California State Prison, Los Angeles County (LAC), houses more than 2,506 patients and is located in the city of Lancaster. The institution has been designated as an *intermediate care prison*, which responds to nonurgent requests for medical services and provides an enhanced outpatient program. The institution conducts patient screenings in its receiving and release (R&R) clinical area, treats patients who require urgent or immediate care in its triage and treatment area (TTA), and treats patients who require inpatient care in its correctional treatment center (CTC).<sup>7</sup>

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<sup>6</sup> Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between January 2022 and November 2022, anticoagulation reviews between January 2022 and October 2022, and transfer reviews between April 2022 and September 2022.

<sup>7</sup> As of July 6, 2023, the department reports on its public tracker that 78% of LAC's incarcerated population is fully vaccinated while 65% of LAC's staff is fully vaccinated:  
<http://www.cdcr.ca.gov/covid19/population-status-tracking/>

## Summary

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

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



**Table 1. LAC Summary Table**

Health Care Indicators	Ratings			Change Since Cycle 6*
	Case Review	Compliance	Overall	
Access to Care	Adequate	Adequate	Adequate	↓
Diagnostic Services	Inadequate	Inadequate	Inadequate	↓
Emergency Services	Inadequate	N/A	Inadequate	==
Health Information Management	Adequate	Proficient	Adequate	==
Health Care Environment	N/A	Inadequate	Inadequate	==
Transfers	Inadequate	Inadequate	Inadequate	==
Medication Management	Inadequate	Inadequate	Inadequate	==
Prenatal and Postpartum Care	N/A	N/A	N/A	N/A
Preventive Services	N/A	Inadequate	Inadequate	==
Nursing Performance	Inadequate	N/A	Inadequate	↓
Provider Performance	Adequate	N/A	Adequate	==
Reception Center	N/A	N/A	N/A	N/A
Specialized Medical Housing	Inadequate	Inadequate	Inadequate	↓
Specialty Services	Inadequate	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 6 and Cycle 7. The equals sign means there was no change in the rating. The single arrow means the rating rose or fell one level, and the double arrow means the rating rose or fell two levels (green, from *inadequate* to *proficient*; pink, from *proficient* to *inadequate*).

† **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 364 patient records and 1,116 data points, and used the data to answer 89 policy questions. In addition, we observed LAC processes during an on-site inspection in December 2022. Table 2 below lists LAC average scores from Cycles 6 and 7.

**Table 2. LAC Policy Compliance Scores**

Medical Inspection Tool (MIT)	Policy Compliance Category	Average Score	
		Cycle 6	Cycle 7
1	Access to Care	90.0%	81.5%
2	Diagnostic Services	59.0%	62.2%
4	Health Information Management	83.0%	85.0%
5	Health Care Environment	44.0%	37.9%
6	Transfers	55.0%	42.7%
7	Medication Management	28.0%	55.4%
8	Prenatal and Postpartum Care	N/A	N/A
9	Preventive Services	68.0%	58.8%
12	Reception Center	N/A	N/A
13	Specialized Medical Housing	84.0%	62.0%
14	Specialty Services	75.0%	49.2%
15	Administrative Operations	68.0%	70.4%

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

The OIG clinicians (a team of physicians and nurse consultants) reviewed 63 cases, which contained 1,142 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in March 2023 to verify their initial findings. The OIG physicians rated the quality of care for 25 comprehensive case reviews. Of these 25 cases, our physicians rated 21 **adequate** and four **inadequate**. Our physicians found one adverse deficiency 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.<sup>8</sup> Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our OIG clinicians acknowledged institutional structures designed to catch and resolve mistakes that may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable for this institution in the LAC Summary Table.

In December 2022, the Health Care Services Master Registry showed that LAC had a total population of 2,506. A breakdown of the medical risk level of the LAC population as determined by the department is set forth in Table 3 below.<sup>9</sup>

**Table 3. LAC Master Registry Data as of December 2022**

Medical Risk Level	Number of Patients	Percentage*
High 1	347	13.8%
High 2	460	18.4%
Medium	1,049	41.9%
Low	650	25.9%
<b>Total</b>	<b>2,506</b>	<b>100.0%</b>

\* Percentages may not total 100% due to rounding.

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

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<sup>8</sup> The indicators for **Reception Center** and **Prenatal and Postpartum Care** did not apply to LAC.

<sup>9</sup> For a definition of *medical risk*, see CCHCS HCDOM 1.2.14, Appendix 1.9.

According to staffing data that the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, LAC had two vacant executive leadership positions, one primary care provider vacancy, 1.2 nursing supervisor vacancies, and 31.6 nursing staff vacancies.

**Table 4. LAC Health Care Staffing Resources as of December 2022**

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff†	Total
Authorized Positions	5.0	8.0	17.2	185.0	215.2
Filled by Civil Service	3.0	7.0	16.0	153.4	179.4
Vacant	2.0	1.0	1.2	31.6	35.8
Percentage Filled by Civil Service	60.0%	87.5%	93.0%	82.9%	83.0%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	4.0	0	15.0	19.0
Percentage Filled by Registry	0	36.36%	0	8.1%	8.8%
Total Filled Positions	3.0	7.0	16.0	153.4	198.4
<b>Total Percentage Filled</b>	<b>60.0%</b>	<b>118.18%</b>	<b>93.0%</b>	<b>82.9%</b>	<b>86.15%</b>
Appointments in Last 12 Months	1.0	1.0	5.0	46.0	53.0
Redirected Staff	0	0	0	7.0	7.0
Staff on Extended Leave‡	0	1.0	6.0	8.0	14.0
<b>Adjusted Total: Filled Positions</b>	<b>3.0</b>	<b>13.0</b>	<b>10.0</b>	<b>138.4</b>	<b>164.4</b>
<b>Adjusted Total: Percentage Filled</b>	<b>60.0%</b>	<b>118.18%</b>	<b>58.13%</b>	<b>74.81%</b>	<b>76.39%</b>

\* Executive Leadership includes the Chief Physician and Surgeon.

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

‡ In Authorized Positions.

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

Source: Cycle 7 medical inspection preinspection questionnaire received on December 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.<sup>10</sup>

The OIG found one adverse event at LAC during the Cycle 7 inspection.

- In case 25, the patient returned from the hospital with the diagnosis of gastrointestinal bleed from inflammatory bowel disease, and the hospitalist recommended monitoring the patient's hemoglobin weekly for two to three weeks. However, the provider did not address the recommendation, placing the patient at risk of severe anemia. Six weeks later, the provider ordered hemoglobin which showed severely low hemoglobin of 7.7 g/dL; however, the provider did not review the laboratory result until 16 days later. The oversight placed the patient at risk of complications from delayed treatment for severe anemia.

## Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to LAC. Of these 10 indicators, OIG clinicians rated three *adequate* and seven *inadequate*. The OIG physicians also rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 21 were *adequate* and four were *inadequate*. In the 1,142 events reviewed, there were 324 deficiencies, 87 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at LAC:

- Staff performed well with access to care as most provider and nursing appointments occurred within required time frames.
- Staff performed well with health information management as the institution retrieved and scanned hospital records, diagnostic tests, and pathology reports timely.

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<sup>10</sup> For a further discussion of an adverse event, see Table A-1.

Our clinicians found the following weaknesses at LAC:

- Staff performed poorly in completing laboratory tests, and the provider did not thoroughly communicate test results to patients.
- Nurses did not always provide appropriate emergency care including basic life support and cardiopulmonary resuscitation.
- Staff performed poorly in most aspects of medication management including chronic medication continuity.
- Staff performed poorly in completing follow-up specialty appointments, and the institution also performed poorly in scanning, retrieving, and reviewing specialty reports.
- Staff performed poorly in the transfer process; when patients transferred into the institution, staff did not always complete the initial nursing assessments and did not always reconcile the orders from the sending institution.

## Compliance Testing Results

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

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

- Medical staff performed well in scanning community hospital discharge reports and requests for health care services into patients' electronic medical records within required time frames.
- Nursing staff processed sick call request forms, performed face-to-face evaluations, and completed nurse-to-provider referrals within required time frames. In addition, LAC housing units contained adequate supplies of health care request forms.

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

- LAC's medical warehouse and clinical areas had multiple medical supplies that were expired.
- Nursing staff did not regularly inspect emergency response bags and treatment carts.
- Health care staff did not follow hand hygiene precautions before or after patient encounters.

- LAC often did not ensure specialty service reports were received timely. Furthermore, providers often did not review these reports within required time frames.
- LAC did not perform well in ensuring that specialty services were provided within specified time frames.
- Providers did not often communicate results of diagnostic services timely. Most patient letters communicating these results were missing the date of the diagnostic service, the date of the results, and whether the results were within normal limits.
- LAC staff frequently failed to maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients admitted to a specialized medical housing unit. In addition, there was poor medication continuity for patients who transferred into the institution, transferred within the institution, or had a temporary layover at LAC.

## 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 7. Likewise, Kaiser (commercial plan) no longer publishes HEDIS scores. However, through the California Department of Health Care Services' *Medi-Cal Managed Care Technical Report*, the OIG obtained California Medi-Cal and Kaiser Medi-Cal HEDIS scores 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 LAC's performance to assess the macroscopic view of the institution's health care delivery. Currently, only one HEDIS measure is available for review: poor HbA1c control, which measures the percentage of diabetic patients who have poor sugar control. LAC's results compared favorably with those found in State health plans for this measure. 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)—LAC's percentage of patients with poor HbA1c control was significantly lower, indicating very good performance on this measure.

## Immunizations

Statewide comparative data were also not available for immunization measures; however, we include these data for informational purposes. LAC had a 36 percent influenza immunization rate for adults 18 to 64 years old and a 61 percent influenza immunization rate for adults 65 years of age and older.<sup>11</sup> The pneumococcal vaccine rate was 82 percent.<sup>12</sup>

## Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. LAC had an 88 percent colorectal cancer screening rate.

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<sup>11</sup> The HEDIS sampling methodology requires a minimum sample of 10 patients to have a reportable result.

<sup>12</sup> The pneumococcal vaccines administered are the 13, 15, and 20 valent pneumococcal vaccines (PCV13, PCV15, and PCV20), or 23 valent pneumococcal vaccine (PPSV23), depending on the patient's medical conditions. For the adult population, the influenza or pneumococcal vaccine may have been administered at a different institution other than the one in which the patient was currently housed during the inspection period.

**Table 5. LAC Results Compared With State HEDIS Scores**

HEDIS Measure	LAC	California		California
	Cycle 7 Results*	Medi-Cal†	Kaiser NorCal Medi-Cal†	Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	-	-	-
Poor HbA1c Control (> 9.0%)‡,§	12%	38%	28%	20%
HbA1c Control (< 8.0%)‡	76%	-	-	-
Blood Pressure Control (< 140/90)‡	82%	-	-	-
Eye Examinations	64%	-	-	-
Influenza—Adults (18–64)	36%	-	-	-
Influenza—Adults (65+)	61%	-	-	-
Pneumococcal—Adults (65+)	82%	-	-	-
Colorectal Cancer Screening	88%	-	-	-

**Notes and Sources**

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

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

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

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

Source: Institutional 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 LAC's performance, we offer the following recommendations to the department:

### Diagnostic Services

- The department should consider developing strategies to ensure that providers generate letters communicating results to their patients and that the letters include all elements as required by policy.
- Medical leadership should ascertain causative factors related to the untimely provisions of laboratory services and implement remedial measures as appropriate.

### Emergency Services

- Nursing leadership should ensure nursing supervisors are trained on accurately completing the emergency medical response review checklist. In addition, nursing and medical leadership should audit LAC's emergency events to ensure nursing supervisors and providers are identifying opportunities for improvement.
- The institution should consider replacing current automated external defibrillators (AED) with models that include reporting features or the electronic health record system (EHRS) synchronization.<sup>13</sup>
- The institution should consider replacing vital signs equipment with models capable of synchronizing data with the EHRS.

### 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 staff properly store medical supplies in medical supply storage areas.
- Nursing leadership should consider performing random spot checks to ensure staff follow equipment and medical supply management protocols.
- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) and

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<sup>13</sup> The department's electronic health record system is used for storing the patient's medical history. The clinicians also use the system to communicate with one another. This record stays with the patient during the patient's time in the prison system.

treatment cart logs to ensure that the EMRBs and treatment carts are regularly inventoried and sealed.

### **Transfers**

- Nursing leadership should develop and implement internal auditing of staff to ensure complete and thorough assessments of patients transferring into the institution or patients returning from hospitalizations.
- Nursing leadership should educate R&R nurses to completely answer and address required initial health screening questions.

### **Medication Management**

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

### **Preventive Services**

- Nursing leadership should consider developing and implementing measures to ensure that nursing staff monitor patients receiving TB medications according to CCHCS guidelines.
- Medical leadership should analyze the challenges related to the untimely provision of preventive vaccines and implement remedial measures as appropriate.

### **Nursing Performance**

- Nursing leadership should work toward improving patient care coordination with medical providers in communications about medication orders, patient refusals, and incomplete specialists' reports.
- The department and nursing leadership should consider resuming random audits to ensure that nursing staff properly perform and document complete assessments including vital signs and appropriate assessments. Leadership should implement remedial measures as appropriate including training of staff.
- The department and nursing leadership should consider a medication management audit that ensures nurses are safely administering medications.

### **Specialized Medical Housing**

- Nursing leadership should ensure that CTC nurses properly document the results of their care plan assessments.

- Nursing leadership should ensure CTC medications are safely administered.

### **Specialty Services**

- Medical leadership should develop a tracking system for retrieving, scanning, and reviewing specialty reports.
- Nursing leadership should remind staff of the expected assessments and documentation required when patients return from specialty appointments.
- Medical leadership should ascertain causative factors related to the untimely provisioning or scheduling of patients' specialty service appointments and follow-up appointments, and implement remedial measures as appropriate.

## Access to Care

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

Overall Rating
<b>Adequate</b>
Case Review Rating
<b>Adequate</b>
Compliance Score
<b>Adequate</b> (81.5%)

## Results Overview

LAC generally provided sufficient access for patients. OIG clinicians found the institution performed poorly with chronic care provider appointments; however, most other appointments were completed in a timely manner including nurse-to-provider, clinic provider after hospitalization, specialized medical housing provider, and clinic nurse appointments. LAC's satisfactory performances in both compliance testing and case review contributed to the OIG rating this indicator *adequate*.

## Case Review and Compliance Testing Results

Our clinicians reviewed 532 provider, nursing, urgent or emergent care, specialty, and hospital events that required the institution to generate appointments. We found 13 deficiencies related to access to care; nine of which were considered significant.<sup>14</sup>

### Access to Care Providers

Compliance testing found poor completion of chronic care follow-up (MIT 1.001, 48.0%); however, the institution performed well in nurse-to-provider and provider-ordered sick call follow-up appointments (MIT 1.005, 85.7% and MIT 1.006, 100%). The OIG clinicians reviewed 117 clinic provider appointments and identified three deficiencies.<sup>15</sup> The following is an example:

- In case 21, a sick call nurse evaluated the patient for hand cramps and initiated a provider appointment to occur within 14 days; however, the appointment did not occur.

### Access to Specialized Medical Housing Providers

LAC performed excellently with access to specialized medical housing providers. The OIG reviewed 19 provider encounters and did not identify any missed or delayed appointments.

<sup>14</sup> Deficiencies occurred twice in cases 2, 10, 21, and 24, and once in cases 20, 26, 53, 61, and 62. Significant deficiencies occurred in cases 10, 21, 24, 26, 61, and 62.

<sup>15</sup> Deficiencies occurred in cases 21, 24, and 53.

## Access to Clinic Nurses

LAC performed well with access for nurse sick calls and provider-to-nurse referrals. Compliance testing found that all nurse sick call requests were reviewed on the same day they were received (MIT 1.003, 100%). Moreover, nurses evaluated 93.3 percent of their patients within the required one business day time frame (MIT 1.004). OIG clinicians identified three deficiencies related to clinic nurse access.<sup>16</sup> The following are examples:

- In case 2, a nurse triaged the patient who complained he had difficulty eating due to his false teeth and requested a nursing appointment to occur within one day. However, the appointment occurred in eight days.
- In case 20, the sick call nurse requested a nursing follow-up appointment to occur in three days for ear irrigation; however, the appointment occurred in eight days.

## Access to Specialty Services

Compliance testing found that 93.3 percent of the initial high-priority specialty appointments (MIT 14.001), 66.7 percent of the initial medium-priority specialty appointments (MIT 14.004), and 80.0 percent of the initial routine-priority specialty appointments (MIT 14.007) occurred within required time frames. However, the institution performed inconsistently with follow-up specialty appointments (MIT 14.003, 30.8%, MIT 14.006, 50.0%, and MIT 14.009, 71.4%). OIG clinicians reviewed 110 specialty events and identified four deficiencies.<sup>17</sup> These deficiencies are discussed in the **Specialty Services** indicator.

## Follow-Up After Specialty Services

LAC showed room for improvement in ensuring patients saw their providers after specialty appointments. Compliance testing revealed that 55.8 percent of provider appointments after specialty services occurred within required time frames (MIT 1.008). OIG clinicians identified one delayed appointment and one missed provider appointment, both of which are discussed below:

- In case 2, the patient returned from a colonoscopy and an upper endoscopy. The nurse ordered a provider appointment to occur in 14 days; however, the appointment occurred 17 days later.
- In case 21, the patient returned from an endocrinology appointment, and the nurse ordered a provider appointment to occur in 14 days; however, the appointment did not occur.

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<sup>16</sup> Deficiencies occurred in cases 2, 10 and 20.

<sup>17</sup> Deficiencies occurred in cases 24, 26, 61, and 62.

## Follow-Up After Hospitalization

LAC performed sufficiently with ensuring that patients saw their providers within required time frames after hospitalizations. Compliance testing found that 76.0 percent of provider appointments occurred within required time frames (MIT 1.007). OIG clinicians reviewed 14 hospital returns and did not identify any missed or delayed provider appointments.

## Follow-Up After Urgent or Emergent Care

Providers generally saw their patients following a TTA event as requested. OIG clinicians reviewed 36 TTA events and identified one deficiency as follows:

- In case 10, the TTA nurse initiated a five-day provider follow-up to address the patient's dizziness; however, the appointment did not occur until 22 days later.

## Follow-Up After Transferring Into LAC

Compliance testing found that 75.0 percent of provider appointments for newly arrived patients occurred within required time frames (MIT 1.002). Our clinicians evaluated four transfer-in events and did not identify any missed or delayed provider appointments.

## Clinician On-Site Inspection

LAC has four main clinics: A, B, C, and D. Each clinic had two assigned providers and an office technician who attended the morning huddles and ensured that provider appointments were met. Each provider saw about 12 patients per day. At the time of the clinician on-site inspection, there was no backlog of provider appointments for any of the four clinics.

Our clinicians discussed missed or delayed appointments with the office technician supervisor, and the supervisor acknowledged that most of the missed or delayed appointments were due to human errors, such as when the medical staff did not order the appointments or did not appropriately order the appointments. For the two missed provider appointments, the supervisor stated that the medical assistant obtained vital signs as the patient was checked in for the appointment; however, there was no provider progress note documenting the encounter.

## Compliance Testing Results

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

## Compliance Testing Results

**Table 6. Access to Care**

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001) *	12	13	0	48.0%
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) *	18	6	1	75.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	30	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004) *	28	2	0	93.3%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005) *	12	2	16	85.7%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006) *	2	0	28	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	19	6	0	76.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) * <sup>,</sup> <sup>†</sup>	24	19	2	55.8%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	5	0	1	100%

Overall percentage (MIT 1): 81.5%

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

† CCHCS changed its 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**

<b>Compliance Questions</b>	<b>Scored Answer</b>			
	<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Yes %</b>
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003) *	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days (prior to 07/2022) or five working days (effective 07/2022)? (12.004) *	N/A	N/A	N/A	N/A
Was a written history and physical examination completed within the required time frame? (13.002) *	6	4	0	60.0%
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) *	14	1	0	93.3%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	4	9	2	30.8%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004) *	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	3	3	9	50.0%
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) *	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) *	5	2	8	71.4%

\* 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.

## ***Recommendations***

The OIG offers no recommendations for this indicator.

## Diagnostic Services

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

Overall Rating
<b>Inadequate</b>
Case Review Rating
<b>Inadequate</b>
Compliance Score
<b>Inadequate (62.2%)</b>

### Results Overview

LAC had a mixed performance in this indicator. LAC performed well in completing radiology tests; however, the institution's performance was poor in completing laboratory tests. Providers performed well in endorsing both radiology and laboratory tests including STAT results, but did not thoroughly communicate test results with their patients. Taking all factors into consideration, the OIG rated this indicator *inadequate*.

### Case Review and Compliance Testing Results

Our clinicians reviewed 286 diagnostic events and identified 38 deficiencies, three of which were significant.<sup>18</sup> Of these 38 deficiencies, 32 of them were related to health information management, and six pertained to completing diagnostic tests.

#### Test Completion

LAC performed well when completing radiology tests. Compliance testing showed the institution completed 100 percent of radiology tests within required time frames (MIT 2.001). OIG clinicians reviewed 27 radiology tests and identified one X-ray test that was completed late.<sup>19</sup>

On the other hand, LAC performed poorly when completing laboratory tests. Compliance testing revealed that only 50.0 percent of laboratory tests were completed as requested (MIT 2.004). Our clinicians identified five deficiencies related to laboratory completion.<sup>20</sup> The following are examples:

- In case 14, a provider ordered an international normalized ratio (INR) blood test as a timed study test, and the test was completed one day late.<sup>21</sup>

<sup>18</sup> Deficiencies occurred as follows: eight in case 12, four in cases 26 and 29, three in case 22, twice in cases 3, 23, 25, and 27, and once in cases 2, 9, 10, 11, 13, 14, 17, 20, 21, 28, and 30. Significant deficiencies occurred in cases 14, 27, and 28.

<sup>19</sup> A deficiency occurred in case 27.

<sup>20</sup> Deficiencies occurred in cases 10, 11, 14, 29, and 30.

<sup>21</sup> The INR is a laboratory test that measures the body's ability to clot blood and is used to monitor the effectiveness of blood thinning medications such as warfarin.

- In case 29, a urine toxicology was not completed.

OIG clinicians reviewed one STAT laboratory order. The test was completed timely, and the TTA nurse appropriately communicated the result to the provider.

LAC performed well with regard to completing electrocardiograms (EKGs). Our clinicians reviewed 18 EKGs and found all were completed within the requested time frame.

### **Health Information Management**

LAC staff retrieved laboratory and diagnostic results promptly, and sent them to the providers for review, who then endorsed both radiology and laboratory results within required time frames (MIT 2.002, 80.0% and MIT 2.005, 100%). Our clinicians identified seven deficiencies related to missed or late endorsement of diagnostic tests.<sup>22</sup> Examples include the following:

- In case 17, the result of a chest CT scan was not endorsed by a provider.
- In case 25, the patient had a low hemoglobin level,<sup>23</sup> and the result was not endorsed by a provider until 16 days later.

LAC performed poorly in relaying results to patients. Compliance scores for communicating radiology results and laboratory results were poor (MIT 2.003, 30.0% and MIT 2.006, 20.0%). Our clinicians also noted this as an area of underperformance, as 24 deficiencies were identified. In addition, 10 patient letters were found to be missing at least one of the required elements, and on 14 occasions, the providers did not generate patient letters. Examples are listed below:

- In case 9, a provider endorsed a hemoglobin A1c test result, but did not generate a patient letter informing that this indicated poorly controlled diabetes.<sup>24</sup>
- In case 23, a provider sent a patient letter informing of laboratory results, but did not include all required elements such as the test date.
- In case 26, a provider endorsed an X-ray result of a left finger, but did not send the patient letter.

Compliance testing showed that while LAC staff retrieved pathology reports timely (MIT 2.010, 90.0%) and providers endorsed pathology reports promptly (MIT 2.011, 90.0%), providers did not notify patients of their pathology results

<sup>22</sup> Deficiencies occurred in twice in case 26, and once in cases 17, 22, 25, 27, and 29.

<sup>23</sup> A low hemoglobin level indicates anemia or low blood count.

<sup>24</sup> Hemoglobin A1c is a blood test that measures the average plasma glucose over the previous 12 weeks.

within the required time frame (MIT 2.012, zero). Our clinicians reviewed two pathology events and found one pathology report was never retrieved, and the other pathology report did not have the results letter.<sup>25</sup>

#### Clinician On-Site Inspection

LAC has a phlebotomist assigned to each of the four main clinics, and samples are collected in the clinic hallway. The clinics have a room for processing and storing laboratory tests prior to sending them out to the laboratory processing vendor. TTA nurses collect urgent and STAT laboratory tests, and inform providers of the results. CTC nurses collect laboratory tests for all CTC patients.

The radiology supervisor informed OIG clinicians that in-house X-ray services were not available for the month of June 2022 as the institution was replacing the X-ray equipment. The supervisor reported that this delayed completion of some routine X-ray orders.

A specialty nurse was responsible for retrieving both pathology reports and numerous off-site specialty reports. Unfortunately, the institution's medical staff does not have a specific tracking system to ensure all pathology reports were retrieved.

The chief physician and surgeon acknowledged the missed or incomplete providers' letters informing patients of their diagnostic results, and providers have taken steps to address these issues.

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<sup>25</sup> Deficiencies occurred in cases 2 and 28.

## 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) *	8	2	0	80.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	3	7	10	30.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	5	5	0	50.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	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) *	9	1	0	90.0%
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)	0	10	0	0
Overall percentage (MIT 2): 62.2%				

\* 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 strategies to ensure that providers generate letters communicating results to their patients and that the letters include all elements as required by policy.
- Medical leadership should ascertain causative factors related to the untimely provisions of laboratory services and implement remedial measures as appropriate.

## Emergency Services

In this indicator, OIG clinicians evaluated the quality of emergency medical care. Our clinicians reviewed emergency medical services by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardio-pulmonary 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.

Overall Rating
<b>Inadequate</b>
Case Review Rating
<b>Inadequate</b>
Compliance Score (N/A)

## Results Overview

LAC performed poorly in emergency services. In Cycle 7, OIG clinicians identified more deficiencies than were identified in Cycle 6. Previously identified patterns continued, and we found additional notable concerns. Nurses did not always perform appropriate emergency care related to basic life support (BLS) CPR. Nurses did not prioritize AED placement when their patients required CPR. As found in Cycle 6, LAC's quality review process did not identify its nurses' deficiencies. Subsequently, opportunities to provide staff with training and education were also missed. Considering all the above issues, we rated this indicator **inadequate**.

### Case Review Results

We reviewed 36 urgent emergent events and found 50 emergency-related deficiencies. Of these 50 deficiencies, 22 were significant.<sup>26</sup>

#### Emergency Medical Response

Health care staff promptly responded to most medical emergencies. Custody staff frequently initiated CPR and administered naloxone when an overdose was suspected.<sup>27</sup>

Of the 21 medical responses we reviewed, 13 events occurred as the result of a medical alarm activation. In the other eight events, nursing or custody staff requested a TTA registered nurse's (RN) assistance by phone. Of the 21 events reviewed, delays were identified in two cases, which are discussed below:

- In case 1, this patient had chest pains, and the psychiatric technician (PT) notified the TTA RN. However, the RN did not respond to the patient immediately and inappropriately advised custody staff to escort the patient to a medical clinic. Twelve minutes later, custody

<sup>26</sup> Deficiencies occurred in cases 1–11, 19, 20, 23–26, 28, and 62. Significant deficiencies occurred in cases 1–8, 10, 19, 20, and 25.

<sup>27</sup> Naloxone is a medication used for the emergency treatment of known or suspected opioid overdose.

staff escorted the patient to the medical clinic, which was locked. Eventually, the patient was transferred to the TTA.

- In case 10, a medical alarm was activated for an unresponsive person, and custody staff was performing CPR. The TTA RN did not arrive on scene, to attend to the patient, until nine minutes later.

### **Cardiopulmonary Resuscitation Quality**

BLS is a set of emergency procedures that are performed to help sustain life in a person experiencing cardiac or respiratory arrests. The BLS sequence is important because it provides the first line of resuscitation for a person with life-threatening illnesses or injuries. The BLS sequence includes steps such as performing CPR timely, early use of an AED, and providing rescue breathing to a person who is not sufficiently breathing or does not have a pulse. The timely and correct performance of these procedures can increase the chances of survival, and reduce the risk of permanent damage to the heart and lungs. Time is of the essence, as the chance of survival decreases significantly with every minute that passes. It is important to note that administration of naloxone should not delay the initiation of CPR in a suspected opioid overdose, as CPR should be started immediately, regardless of the suspected cause.

We reviewed eight cases in which cardiopulmonary resuscitation was initiated. Custody staff began CPR in four of the eight cases and administered naloxone to three patients. In addition, staff activated the 9-1-1 system from the scene.

We identified several deficiencies related to patients who were not responsive and required CPR. In 50 percent of the events in which staff performed CPR, the medical staff did not follow the BLS sequence of events. Instead, they prioritized administering multiple doses of nasal naloxone, prior to placement of the AED.<sup>28</sup> In addition, when patients had a return of spontaneous circulation, nurses did not always promptly assess their patients. The following are examples:

- In case 5, health care staff did not promptly attach an AED during CPR. Instead, three doses of nasal naloxone were administered. An AED was not applied to the patient for eight minutes.
- In case 7, health care staff performed CPR and administered nasal naloxone for a suspected opioid overdose. However, nurses did not assess the patient's vital signs, including respiratory rate for 11 minutes. Fortunately, the patient had a return of spontaneous circulation.
- In case 8, custody staff had administered two doses of nasal naloxone and initiated CPR. However, when the first medical responder arrived on the scene, the responder administered two additional

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<sup>28</sup> According to the manufacturer, nasal naloxone doses can be safely administered every two to three minutes. CCHCS emergency medical training allows nurses to administer five nasal naloxone doses when an opioid overdose is suspected.

doses of naloxone prior to attaching an AED. In cases 4 and 7, we found similar delays.

### **Provider Performance**

Providers performed adequately in urgent and emergent events. They were available for consultation from TTA staff. The providers made appropriate decisions, transferred patients to a community hospital when necessary, and generally documented these events thoroughly. Our clinicians identified two deficiencies related to providers not documenting a progress note for an emergency event.<sup>29</sup>

### **Nursing Performance**

Nurses had opportunities for improvement in the areas of BLS, CPR-related care and assessment, interventions, and planning. The following cases offer examples:

- In case 1, the patient arrived in the TTA with abdominal pain. The nurse did not subjectively assess the location of the abdominal pain and did not palpate the abdomen for tenderness.
- In case 25, the patient with a history of ulcerative colitis arrived in the TTA with complaints of dizziness, rectal bleeding, and a headache.<sup>30</sup> The patient's heart rate was elevated, which led to concern over dehydration. However, the nurse did not perform thorough subjective and objective assessments, and reassess the patient's elevated heart rate prior to discharge.
- In cases 3, 7, and 10, nurses did not check the patients' blood sugar levels when their conditions warranted.

### **Nursing Documentation**

Nurses generally documented their urgent and emergent events. However, we identified areas in which documentation was less than adequate.<sup>31</sup> Examples of documentation deficiencies included naloxone administration discrepancies, inaccurate time-line occurrences, and inconsistent activities. The following cases offer examples:

- In case 8, the nurse responded to a medical emergency for a patient with a suspected overdose. Multiple time-line discrepancies were identified. The nurse documented that five doses of nasal naloxone were administered; however, the nurse documented administering the first dose before the nurse's arrival to the patient. The first responder nurse also did not document providing positive pressure

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<sup>29</sup> Deficiencies occurred in cases 10 and 25.

<sup>30</sup> Ulcerative colitis is a chronic inflammatory bowel disease that causes inflammation and ulcers in the intestines.

<sup>31</sup> Deficiencies in TTA nursing documentation occurred in cases 3–5, 7–10, 19, 23, 25, and 28.

ventilations, but instead documented respiratory interventions that occurred later, and by a different nurse.

- In case 9, nursing staff performed CPR, and emergency medical services personnel (EMS) pronounced the patient's death. However, the nurse incorrectly documented CPR efforts were discontinued before EMS had arrived.

### **Emergency Medical Response Review Committee**

Compliance testing showed that events were either not reviewed timely, were not reviewed at all, or the incident package was incomplete (MIT 15.003, zero). Our clinicians found that supervising RNs (SRNs) frequently completed the Emergency Response and Unscheduled Transport Event Checklist form, and designated nursing and physician staff members also conducted clinical reviews. Even so, OIG clinicians found in four of the 18 events a clinical review was not completed. Also, on four of the completed event checklists, the SRN did not accurately record the time line of events. Finally, none of the clinical reviews conducted by LAC captured any of the multiple opportunities for improvement identified by our clinicians. The following two cases provide examples:

- In case 5, the nursing staff did not prioritize placement of the AED during CPR. Three doses of nasal naloxone were administered prior to placement of the AED. Clinical reviews conducted by the health care staff did not identify this significant opportunity for improvement.
- In case 7, an SRN completing the Emergency Response and Unscheduled Transport Event Checklist did not identify the responding licensed vocational nurse (LVN) as the health care first responder. This subsequently resulted in an inaccurate time line of events. In addition, none of LAC's health care staff who performed clinical reviews identified the SRN's time-line inaccuracies or the clinical opportunities for improvement. Time-line inaccuracies were also identified in cases 5, 8, and 10.

### **Clinician On-Site Inspection**

OIG clinicians toured the TTA and interviewed an RN. They learned that the TTA was staffed with two RNs on each shift. In the TTA, there were four separate areas to provide patient care. Two of these were designated for emergencies; the other two were designated for observation and urgent care. There was an assigned provider during regular business hours; otherwise, an on-call provider was available by telephone.

The TTA nurses had two institutional radios, one for each of the RNs. A custody officer was assigned to the TTA and also served as an escort for the TTA RN. According to the nurse our clinicians interviewed, the TTA-assigned custody officer had keys to every gate, and there were no challenges when having to respond and move past multiple gates.

Nursing supervisors indicated that LAC's AEDs and vital signs machines were not capable of directly synchronizing with and transmitting data into the patients' electronic health records.

During our interview with the SRN III, we learned that she had also identified challenges in the emergency responses: the inaccuracy of the data recorded on emergency clinical review checklists and supervisors' failures to identify deviations from the required standards of care. The SRN III reported providing ongoing education to the nursing supervisors on this process. The SRN III also shared the intent to improve emergencies by implementing "code teams," whereupon when assuming a shift, nursing staff would be assigned a specific role in the event of an emergency to reduce confusion and expedite care delivery.

While on-site, our clinicians reviewed emergency medical response program (EMRP) training records that indicated LVN first medical responders had been trained in the placement of an airway adjunct.<sup>32</sup> Yet during our discussions with nursing supervisors, they indicated that, during the EMRP training, instructors advised that LVNs should not perform this intervention pending further clarification. However, during our visit, nursing supervisors reported receiving direction which indicated an LVN first responder could initiate an airway adjunct. Subsequently, nursing leadership planned to conduct training with their LVNs.

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<sup>32</sup> An airway adjunct is a device that is inserted in the nose or mouth to assist with providing adequate oxygenation and ventilation as part of resuscitation efforts.

## ***Recommendations***

- Nursing leadership should ensure nursing supervisors are trained on accurately completing the emergency medical response review checklist. In addition, nursing and medical leadership should audit LAC's emergency events to ensure nursing supervisors and providers are identifying opportunities for improvement.
- The institution should consider replacing current AEDs with models that include reporting features or EHRS synchronization.
- The institution should consider replacing vital signs equipment with models capable of synchronizing data with the EHRS.

## 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	<b>Adequate</b>
Case Review Rating	<b>Adequate</b>
Compliance Score	<b>Proficient (85.0%)</b>

### Results Overview

Overall, LAC staff managed health information well. Staff performed very well in retrieving and scanning hospital records, diagnostic tests, and pathology reports. Nurses and providers recorded urgent and emergent events thoroughly. However, staff performed poorly with receiving or reviewing specialty reports. Taking all aspects of LAC's performance in this indicator, we rated this indicator **adequate**.

### Case Review and Compliance Results

During the period of review, our clinicians found 56 deficiencies related to health information management, three of which were significant.<sup>33</sup>

#### Hospital Discharge Reports

LAC performed well in retrieving and scanning hospital records. Compliance testing found that LAC staff scanned most hospital discharge records within required time frames (MIT 4.003, 90.0%). Most discharge records included the important physician discharge summary, and providers endorsed reports within five days (MIT 4.005, 84.0%). Our clinicians reviewed 14 hospital events and identified one deficiency related to late endorsement, which is described in the following example:

- In case 62, a provider did not endorse a hospital record until eight days after the record was scanned into the medical record.

#### Specialty Reports

LAC performed poorly in receiving or reviewing the high-priority, medium-priority, and routine-priority specialty reports within required time frames (MIT 14.002, 21.4%, MIT 14.005, 7.1%, and MIT 14.008, 46.7%). LAC also needs improvement in scanning specialty reports as compliance testing showed that 63.3 percent of specialty reports were scanned within the required time frame (MIT 4.002). Our clinicians reviewed 110 specialty reports and identified two reports that were not retrieved, one report that was retrieved late, and one report

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<sup>33</sup> Deficiencies occurred in cases 1–3, 9, 12, 13, 17, 18, 20–23, 25–29, 40, 42, 45–48, 57, 58, 62, and 63. Significant deficiencies occurred in cases 1, 28, and 63.

that was endorsed late. These deficiencies are discussed in the **Specialty Services** indicator.

### **Diagnostic Reports**

Compliance testing showed providers endorsed most radiology and laboratory reports timely (MIT 2.002, 80.0% and MIT 2.005, 100%). Our clinicians identified a lack of endorsement of one radiology report, and late endorsements of two radiology reports, two laboratory reports, and two EKGs.

Providers performed poorly in thoroughly communicating the results of radiology studies or laboratory tests to their patients (MIT 2.003, 30.0% and MIT 2.006, 20.0%). Our clinicians also identified 23 deficiencies related to insufficient communication of radiology or laboratory tests to patients. These deficiencies are discussed in the **Diagnostic Services** indicator.

LAC performed proficiently in retrieving pathology reports (MIT 2.010, 90.0%). The providers endorsed most pathology reports within required time frames (MIT 2.011, 90.0%), but did not send pathology result letters to their patients within required time frames (MIT 2.012, zero). Our clinicians reviewed two events associated with pathology reports and found one pathology report not retrieved and one pathology report in which a letter was not sent.

### **Urgent and Emergent Records**

Our clinicians reviewed 36 emergency care events and found that nurses and providers recorded these events sufficiently. However, we identified one deficiency in which staff did not document the AED analysis during an emergent event.

### **Scanning Performance**

LAC performed very well with the scanning process. Compliance testing showed that the institution scanned, labeled, and named medical files accurately (MIT 4.004, 87.5%). Our clinicians identified one incorrectly labeled specialty report.<sup>34</sup>

### **Clinician On-Site Inspection**

LAC medical record staff scanned records as they received them. Staff stated that most patients returning from community hospitals had their hospital records with them. TTA nurses were instructed to contact the hospital directly for any missing hospital records.

For on-site specialty reports, on-site specialty nurses scanned the reports on the same day the visit occurred. For off-site specialty reports, medical record staff scanned handwritten reports on the day the visit occurred and the formal specialty reports as they received them. Specialty nurses also contacted the specialists directly for any missing specialty reports.

<sup>34</sup> A deficiency occurred in case 23.

## 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) *	19	11	15	63.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	18	2	5	90.0%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	21	3	0	87.5%
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) *	21	4	0	84.0%
Overall percentage (MIT 4): 85.0%				

\* 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.

**Table 10. Other Tests Related to Health Information Management**

<b>Compliance Questions</b>	<b>Scored Answer</b>			
	<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Yes %</b>
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	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 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) *	9	1	0	90.0%
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)	0	10	0	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	3	11	1	21.4%
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) *	1	13	1	7.1%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	7	8	0	46.7%

\* 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. Our case review clinicians do not rate this indicator.

Overall Rating
<b>Inadequate</b>
Case Review Rating (N/A)
Compliance Score
<b>Inadequate (37.9%)</b>

### Results Overview

In this cycle, multiple aspects of LAC's health care environment needed improvement: medical supply storage areas in and outside the clinics contained expired medical supplies; EMRB logs were missing staff verification or inventory was not performed; several clinics did not meet the requirements for essential core medical equipment and supplies; and staff did not regularly sanitize their hands before and after examining, or performing invasive procedures on, patients. These factors resulted in an **inadequate** rating for this indicator.

### Compliance Testing Results

#### Outdoor Waiting Areas

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

#### Indoor Waiting Areas

We inspected indoor waiting areas. Health care and custody staff reported existing waiting areas contained sufficient seating capacity (see Photo 1). During our inspection, we did not observe overcrowding in any of the clinics' indoor waiting areas.

#### Clinic Environment

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

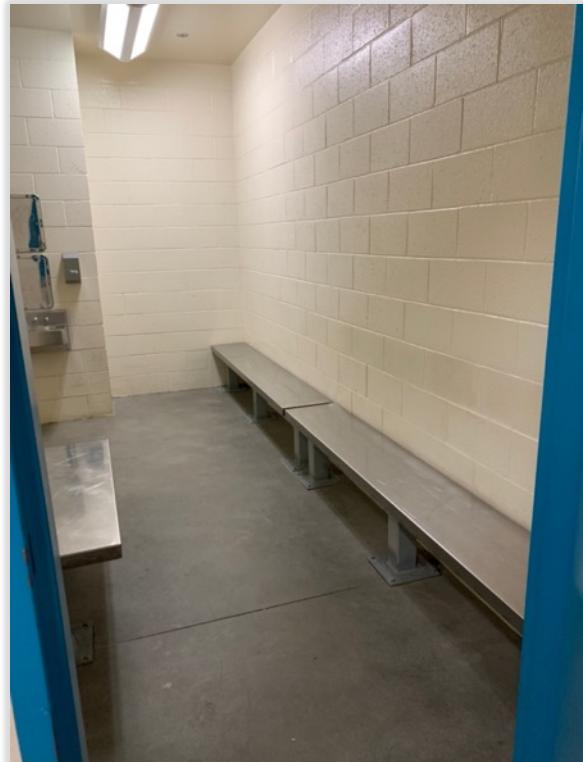


Photo 1. Indoor waiting area (photographed on 1-10-23).

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%). The remaining four clinics had one or more of the following deficiencies: the examination room lacked auditory and visual privacy for conducting clinical examinations; nurses in the clinic's triage area conducted examinations on two patients at the same time and did not provide auditory and visual privacy for the patients during their clinical encounters (see Photo 2); examination room chairs and tables had torn covers; and clinics had unsecured confidential medical records.



Photo 2. The clinic's triage area did not provide auditory and visual privacy (photographed on 1-9-23).

### Clinic Supplies

Only one of the nine clinics followed adequate medical supply storage and management protocols (MIT 5.107, 11.1%). We found one or more of the following deficiencies in eight clinics: expired medical supplies (see Photo 3 and Photo 4, next page); unidentified or inaccurately labeled medical supplies; cleaning materials stored with medical supplies; staff members' food stored with medical supplies (see Photo 5, page 40); medical supplies stored directly on the floor; and compromised medical supply packaging (see Photo 6, page 40).



Photo 3. Expired medical supplies dated September 2022 (photographed 1-11-23).

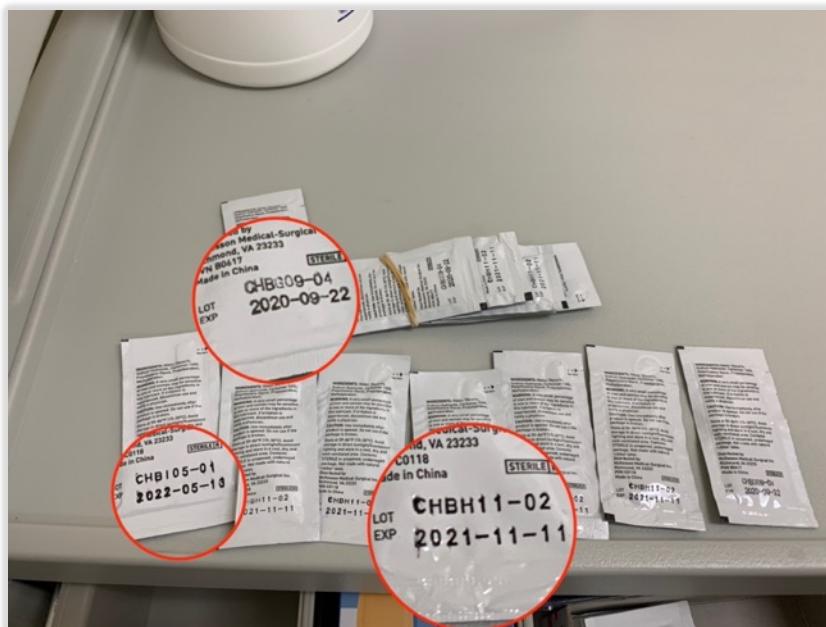


Photo 4. Expired medical supplies dated between September 2020 and May 2022 (photographed on 1-11-23).

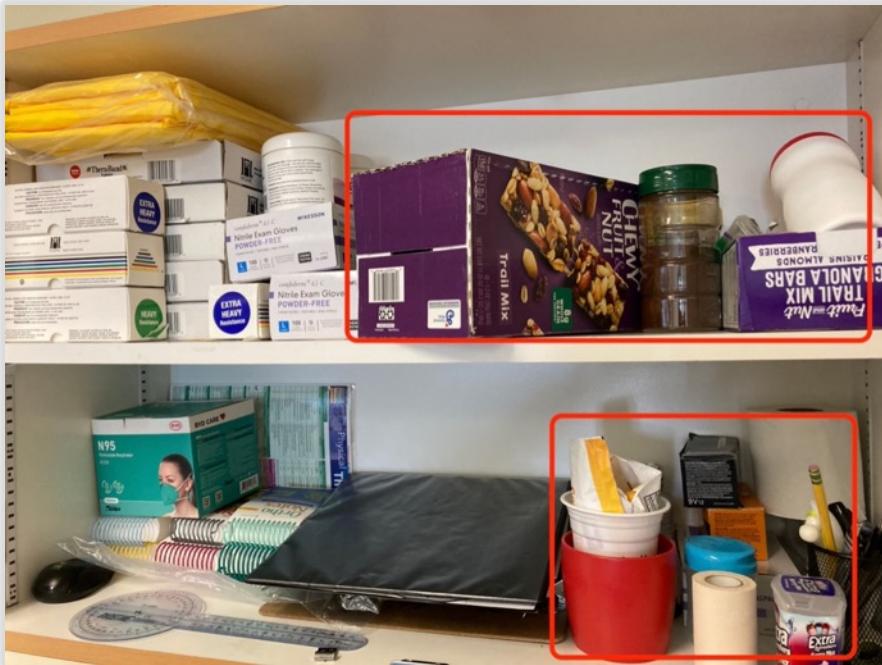


Photo 5. Staff members' food stored with medical supplies (photographed on 1-11-23).



Photo 6. Compromised medical supply packaging (photographed on 1-9-23).

None of the nine clinics met the requirements for essential core medical equipment and supplies (MIT 5.108, zero). We found one or more of the following deficiencies in all nine clinics: examination-table paper was missing; staff either did not perform daily performance checks of the AED or did not complete the defibrillator performance test log documentations within the last 30 days; clinic daily glucometer quality control logs were incomplete; and oto-ophthalmoscopes were not functioning.

We examined EMRBs to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only one of the seven EMRBs passed our test (MIT 5.111, 14.3%). We found one or more of the following deficiencies with six of the EMRBs: staff failed to ensure the EMRBs' compartments were sealed and intact; staff had not thoroughly inventoried the EMRBs in the previous 30 days; staff failed to log EMRB daily glucometer quality control results; and the treatment cart in the CTC had a nonfunctional laryngoscope resulting from no available batteries at the time of the OIG's inspection.

### Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). We found expired medical supplies (see Photo 7, right); medical supplies stored directly on the floor (see Photo 8, next page); and medical supplies stored under the leaking roof of the medical warehouse (see Photo 9, next page).

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



Photo 7. Expired medical supplies dated November 2021 (photographed on 1-9-23).



Photo 8. Medical supplies stored directly on the floor (photographed on 1-9-23).

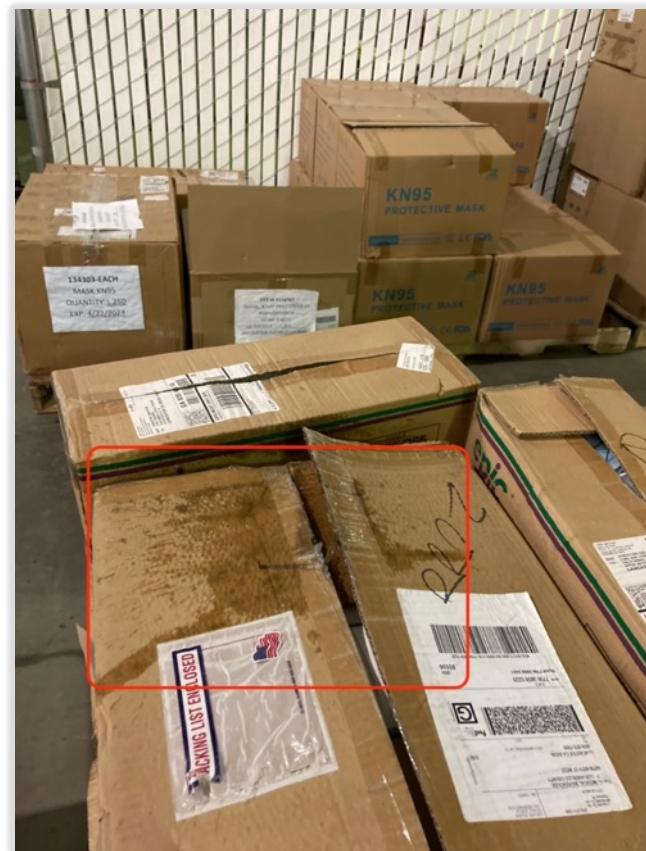


Photo 9. Medical supplies stored underneath a leaking roof in the medical supply warehouse (photographed on 1-9-23).

## **Infection Control and Sanitation**

Staff appropriately cleaned, sanitized, and disinfected seven of nine clinics (MIT 5.101, 77.8%). In one clinic, a patient restroom was unsanitary. In another clinic, the gurney was unsanitary and rusty.

Staff in one of nine clinics properly sterilized or disinfected medical equipment (MIT 5.102, 11.1%). In eight clinics, we found one or more of the following deficiencies: staff did not mention disinfecting the examination table as part of their daily start-up protocol; examination table disposable paper was not removed and replaced in between patient encounters; staff did not routinely log previously sterilized reusable invasive medical equipment; staff did not date stamp and initial the packaging of sterilized medical equipment; and staff did not clean and disinfect reusable noninvasive medical equipment after each patient use.

We found operating sinks and hand hygiene supplies in the examination rooms in three of nine clinics (MIT 5.103, 33.3%). In five clinics, patient restrooms lacked either antiseptic soap or disposable hand towels. The remaining clinic had a nonfunctional examination room sink.

We observed patient encounters in eight clinics. In six clinics, clinicians did not wash their hands before or after examining their patients, before applying gloves, or before performing blood draws (MIT 5.104, 25.0%).

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, staff did not mention following an adequate disinfecting process when medical equipment came into contact with biohazardous waste.

## **Physical Infrastructure**

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

- Project D3: Construction of a new medication distribution room at D Yard Housing Unit 3 that began in December 2022 and was expected to be completed by October 2023.
- Projects D4 and D5: Construction of new medication distribution Rooms at D Yard Housing Units 4 and 5 that will begin in February 2023 and July 2023, respectively. The projects are expected to be completed by January 2024 and June 2024 . The health care managers reported a delay of project completions due to the COVID-19 pandemic.

- Upcoming Project: At the time of inspection, the CEO reported that construction of a new pharmacy was still awaiting a construction start date.

Despite the delay of Projects D4 and D5 described above, the CEO did not believe this negatively impacted the institution's current ability to provide good patient care (MIT 5.999).

## Compliance Testing Results

**Table 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)	7	2	1	77.8%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	1	8	1	11.1%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	3	6	1	33.3%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	2	6	2	25.0%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	8	1	1	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)	1	8	1	11.1%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	0	9	1	0
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	9	0	1	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	5	4	1	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)	1	6	3	14.3%
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): 37.9%				

\* 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 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 staff properly store medical supplies in medical supply storage areas.
- Nursing leadership should consider performing random spot checks to ensure staff follow equipment and medical supply management protocols.
- Nursing leadership should direct each clinic nurse supervisor to review the monthly EMRB and treatment cart logs to ensure that the EMRBs and treatment carts are regularly inventoried and sealed.

## Transfers

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

Overall Rating	<b>Inadequate</b>
Case Review Rating	<b>Inadequate</b>
Compliance Score	<b>Inadequate</b> (42.7%)

## Results Overview

LAC performed poorly in the transfer process. For patients transferring into the institution, initial nursing assessments were generally incomplete and reconciliation of orders from the sending institution was often missed. For patients transferring out of the institution, the required documents frequently did not have pertinent information. For patients returning from the hospital, the receiving nurses did not consistently perform thorough assessments. The OIG rated this indicator **inadequate**.

### Case Review and Compliance Testing Results

We reviewed 48 events in 21 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 21 deficiencies, six of which were significant.<sup>35</sup>

#### Transfers In

The transfer-in process had a mixed performance. OIG clinicians reviewed 11 events in four cases in which patients transferred into the facility from other institutions. We identified five deficiencies, one which was significant.<sup>36</sup> Most of the deficiencies were related to poor reconciliation of orders from the sending institutions. Examples of transfer deficiencies are listed below:

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<sup>35</sup> Deficiencies occurred in cases 2, 3, 20, 23–26, 28, 31, 33, 36, and 61–63. Significant deficiencies occurred in cases 20, 23, 25, 31, and 62.

<sup>36</sup> Deficiencies occurred in cases 31, 33, 63. Case 31 had a significant deficiency.

- In case 31, the patient refused COVID-19 testing prior to transfer. When the patient arrived at LAC, the R&R nurse did not initiate a COVID-19 quarantine; instead, the patient was released to general housing.
- In case 33, the sending institution placed an order for a time-study laboratory test. However, LAC staff did not timely reconcile the order, and the test was completed eight days late.

The compliance team found that nurses who performed an initial intake assessment were not thorough (MIT 6.001, zero). Frequently, the patient responses warranted additional nursing inquiry, but this did not occur. Also, staff did not always obtain complete vital signs assessments. In addition, nurses did not always complete all sections of the assessment and disposition portion of the initial health screening form (MIT 6.002, 72.0%).

The compliance team found poor medication transfer continuity (MIT 6.003, 21.1%). Compliance testing also showed room for improvement in ensuring newly arrived patients were seen by a provider within required time frames (MIT 1.002, 75.0%). In contrast, our clinicians did not identify any medication continuity concerns or delayed provider appointments.

Compliance testing also showed patient layovers frequently did not receive their medications (MIT 7.006, 33.3%).

### **Transfers Out**

LAC's transfer-out process had a varied performance. OIG clinicians reviewed seven transfer-out cases and found four deficiencies, one of which was significant.<sup>37</sup> Compliance testing found that patients who transferred out of the institution often had their medications and required documents (MIT 6.101, 77.8%). However, OIG clinicians determined that the required documents did not always include pertinent details for transfer. Examples are seen in the following cases:

- In cases 2 and 36, prior to the patients' transfers, nurses did not obtain a complete set of vital signs.
- In cases 36 and 62, the patients were transferred to another institution; however, a nurse did not accurately complete interfacility documentation to include all pending specialist appointments.

### **Hospitalizations**

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

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<sup>37</sup> Deficiencies occurred in cases 2, 36, and 62. A significant deficiency occurred in case 62.

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

LAC's hospitalization transfer process was unsatisfactory. The OIG clinicians reviewed 27 events that occurred in 13 cases for patients who were treated at a community hospital. We identified 13 deficiencies, four of which were significant.<sup>38</sup>

LAC generally provided follow-up appointments within required time frames to patients returning from hospitalizations and emergency room visits (MIT 1.007, 76.0%). Compliance testing found that, frequently, discharge documents were scanned into the electronic health record within the required time frame (MIT 4.003, 90.0%); however, at times, the discharge documentation was not timely reviewed by the providers, and in one sample, was not reviewed at all. Case reviewers' findings were similar to compliance testing results, and in addition, we found that, at times, hospital recommendations were not addressed. Case reviewers also found that nurses who evaluated patients did not consistently provide thorough assessments. Examples are seen in the follow cases:

- In case 20, the patient returned to LAC after a community hospital emergency room (ER) visit and had a low heart rate. The nurse did not recheck the heart rate and did not perform a thorough assessment. Moreover, the nurse did not initiate a provider visit within one day as recommended by the ER physician.
- In cases 20, 25, 28, and 61, nurses did not provide thorough assessments in relation to the discharge diagnoses upon the patients' return from the hospital.

Compliance testing showed significant lapses in the continuity of medication upon patients' return to the institution (MIT 7.003, 40.0%). However, case reviewers found medication continuity satisfactory.

### **Clinician On-Site Inspection**

During the tour of the R&R area, OIG clinicians interviewed the assigned R&R nurse who reported being in the position for three weeks. Although the nurse was newly assigned to the role, this individual was knowledgeable concerning the processes, and described what a typical day and week looked like in relation to transfers. The R&R nurse stated there was one RN staffed on each shift, and all were responsible for transfer in and out processes. The nurse reported receiving a list of patients who were scheduled for transfer from custody, with revisions made throughout the week. The nurse also reported the average number of patients transferring varied, with a weekly average of 30 to 50 patients transferring in and an average of 20 to 30 patients transferring out.

The R&R nurse detailed the transfer-out process, which included interviewing the patient prior to the day of transfer to review durable medical equipment,

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<sup>38</sup> Deficiencies occurred in cases 2, 3, 20, 23–26, 28, 61, and 62. Significant deficiencies occurred in cases 20, 23, and 25.

medical holds, and specialty appointments; to schedule COVID-19 testing; and to contact the provider for any unmet needs. In addition, on the day of transfer, the nurse reported validating all previous information and reviewing for any changes, as well as medicating patients prior to their departure.

The nurse communicated there was a team effort with delineated shift duties, and staffing support from leadership when indicated.

## Compliance Testing Results

**Table 12. Transfers**

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	0	25	0	0
For endorsed patients received from another CDCR institution: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	18	7	0	72.0%
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	4	15	6	21.1%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	7	2	0	77.8%
Overall percentage (MIT 6): 42.7%				

\* 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**

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	18	6	1	75.0%
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) *	19	6	0	76.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	18	2	5	90.0%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	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) *	10	15	0	40.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	15	10	0	60.0%
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) *	3	6	0	33.3%
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	15	0	25.0%

\* 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***

- Nursing leadership should develop and implement internal auditing of staff to ensure complete and thorough assessments of patients transferring into the institution or patients returning from hospitalizations.
- Nursing leadership should educate R&R nurses to completely answer and address required initial health screening questions.

## 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
<b>Inadequate</b>
Case Review Rating
<b>Inadequate</b>
Compliance Score
<b>Inadequate (55.4%)</b>

### Results Overview

LAC generally performed poorly in this indicator. The institution also performed poorly in hospital discharge, specialized medical housing, and transfer medications. The OIG rated this indicator *inadequate*.

### Case Review and Compliance Testing Results

We reviewed 148 events related to medications and found 29 medication deficiencies, nine of which were significant.<sup>39</sup>

#### New Medication Prescriptions

LAC compliance testing showed insufficient performance in ensuring newly prescribed medications were issued to patients (MIT 7.002, 68.0%). Case review found three cases in which there was a lack of continuity of a newly prescribed medication.<sup>40</sup> The following case provides an example:

- In case 26, a newly prescribed antidepressant was not immediately available for administration.

#### Chronic Medication Continuity

Compliance testing found that chronic care medications were either not made available within the required timeframes, or the institution did not follow policy for refusals (MIT 7.001, 11.8%). Our clinicians found 11 cases with a lapse in chronic care medication continuity.<sup>41</sup> The following cases provide examples:

- In cases 3 and 9, diabetic patients were prescribed insulin. However, the patients frequently did not receive insulin due to ordering errors.

<sup>39</sup> Deficiencies occurred in cases 1–3, 9–11, 16, 18, 22, 25, 26, 28, 36, and 61. Cases 1, 3, 9, 18, 26, and 61 had significant deficiencies.

<sup>40</sup> Cases 16, 18, and 26 showed lapses in newly prescribed medication continuity.

<sup>41</sup> Cases 1–3, 9, 10, 11, 18, 22, 25, 26, and 61 showed a lapse in chronic care medication continuity.

- Also in case 9, the patient did not receive his chronic care cholesterol medication. Although the medication was prescribed as being an automatic refill, a nurse documented that the patient had not requested a refill, with the result being the medication was not issued to the patient for a month.
- In case 10, nurses documented the patient did not show for administration of a chronic care medication; however, nurses administered other medications that were scheduled at the same time.
- In case 18, the patient was prescribed a medication to improve neuromuscular function; however, the pharmacy was only issuing a 30-day medication supply every 45 days. This pharmacy error occurred before, during, and after the review period.
- In case 25, the patient was prescribed an injectable immuno-suppressive medication every two weeks for the treatment of an inflammatory bowel disease. However, the provider did not ensure timely renewal. In addition, when it was renewed, the nurses did not administer the medication or obtain a refusal. The patient did not receive the medication for 32 days.

### **Hospital Discharge Medications**

Compliance testing revealed a variety of concerns with continuity of hospital medications. On several occasions, patients missed doses, or the pharmacy did not make the medication available for administration (MIT 7.003, 40.0%). Our clinicians found one deficiency related to missed doses of medications upon the patient's return from the hospital.<sup>42</sup>

### **Specialized Medical Housing Medications**

LAC performed poorly in assuring medications were available and administered timely (MIT 13.003, 50.0%). Our clinicians also found similar findings in two cases.<sup>43</sup> In addition, clinicians found that nurses frequently administered cardiac medications without first obtaining their patients' blood pressure and pulse readings. This situation is further discussed in the **Specialized Medical Housing and Nursing Performance** indicators.

### **Transfer Medications**

Compliance testing showed that patients who arrived at LAC had poor medication continuity (MIT 6.003, 21.1%). In contrast, our clinicians did not identify concerns with medication continuity of transfer patients. Compliance testing also showed there were opportunities for improvement when patients transferred within LAC (MIT 7.005, 60.0%) and had layovers (MIT 7.006, 33.3%).

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<sup>42</sup> A deficiency occurred in case 3.

<sup>43</sup> Deficiencies occurred in cases 26 and 61.

## Medication Administration

LAC performed poorly in ensuring TB medication continuity and did not ensure that its patients were sufficiently monitored (MIT 9.001, 54.6% and MIT 9.002, 10.0%). Our clinicians also identified one case in which medications were not monitored sufficiently as described below:

- In case 1, the patient was prescribed nitroglycerin to self-administer as needed for chest pains. During our six-month period of review, the patient requested and received 375 pills (25 pills, on 15 occasions). Frequent use of this medication could indicate a worsening cardiac issue. The high usage was not addressed by health care staff.

## Clinician On-Site Inspection

OIG clinicians interviewed medication nurses and found they were knowledgeable about the medication administration process. We learned that in Facility D, for Units One and Two, medication administration areas were located within the housing units; whereas for Units Three and Four, patients went to a separate location to receive their medications. Although medication administration nurses did not always attend huddles, the care teams discussed medication compliance, including medication nonadherence, and medication continuity for patients transferring into the institution, arriving from another yard, or returning from the hospital. In addition, nursing supervisors indicated that nurses provided education to patients who missed or refused two doses of medications.

Our clinicians also met with the pharmacist in charge (PIC), who thoroughly answered our questions and seemed knowledgeable about medication-related processes. During the clinician on-site inspection, we discussed cases involving incorrectly ordered regular insulin sliding-scale orders with directions to administer “as needed.”<sup>44</sup> This error resulted in patients not receiving insulin as intended. The PIC and the nursing supervisor indicated they had identified additional patients whose records showed similar errors, and they were actively addressing these orders. In addition, they indicated providers and pharmacy staff had received training. Our clinicians also discussed the refill process for nitroglycerin orders that were prescribed “as needed.” The PIC indicated that there was not an alert to either pharmacy staff or the ordering provider when patients made frequent requests for nitroglycerin. The PIC recognized the concern and indicated he would train his pharmacist to check for frequent refills, as well as to consult a provider and to consider other possible solutions.

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<sup>44</sup> An insulin sliding-scale order is a set of instructions for administering a specific amount of insulin based on the patient’s blood glucose reading or test result.

## Compliance Testing Results

### Medication Practices and Storage Controls

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

LAC appropriately stored and secured nonnarcotic medications in five of 10 clinic and medication line locations (MIT 7.102, 50.0%). In five locations, we observed one or more of the following deficiencies: the medication storage cabinet was disorganized; the medication area lacked a clearly labeled designated area for medications that were to be returned to the pharmacy; and nurses did not maintain unissued medication in its original labeled packaging.

Staff kept medications protected from physical, chemical, and temperature contamination in four of the 10 clinic and medication line locations (MIT 7.103, 40.0%). In six 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; the medication refrigerator was unsanitary; and staff members' personal food was stored with medications.

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

Nurses did not exercise proper hand hygiene and contamination control protocols in all of six applicable locations (MIT 7.105, zero). In the six locations, some nurses neglected to wash or sanitize their hands before preparing and administering medications, prior to donning gloves, before each subsequent regloving, or after intentionally touching the patient's skin.

Staff in two of six medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 33.3 %). In four locations, medication nurses did not describe the process they followed when reconciling newly received medication and the medication administration record (MAR) against the corresponding physician's order.

Staff in five of six medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 83.3%). In one location, medication nurses did not distribute medications to patients within the time frame of one hour before or one hour after the normal distribution time.

### Pharmacy Protocols

LAC followed general security, organization, and cleanliness management protocols in its pharmacy (MIT 7.108, 100%).

In its main pharmacy, staff did not properly store nonrefrigerated medication. Staff stored food items within the medication preparation area. As a result, LAC received a score of zero in this test (MIT 7.109).

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

The PIC correctly accounted for narcotic medications stored in LAC's pharmacy (MIT 7.111, 100%).

We examined 14 medication error reports. The PIC timely or correctly processed only three of these 14 reports (MIT 7.112, 21.4%), but had no evidence a pharmacy error follow-up review was performed for the other 11 reports.

### **Nonscored Tests**

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

The OIG interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Of 19 applicable patients interviewed, 12 indicated they had access to their rescue medications. Seven patients reported they did not have their prescribed rescue inhaler. Four patients stated the medication was taken away when they were transferred to the restricted housing unit. One patient stated his medication was not reissued upon returning from the hospital. Another patient stated that, for the past month, he had asked the provider and the medication nurse to provide his medication without success, and a third patient stated his medication was never given to him. We promptly notified the CEO of this concern, and health care management immediately issued replacement rescue medications to the patients (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	15	8	11.8%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	17	8	0	68.0%
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) *	10	15	0	40.0%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004) *	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	15	10	0	60.0%
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) *	3	6	0	33.3%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	9	0	2	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	5	5	1	50.0%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	4	6	1	40.0%
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)	9	0	2	100%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	0	6	5	0
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	2	4	5	33.3%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	5	1	5	83.3%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	1	0	0	100%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	3	11	0	21.4%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
Overall percentage (MIT 7): 55.4%				

\* 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 15. Other Tests Related to Medication Management**

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	4	15	6	21.1%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	7	2	0	77.8%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	6	5	0	54.6%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	1	9	1	10.0%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003) *	5	5	0	50.0%

\* 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 institution should consider developing and implementing measures to ensure that staff timely make available and administer medications to patients and that staff document accordingly in the EHRS as described in CCHCS policy and procedures.

## Preventive Services

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

Overall Rating
<b>Inadequate</b>
Case Review Rating (N/A)
Compliance Score
<b>Inadequate (58.8%)</b>

## Results Overview

LAC had a mixed performance in preventive services. LAC performed well in screening patients annually for TB, offering patients an influenza vaccine for the most recent influenza season, and offering colorectal cancer screening for patients from ages 45 through 75. However, the institution faltered in administering TB medications as prescribed, 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, the OIG rated this indicator **inadequate**.

## 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)	6	5	0	54.6%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	1	9	1	10.0%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	20	5	0	80.0%
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)	24	1	0	96.0%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	2	14	9	12.5%
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): 58.8%				

\* 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***

- Nursing leadership should consider developing and implementing measures to ensure that nursing staff monitor patients receiving TB medications according to CCHCS guidelines.
- Medical leadership should analyze the challenges related to the untimely provision of preventive vaccines to chronic care patients and implement remedial measures as appropriate.

## Nursing Performance

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

Overall Rating
<b>Inadequate</b>
Case Review Rating

Compliance Score (N/A)
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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

The overall nursing care was insufficient. Compared with Cycle 6, we reviewed fewer nursing encounters, but found more overall and significant nursing deficiencies. In Cycle 6, nursing emergency care, assessments, interventions, and documentation showed opportunities for improvement in multiple areas. In Cycle 7, these patterns continued, revealing a further cause for concern when nurses frequently did not initiate the use of an AED when their patients required CPR. A further decline in nursing care was also found in the CTC, R&R, and in medication management practices. After taking all these factors into consideration, the OIG rated this indicator **inadequate**.

### Case Review Results

We reviewed 254 nursing encounters in 60 cases. Of the nursing encounters we reviewed, 132 occurred in the outpatient setting, and 67 were sick call requests. We identified 170 nursing performance deficiencies, 47 of which were significant.<sup>45</sup>

### Outpatient Nursing Assessment and Interventions

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

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<sup>45</sup> Deficiencies occurred in cases 1–11, 16, 18–20, 22–26, 28, 31, 33, 36, 38–40, 42, 44–48, and 50–63. Significant deficiencies occurred in cases 1–11, 19, 20, 22, 23, 25, 26, 31, 50, and 60–63.

Nurses had opportunities for improvement in their assessments and interventions. Our clinicians identified 92 outpatient nursing deficiencies, 20 of which were considered significant. These deficiencies occurred when nurses in the medical clinics did not always properly identify symptomatic sick call requests, and frequently their assessments were incomplete. Examples of incomplete assessments and interventions are listed in the following cases:

- In case 3, the patient submitted a sick call request for lower extremity pain. The nurse incorrectly indicated the request did not include symptoms and initiated an appointment to occur within 14 days, instead of on the next business day.
- In case 10, a nurse saw the patient after a TTA evaluation for chest pains. The nurses did not obtain the patient's vital signs and did not perform a physical assessment.
- In case 25, the patient with a history of ulcerative colitis had diarrhea and weakness. The sick call nurse did not obtain the patient's weight and did not assess for frequency of diarrhea. Further, the nurse did not assess the patient for signs of dehydration and did not perform an abdominal assessment.

### **Outpatient Nursing Documentation**

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. Nurses did not always document their assessment findings and interventions. Examples are listed in the following cases:

- In case 1, a TTA RN documented the patient was referred by a PT for abdominal pain. However, the PT did not document having contact with the patient and did not document a hand-off with the TTA nurse. Furthermore, on another occasion, a PT did not document the administration of nitroglycerin in the patient's MAR.
- In case 51, the nurse documented checking the patient's vital signs, but did not document the results.

### **Wound Care**

We reviewed five cases in which patients had wounds and found three deficiencies.<sup>46</sup> A deficiency example is given in the following case:

- In case 44, this diabetic patient was evaluated by a nurse for a foot laceration. The nurse did not initiate a follow-up to ensure the wound healed.

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<sup>46</sup> Deficiencies occurred in cases 1, 24, and 44.

## **Emergency Services**

We reviewed 36 urgent or emergent events and found 29 nursing deficiencies. Nurses did not always provide sufficient BLS CPR when the placement of an AED was not prioritized. In addition, TTA nurses did not perform thorough assessments and interventions. Please see the **Emergency Services** indicator for additional information.

## **Hospital Returns**

We reviewed 13 events that involved returns from off-site hospitals or emergency rooms. We identified eight deficiencies, one of which was considered significant.<sup>47</sup> Nonetheless, nurses mostly performed sufficient nursing assessments, which we detailed further in the **Transfers** indicator.

## **Transfers**

We reviewed 21 cases involving transfer-in and transfer-out processes. We found that nurses frequently did not thoroughly complete initial assessments, and when patients transferred from LAC, nurses' documentation was not always complete. Please refer to the **Transfers** indicator for further details.

## **Specialized Medical Housing**

We reviewed four cases with a total of 65 events. In the CTC, we found that, often, nurses did not thoroughly evaluate their patients and did not follow safety measures prior to administering medications. Please refer to the **Specialized Medical Housing** indicator.

## **Specialty Services**

We reviewed 26 events within 10 cases, in which nurses evaluated patients prior to or after their return from off-site specialist appointments or procedures. We identified 13 nursing deficiencies related to specialty services. We found that when patients returned without recommendations or specialist records, nurses did not attempt to obtain missing records and did not inform a provider. In addition, nurses frequently did not perform thorough assessments. Please refer to the **Specialty Services** indicator for additional details. The following case provides an example:

- In case 26, the patient had a urology procedure and returned without the specialist's records. The nurse did not attempt to obtain the recommendations and did not inform a provider.

## **Medication Management**

OIG clinicians reviewed 148 events involving medication management. Our clinicians found that nursing staff did not always follow the prescriber's orders prior to administering medications and administered medications without an

<sup>47</sup> Deficiencies occurred in cases 2, 20, 23–26, 28, and 61.

order. In addition, when patients refused several doses of medications, nurses and the primary care team did not provide education to these patients. Additional information is found above and in the **Medication Management** indicator. The following three cases provide examples:

- In case 1, on multiple occasions, PTs administered medications for chest pain without contacting a provider for an order.
- In case 3, the patient refused long-acting insulin numerous times in one month, but nurses did not educate him on the risks associated with the refusals.
- In case 22, on multiple occasions, nurses administered heart medication without first checking the patient's pulse and blood pressure.

### **Legibility**

Most provider and nursing notes were electronically entered into the patient's electronic health record. Nurses occasionally reviewed patients' health care services request forms and signed them, with the OIG clinicians identifying eight deficiencies related to an illegible name or signature of a nurse.<sup>48</sup>

### **Clinician On-Site Inspection**

On-site, our clinicians toured the facilities, and interviewed staff and supervisors. We learned that the chief nurse executive (CNE) and SRN III had been serving in acting roles for one month and three months, respectively. Previously, these leadership positions had also been filled with other staff who had also served in an acting capacity. Although neither of those leaders were in their current positions during the OIG review periods, they attempted to answer the OIG clinicians' questions thoroughly. In addition, the SRN III shared her own quality improvement process, part of which involved the institution's emergency medical response clinical review. The SRN III acknowledged that she had noted some concerns in the accuracy of the reviews and had implemented actions to improve this process.

Our clinicians attended huddles and toured LAC's CTC, TTA, R&R, medical clinics, and selected medication administration areas. During a clinic huddle, nursing supervisors indicated that any patients who missed two doses of medications were scheduled to be evaluated by nurses to receive education to improve compliance.

### **Recommendations**

- Nursing leadership should work toward improving patient care coordination with medical providers in communications about

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<sup>48</sup> Deficiencies occurred in cases 40, 42, 45–48, 57, and 58.

medication orders, patient refusals, and incomplete specialists' reports.

- The department and nursing leadership should consider resuming random audits to ensure that nursing staff properly perform and document complete assessments including vital signs and appropriate assessments. The leadership should implement remedial measures as appropriate including training of staff.
- The department and nursing leadership should consider a medication management audit that ensures nurses are safely administering medications.

## 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
<b>Adequate</b>
Case Review Rating
<b>Adequate</b>
Compliance Score (N/A)

## Results Overview

LAC providers delivered generally good care consistent with Cycle 6. They made appropriate assessments and decisions, managed chronic medical conditions effectively, reviewed medical records thoroughly, and addressed the specialists' recommendations adequately. The OIG rated this indicator **adequate**.

### Case Review Results

OIG clinicians reviewed 154 medical provider encounters and identified 25 deficiencies, eight of which were significant.<sup>49</sup> OIG physicians also rated the overall adequacy of care for each of the 25 comprehensive case reviews. Of these 25 cases, 21 were **adequate** and four were **inadequate**.

### Outpatient Assessment and Decision-Making

Providers generally made appropriate assessments and sound medical plans for their patients. They diagnosed medical conditions correctly, ordered appropriate tests, and coordinated effective treatment plans for their patients. However, there was one significant deficiency related to poor decision making.

- In case 25, the provider endorsed a laboratory test result showing a severely low hemoglobin level of 7.7 g/dL.<sup>50</sup> However, the provider did not evaluate the patient urgently for signs and symptoms of severe anemia.

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<sup>49</sup> Deficiencies occurred five times in case 25, four times in case 15, three times in case 9, twice in cases 2 and 12, and once in cases 1, 10, 17, 20, 24, 26, 29, and 33. Significant deficiencies occurred three times in case 15, twice in cases 9 and 25, and once in case 12.

<sup>50</sup> The normal hemoglobin range is from 13.2 to 17.1 g/dL. A level of 6 g/dL is a critically low level. A level of 7.7 g/dL is significant and indicates anemia, which is a low blood count. A low blood count can affect normal bodily functions.

## **Outpatient Review of Records**

For patients returned from hospitalizations, providers generally performed well in reviewing medical records and addressing hospitalists' recommendations. However, there was one significant deficiency as noted below:

- In case 25, the patient returned from the hospital with diagnoses of anemia and gastrointestinal bleed, and the hospitalist recommended to closely monitor the patient's blood count weekly for two to three weeks. However, the provider did not order the recommended weekly blood count testing.

Providers also performed well in reviewing patients' MARs and in timely renewing patients' medications. However, there were two deficiencies related to delay in renewing medications.<sup>51</sup> The following case provides an example:

- In case 15, a nurse messaged a provider that the patient's regular insulin sliding scale expired. However, there was no response from the provider. Two weeks later, a different provider renewed the insulin.

## **Emergency Care**

Providers made appropriate triage decisions when the patients arrived at the TTA for emergency treatment. In addition, providers were available for consultation with the TTA nursing staff. We identified two deficiencies related to the lack of a provider progress note for an emergent event.<sup>52</sup>

## **Chronic Care**

Providers performed well in managing chronic medical conditions such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease. For patients with diabetes, the providers regularly monitored patients' blood glucose levels and adjusted diabetic medications. However, our clinicians identified six deficiencies related to diabetic care.<sup>53</sup> The following cases provide examples:

- In case 9, the patient had poorly controlled diabetes; however, the provider did not timely adjust the patient's insulin or have the patient follow up sooner than 90 days.
- In case 15, the patient had poorly controlled diabetes; however, the provider did not review the patient's glucose log or adjust the patient's insulin as medically indicated.

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<sup>51</sup> Deficiencies occurred in cases 15 and 25.

<sup>52</sup> Deficiencies occurred in cases 10 and 25.

<sup>53</sup> Deficiencies occurred three times in cases 9 and 15.

## Specialty Services

Providers appropriately referred to specialists and reviewed specialty reports in a timely manner, and the providers also adequately addressed the specialists' recommendations. Our clinicians identified two provider deficiencies related to specialty services.<sup>54</sup> The case below provides an example:

- In case 12, the optometrist recommended to have the patient follow up in two weeks for an eye examination; however, the provider did not order the follow-up eye examination.

## Outpatient Documentation Quality

Providers generally documented outpatient encounters on the same day of the encounter. Our clinicians did not identify any deficiencies related to documentation quality.

## Patient Notification Letter

Providers performed poorly in relaying diagnostic results to their patients as the providers did not send patient letters or thoroughly communicate test results with their patients. These deficiencies are discussed in the **Diagnostic Services** indicator.

## Clinician On-Site Inspection

LAC had eight full-time providers and two and a half vacant provider positions. The providers were enthusiastic about their work and generally satisfied with nursing, diagnostic, and specialty services. The provider morning report occurred every morning of the working days; the providers discussed patients returning from the hospital and significant TTA events.

Our clinicians attended morning huddles during which the patient care team discussed the specialty appointments. Nurses informed providers of scheduled clinic appointments, expiring medications, and new arrivals coming from other institutions.

Our clinicians attended a population health management meeting for Clinic C. The medical staff discussed delays in chronic care appointments and strategized solutions to eliminate these delays. The medical staff reviewed health care measures such as hemoglobin A1c to identify patients with poorly controlled diabetes and discussed solutions to reach diabetic care goals. Medical staff also discussed preventive health screening guidelines and identified patient-required screening services such as providing colonoscopy screening.

The chief medical executive (CME) had been at LAC for one and a half years, and reported achieving success in reducing previous backlogs of provider appointments in the four main clinics. The CME noted that the biggest challenge

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<sup>54</sup> Deficiencies occurred in cases 12 and 26.

at LAC in this indicator was the ongoing concern of specialty appointment backlogs as further discussed in the **Specialty Services** indicator.

## ***Recommendations***

The OIG offers no recommendations for this indicator.

## Specialized Medical Housing

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

Overall Rating
<b>Inadequate</b>
Case Review Rating
<b>Inadequate</b>
Compliance Score
<b>Inadequate</b>
(62.0%)

## Results Overview

Compared with Cycle 6, case review found LAC had more overall and significant deficiencies. CTC nurses did not always perform thorough assessments and often administered medications without ensuring that ordered parameters were met. In addition, nurses documented conflicting information and completed a care plan without documenting the result of the task performed. Compliance testing also showed a decline, compared with Cycle 6, in medication compliance for newly admitted patients. Taking all factors into consideration, the OIG rated this indicator *inadequate*.

## Case Review and Compliance Testing Results

We reviewed four CTC cases that included 23 provider encounters and 21 nursing encounters. Due to the frequency of nursing and provider contacts in specialized medical housing, we bundled up to two weeks of patient care into a single event for review. We identified 30 deficiencies, 10 of which were significant.<sup>55</sup>

### Provider Performance

Compliance testing found that providers did not always perform timely admission history and physical examinations (MIT 13.002, 60.0%). However, in case review, providers generally delivered good care: they completed their rounds at clinically appropriate intervals, timely reviewed off-site medical records, and made appropriate medical decisions.

### Nursing Performance

Compliance testing concluded that patients admitted to the CTC received timely initial health assessments (MIT 13.001, 100%). Our clinicians discovered one instance in which the admission assessment was not completed timely and also did not include a fall risk assessment as indicated. While nurses did perform assessments, their assessments did not occur each shift and were frequently

<sup>55</sup> Deficiencies occurred in cases 26, 61, 62, and 63. Cases 26, 61, and 63 had significant deficiencies.

incomplete. OIG clinicians concluded that, of the 30 deficiencies identified in this indicator, 21 of them were directly related to the quality of nursing care. Prominent areas of concern were incomplete assessments, lack of documentation of completed care-plan tasks, and failure to implement safety measures resulting in patient harm. Examples are described below:

- In case 26, after a recent stroke, the patient with impaired mobility was admitted to the CTC. The nurse did not perform a timely admission assessment and accurately record the patient's fall risk. Unfortunately, only a few hours after admission, the patient fell, resulting in a finger fracture. Furthermore, nurses subsequently recorded additional patient falls, but did not always perform assessments and interventions.
- In case 63, the patient was admitted to the CTC after a jaw fracture and surgical repair. The patient had a limited ability to open his mouth and eat normally, which placed him at risk for aspiration.<sup>56</sup> CTC nurses developed a care plan that included assessing the patient's ability to swallow and listening to the patient's lungs before and after meals; however, nurses rarely documented the results of their assessments.

The compliance team identified that the CTC's call light system, which works to ensure patients have access to requesting health care, was not operational (MIT 13.101, zero). However, the compliance team did report health care staff were able to perform patient safety checks and access patient cells in urgent or emergent situations within a minute of receiving notice (MIT 13.102, 100%).

### **Medication Administration**

CTC nursing staff performed poorly in medication administration. Compliance testing showed 50.0 percent of newly admitted patients received their medications within required time frames (MIT 13.003). Our clinicians found in two cases, nurses did not check their patients' blood pressure and pulse readings prior to administering medication or administered medication despite orders to hold. OIG clinicians identified eight deficiencies related to medication management; five were considered significant.<sup>57</sup> The following are examples:

- In case 26, nursing staff administered metoprolol on numerous occasions without first obtaining the patient's blood pressure and pulse readings.<sup>58</sup>
- In case 61, on multiple occasions, nurses inappropriately administered medication to lower the patient's blood pressure. However, nurses frequently did not first check the patient's blood

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<sup>56</sup> Aspiration means to inhale food or liquid into the lungs.

<sup>57</sup> Deficiencies occurred three times in case 26 and 61, and once in case 63.

<sup>58</sup> Metoprolol is a blood pressure medication that can decrease blood pressure and heart rate.

pressure, or often administered the medication when the patient's blood pressure was outside the ordered parameter.

### **Clinician On-Site Inspection**

Our clinicians toured LAC's CTC, and interviewed a registered nurse and nursing supervisor. They reported there were four medically designated beds, two of which were negative pressure rooms. There were an additional 12 mental health beds located within the CTC. The nursing supervisor reported that the unit was staffed with RNs, LVNs, and PTs each shift. The nursing supervisor indicated that the medical patients were divided among the nurses caring for patients within the mental health area.

The CTC nursing supervisor described nursing expectations in the CTC; this included a thorough admission assessment and a fall risk assessment. In addition, the nursing supervisor indicated that nurses were expected to perform complete assessments each shift and to document their assessments at the time the nurses assessed the patients. Nurses also described their workflow, which included morning rounds to collect vital signs, perform nursing assessments, and administer medications. They also indicated that patients were weighed each week unless ordered more frequently. Our clinicians inquired about the "24-hour chart check" that we identified during case reviews. The nursing supervisor stated that, in this chart check, the RN is required to review all events and orders occurring in the previous 24 hours to ensure orders were accurately carried out. However, in our case reviews, we found that these 24-hour chart checks had not captured the lapses that we identified.

## Compliance Testing Results

**Table 17. Specialized Medical Housing**

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission? (13.001) *	10	0	0	100%
Was a written history and physical examination completed within the required time frame? (13.002) *	6	4	0	60.0%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003) *	5	5	0	50.0%
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101) *	0	1	0	0
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) *	1	0	0	100%
Overall percentage (MIT 13): 62.0%				

\* 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***

- Nursing leadership should ensure that CTC nurses properly document the results of their care plan assessments.
- Nursing leadership should ensure CTC medications are safely administered.

## 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	<b>Inadequate</b>
Case Review Rating	<b>Inadequate</b>
Compliance Score	<b>Inadequate</b>
(49.2%)	

### Results Overview

Overall, LAC demonstrated room for improvement in this indicator. Although the institution's staff performed well in completing the initial specialty appointments, their performance was poor in completing follow-up specialty appointments, and in scanning, retrieving, and reviewing specialty reports. Considering both the compliance score and case review rating, the OIG rated this indicator *inadequate*.

### Case Review and Compliance Testing Results

Our clinicians reviewed 136 events related to specialty services, including 110 specialty consultations and procedures, and found 30 deficiencies; six of which were significant.<sup>59</sup>

#### Access to Specialty Services

Compliance testing found that 93.3 percent of the initial high-priority specialty appointments (MIT 14.001), 66.7 percent of the initial medium-priority specialty appointments (MIT 14.004), and 80.0 percent of the initial routine-priority specialty appointments (MIT 14.007) occurred within required time frames. However, the institution performed inconsistently with follow-up specialty appointments (MIT 14.003, 30.8%, MIT 14.006, 50.0%, and MIT 14.009, 71.4%). OIG clinicians identified four significant deficiencies,<sup>60</sup> two of which are described below:

- In case 61, a provider requested a neurology appointment to occur within 14 days; however, the appointment did not occur.
- In case 62, a provider requested a plastic surgery appointment to occur within 14 days; however, the appointment did not occur.

#### Provider Performance

Providers generally referred appropriately, reviewed specialty reports within recommended time frames, and addressed specialists' recommendations. We

<sup>59</sup> Deficiencies occurred seven times in case 26, five times in case 62, three times in cases 25 and 26, twice in cases 1, 10, 23, and 29, and once in cases 2, 24, 27, and 61. Significant deficiencies occurred in cases 1, 24, 26, 61, 62, and 63.

<sup>60</sup> Deficiencies occurred in cases 24, 26, 61, and 62.

identified one deficiency when the provider did not address the podiatrist's recommendation of daily wound dressing.

### **Nursing Performance**

Specialty nurses reviewed requests for specialty services and arranged for specialty appointments. The nurses performed nursing assessments when patients returned from their specialty appointments, reviewed specialists' findings and recommendations, and communicated those results to providers. Nurses also requested provider follow-up appointments. We reviewed 26 nursing encounters related to specialty services and identified 13 deficiencies.<sup>61</sup> These deficiencies generally related to inadequate nursing assessments after patients returned from their specialty appointments. The following case offers an example:

- In case 62, the patient returned from an off-site neurology appointment; the nurse could not determine the specialist's recommendations and did not attempt to contact the specialist for clarification or to notify the provider.

### **Health Information Management**

Compliance testing showed that LAC needed to improve its performance in scanning specialty reports within required time frames (MIT 4.002, 63.3%). The institution also performed poorly in receiving or reviewing the high-priority, medium-priority, and routine-priority specialty reports within required time frames (MIT 14.002, 21.4%, MIT 14.005, 7.1%, and MIT 14.008, 46.7%). Our clinicians identified 12 deficiencies related to scanning, retrieving, or reviewing specialty reports.<sup>62</sup> The examples are discussed below:

- In case 1, the patient had a cardiac stress test; however, the report was not retrieved or scanned into the EHRS.
- In case 25, the gastroenterologist evaluated the patient; however, the report was not reviewed by a provider.
- In case 63, the patient had a surgical repair of the jaw, but the procedure note was not retrieved or scanned into the EHRS.

### **Patient Care Environment**

The telemedicine staff appeared to have appropriately maintained the video, audio, and remote medical equipment such as stethoscope and otoscope, so the telemedicine specialists could effectively assess their patients. We did not identify any deficiencies related to the medical equipment.

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<sup>61</sup> Deficiencies occurred in cases 2, 10, 23, 25, 26, 62, and 63.

<sup>62</sup> Deficiencies occurred in cases 1, 23, 25, 26, 27, 29, 62, and 63.

### Clinician On-Site Inspection

LAC specialty staff processed about 20 to 40 specialty requests per day and arranged for about 25 off-site specialty appointments per day. At the time of the OIG visit, there was a backlog of around 40 specialty appointments. The CME observed that the biggest medical challenge at LAC is the specialty appointment backlogs. Certain specialty appointments such as those for neurology, orthopedic surgery, and plastic surgery are still difficult to obtain, as some of these specialists do not treat inmate-patients; thus, the CME had reached out to specialists who were located as far away as the city of Los Angeles.

Specialty staff often informed providers when delays might occur or appointments were not available. Specialty staff often used the department's email system to communicate with providers; however, these communications were not captured in the EHRS.

LAC had a nurse who was responsible for retrieving specialty off-site reports. Specialty staff acknowledged the missed off-site specialty reports, and it appeared that LAC did not have a dedicated tracking process to ensure all off-site specialty reports were retrieved.

## 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) *	14	1	0	93.3%
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) *	3	11	1	21.4%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	4	9	2	30.8%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004) *	10	5	0	66.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	1	13	1	7.1%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	3	3	9	50.0%
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) *	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) *	7	8	0	46.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	5	2	8	71.4%
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	15	0	25.0%
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): 49.2%				

\* 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) *,†	24	19	2	55.8%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	19	11	15	63.3%

\* 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 develop a tracking system for retrieving, scanning, and reviewing specialty reports.
- Nursing leadership should remind staff of the expected assessments and documentation required when patients return from specialty appointments.
- Medical leadership should ascertain causative factors related to the untimely provisioning or scheduling of patients' specialty service appointments and follow-up appointments, and implement remedial measures as appropriate.

## Administrative Operations

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

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

Overall Rating
<b>Inadequate</b>
Case Review Rating
<b>N/A</b>
Compliance Score
<b>Inadequate (70.4%)</b>

## Results Overview

LAC's performance was mixed in this indicator. While the institution scored well in some applicable tests, it showed room for improvement in several areas. The EMRRC did not complete the event checklist or the review was not completed timely. The institution conducted medical emergency response drills, yet documentation was incomplete. Nurse managers did not complete documentation of the annual training of nurses who administer medications, and nurse educators did not ensure newly hired nurses received required onboarding training. These findings are set forth in the table on page 90. The OIG rated this indicator *inadequate*.

## Compliance Testing Results

### Nonscored Results

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

Our testing period reviewed mortality reports that occurred before newly revised CCHCS mortality review policy requirements. Prior to May 2022, we obtained CCHCS Death Review Committee (DRC) reporting data. Four unexpected (Level 1) deaths occurred during our review period. In our inspection, we found that the DRC did not timely complete three death review reports; the DRC finished three reports five to 69 days late and submitted the reports to the institution's CEO three to 62 days late. The remaining death report was completed in the appropriate time frame. Effective May 2022, we obtained CCHCS Mortality Case Review reporting data. At the time of the OIG's

inspection, for four patients, we found no evidence in the submitted documentation that the preliminary mortality report had been completed. These reports were overdue at the time of OIG's inspection (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) *				This is a nonscored test. Please refer to the discussion in this indicator.
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	0	12	0	0
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	4	0	0	100%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the patients' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial patient death reports to the CCHCS Mortality Case Review Unit on time? (15.103)	8	2	0	80.0%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	6	4	0	60.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	6	2	0	75.0%
Did the providers maintain valid state medical licenses? (15.106)	17	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates, and did the pharmacy maintain valid Automated Drug Delivery System (ADDS) licenses? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? Effective 05/2022: Did the Headquarters Mortality Case Review process mortality review reports timely? (15.998)				This is a nonscored test. Please refer to the discussion in this indicator.
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)				This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information.
Overall percentage (MIT 15): 70.4%				

\* 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.

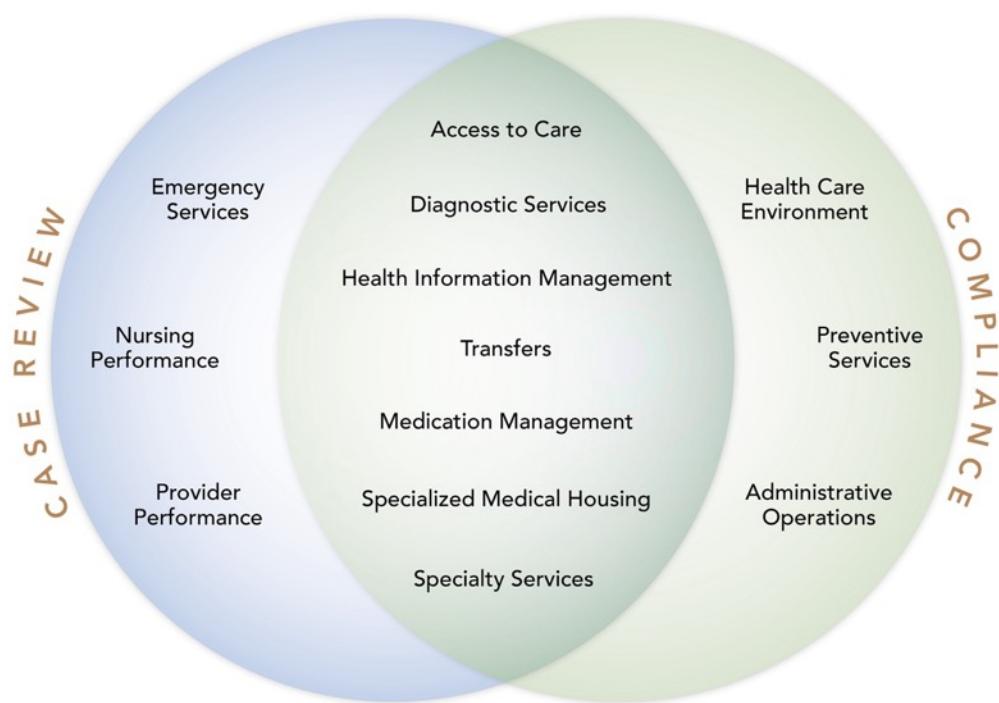
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## Appendix A: Methodology

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

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

**Figure A-1. Inspection Indicator Review Distribution for LAC**



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

## Case Reviews

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

**Table A-1. Case Review Definitions**

<b>Case, Sample, or Patient</b>	The medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.
<b>Comprehensive Case Review</b>	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.
<b>Focused Case Review</b>	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.
<b>Event</b>	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.
<b>Case Review Deficiency</b>	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.
<b>Adverse Event</b>	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***

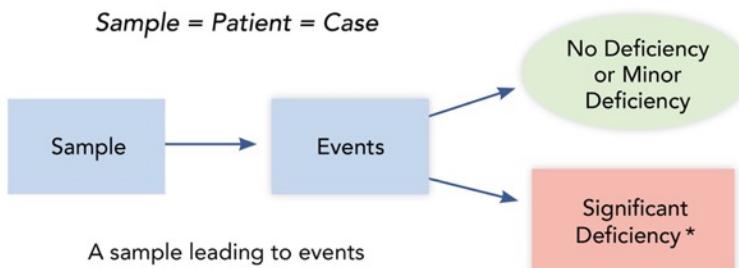
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

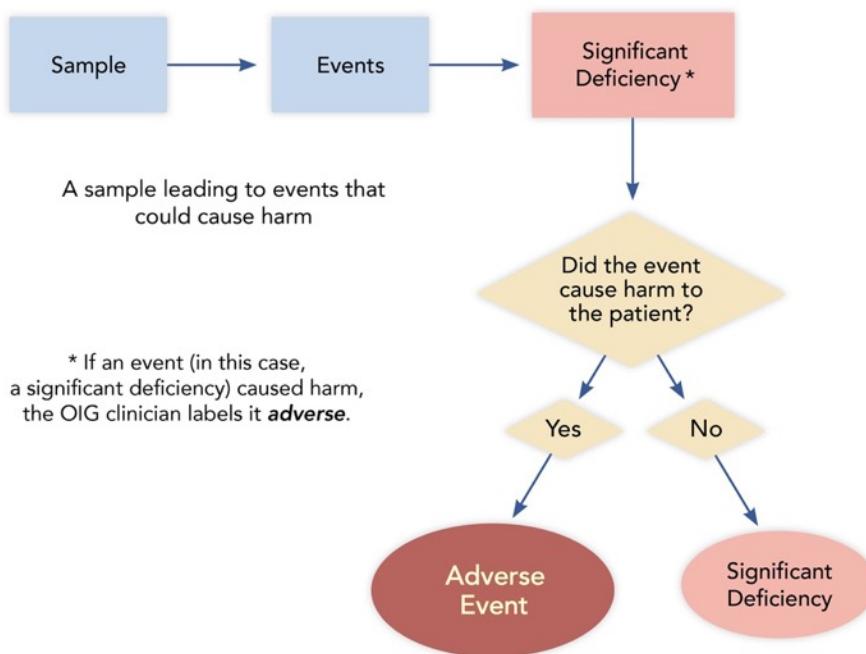
### Figure A-2. Case Review Testing

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**.



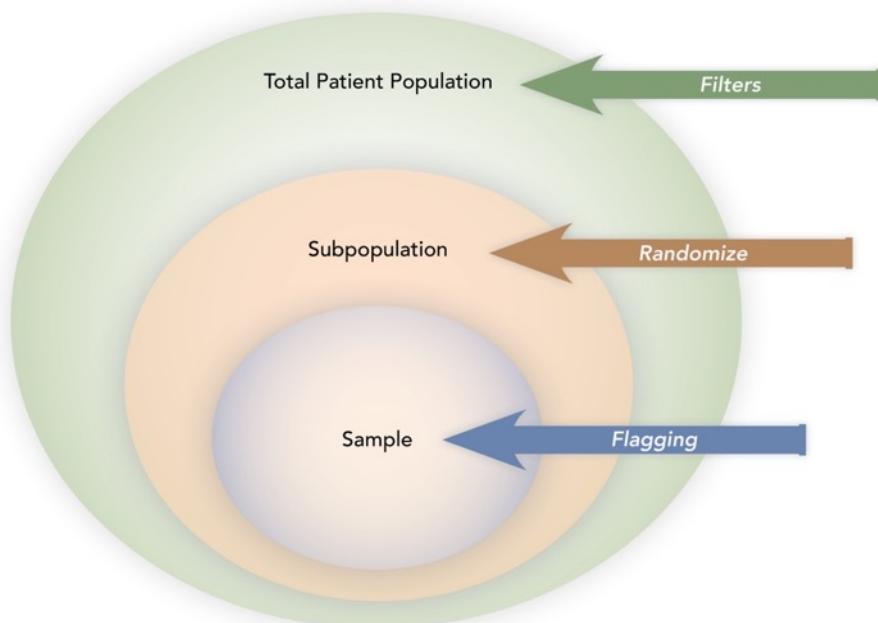
Source: The Office of the Inspector General medical inspection analysis.

## 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. LAC Case Review Sample Sets**

Sample Set	Total
Anticoagulation	3
CTC/OHU	3
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intrasytem Transfers In	3
Intrasytem Transfers Out	3
RN Sick Call	24
Specialty Services	4
	<b>63</b>

**Table B-2. LAC Case Review Chronic Care Diagnoses**

<b>Diagnosis</b>	<b>Total</b>
Anemia	4
Anticoagulation	5
Arthritis/Degenerative Joint Disease	5
Asthma	12
COPD	2
Cancer	4
Cardiovascular Disease	8
Chronic Kidney Disease	2
Chronic Pain	18
Cirrhosis/End-Stage Liver Disease	6
Coccidioidomycosis	6
Deep Venous Thrombosis/Pulmonary Embolism	2
Diabetes	13
Gastroesophageal Reflux Disease	14
Gastrointestinal Bleed	1
Hepatitis C	20
Hyperlipidemia	22
Hypertension	26
Mental Health	32
Migraine Headaches	3
Seizure Disorder	5
Sleep Apnea	5
Substance Abuse	27
Thyroid Disease	4
	<b>246</b>

**Table B-3. LAC Case Review Events by Program**

<b>Diagnosis</b>	<b>Total</b>
Diagnostic Services	322
Emergency Care	58
Hospitalization	27
Intrasytem Transfers In	11
Intrasytem Transfers Out	10
Outpatient Care	466
Specialized Medical Housing	65
Specialty Services	183
	<b>1,142</b>

**Table B-4. LAC Case Review Sample Summary**

<b>Clinician</b>	<b>Total</b>
MD Reviews Detailed	25
MD Reviews Focused	4
RN Reviews Detailed	14
RN Reviews Focused	38
Total Reviews	81
Total Unique Cases	63
Overlapping Reviews (MD & RN)	18

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## Appendix C: Compliance Sampling Methodology

### California State Prison, Los Angeles County

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<b>Access to Care</b>				
MIT 1.001	Chronic Care Patients	25	Master Registry	<ul style="list-style-type: none"> <li>• Chronic care conditions (at least one condition per patient—any risk level)</li> <li>• Randomize</li> </ul>
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	<ul style="list-style-type: none"> <li>• See Transfers</li> </ul>
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	<ul style="list-style-type: none"> <li>• Clinic (each clinic tested)</li> <li>• Appointment date (2–9 months)</li> <li>• Randomize</li> </ul>
MIT 1.007	Returns From Community Hospital	25	OIG Q: 4.005	<ul style="list-style-type: none"> <li>• See Health Information Management (Medical Records) (returns from community hospital)</li> </ul>
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	<ul style="list-style-type: none"> <li>• See Specialty Services</li> </ul>
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	<ul style="list-style-type: none"> <li>• Randomly select one housing unit from each yard</li> </ul>
<b>Diagnostic Services</b>				
MITs 2.001–003	Radiology	10	Radiology Logs	<ul style="list-style-type: none"> <li>• Appointment date (90 days–9 months)</li> <li>• Randomize</li> <li>• Abnormal</li> </ul>
MITs 2.004–006	Laboratory	10	Quest	<ul style="list-style-type: none"> <li>• Appt. date (90 days–9 months)</li> <li>• Order name (CBC or CMPs only)</li> <li>• Randomize</li> <li>• Abnormal</li> </ul>
MITs 2.007–009	Laboratory STAT	0	Quest	<ul style="list-style-type: none"> <li>• Appt. date (90 days–9 months)</li> <li>• Order name (CBC or CMPs only)</li> <li>• Randomize</li> <li>• Abnormal</li> </ul>
MITs 2.010–012	Pathology	10	InterQual	<ul style="list-style-type: none"> <li>• Appt. date (90 days–9 months)</li> <li>• Service (pathology related)</li> <li>• Randomize</li> </ul>

<b>Quality Indicator</b>	<b>Sample Category</b>	<b>No. of Samples</b>	<b>Data Source</b>	<b>Filters</b>
<i>Health Information Management (Medical Records)</i>				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	<ul style="list-style-type: none"> <li>• Nondictated documents</li> <li>• First 20 IPs for MIT 1.004</li> </ul>
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	<ul style="list-style-type: none"> <li>• Specialty documents</li> <li>• First 10 IPs for each question</li> </ul>
MIT 4.003	Hospital Discharge Documents	25	OIG Q: 4.005	<ul style="list-style-type: none"> <li>• Community hospital discharge documents</li> <li>• First 20 IPs selected</li> </ul>
MIT 4.004	Scanning Accuracy	24	Documents for any tested inmate	<ul style="list-style-type: none"> <li>• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)</li> </ul>
MIT 4.005	Returns From Community Hospital	25	CADDIS off-site admissions	<ul style="list-style-type: none"> <li>• Date (2–8 months)</li> <li>• Most recent 6 months provided (within date range)</li> <li>• Rx count</li> <li>• Discharge date</li> <li>• Randomize</li> </ul>
<i>Health Care Environment</i>				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	10	OIG inspector on-site review	<ul style="list-style-type: none"> <li>• Identify and inspect all on-site clinical areas.</li> </ul>
<i>Transfers</i>				
MITs 6.001–003	Intrasytem Transfers	25	SOMS	<ul style="list-style-type: none"> <li>• Arrival date (3–9 months)</li> <li>• Arrived from (another departmental facility)</li> <li>• Rx count</li> <li>• Randomize</li> </ul>
MIT 6.101	Transfers Out	9	OIG inspector on-site review	<ul style="list-style-type: none"> <li>• R&amp;R IP transfers with medication</li> </ul>

<b>Quality Indicator</b>	<b>Sample Category</b>	<b>No. of Samples</b>	<b>Data Source</b>	<b>Filters</b>
<i>Pharmacy and Medication Management</i>				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	<p>See Access to Care</p> <ul style="list-style-type: none"> <li>At least one condition per patient—any risk level</li> <li>Randomize</li> </ul>
MIT 7.002	New Medication Orders	25	Master Registry	<ul style="list-style-type: none"> <li>Rx count</li> <li>Randomize</li> <li>Ensure no duplication of IPs tested in MIT 7.001</li> </ul>
MIT 7.003	Returns From Community Hospital	25	OIG Q: 4.005	<ul style="list-style-type: none"> <li>See Health Information Management (Medical Records) (returns from community hospital)</li> </ul>
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	<ul style="list-style-type: none"> <li>See Reception Center</li> </ul>
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	<ul style="list-style-type: none"> <li>Date of transfer (2–8 months)</li> <li>To location/from location (yard to yard and to/from ASU)</li> <li>Remove any to/from MHCB</li> <li>NA/DOT meds (and risk level)</li> <li>Randomize</li> </ul>
MIT 7.006	En Route	9	SOMS	<ul style="list-style-type: none"> <li>Date of transfer (2–8 months)</li> <li>Sending institution (another departmental facility)</li> <li>Randomize</li> <li>NA/DOT meds</li> </ul>
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	<ul style="list-style-type: none"> <li>Identify and inspect clinical &amp; med line areas that store medications</li> </ul>
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	<ul style="list-style-type: none"> <li>Identify and inspect on-site clinical areas that prepare and administer medications</li> </ul>
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	<ul style="list-style-type: none"> <li>Identify &amp; inspect all on-site pharmacies</li> </ul>
MIT 7.112	Medication Error Reporting	14	Medication error reports	<ul style="list-style-type: none"> <li>All medication error reports with Level 4 or higher</li> <li>Select total of 25 medication error reports (recent 12 months)</li> </ul>
MIT 7.999	Restricted Unit KOP Medications	20	On-site active medication listing	<ul style="list-style-type: none"> <li>KOP rescue inhalers &amp; nitroglycerin medications for IPs housed in restricted units</li> </ul>

<b>Quality Indicator</b>	<b>Sample Category</b>	<b>No. of Samples</b>	<b>Data Source</b>	<b>Filters</b>
<b>Prenatal and Postpartum Care</b>				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	<ul style="list-style-type: none"> <li>Delivery date (2–12 months)</li> <li>Most recent deliveries (within date range)</li> </ul>
	Pregnant Arrivals	N/A at this institution	OB Roster	<ul style="list-style-type: none"> <li>Arrival date (2–12 months)</li> <li>Earliest arrivals (within date range)</li> </ul>
<b>Preventive Services</b>				
MITs 9.001–002	TB Medications	11	Maxor	<ul style="list-style-type: none"> <li>Dispense date (past 9 months)</li> <li>Time period on TB meds (3 months or 12 weeks)</li> <li>Randomize</li> </ul>
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least 1 year prior to inspection)</li> <li>Birth month</li> <li>Randomize</li> </ul>
MIT 9.004	Influenza Vaccinations	25	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least 1 year prior to inspection)</li> <li>Randomize</li> <li>Filter out IPs tested in MIT 9.008</li> </ul>
MIT 9.005	Colorectal Cancer Screening	25	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least 1 year prior to inspection)</li> <li>Date of birth (45 or older)</li> <li>Randomize</li> </ul>
MIT 9.006	Mammogram	N/A at this institution	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least 2 yrs. prior to inspection)</li> <li>Date of birth (age 52–74)</li> <li>Randomize</li> </ul>
MIT 9.007	Pap Smear	N/A at this institution	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least three yrs. prior to inspection)</li> <li>Date of birth (age 24–53)</li> <li>Randomize</li> </ul>
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	<ul style="list-style-type: none"> <li>Chronic care conditions (at least 1 condition per IP—any risk level)</li> <li>Randomize</li> <li>Condition must require vaccination(s)</li> </ul>
MIT 9.009	Valley Fever	N/A at this institution	Cocci transfer status report	<ul style="list-style-type: none"> <li>Reports from past 2–8 months</li> <li>Institution</li> <li>Ineligibility date (60 days prior to inspection date)</li> <li>All</li> </ul>

<b>Quality Indicator</b>	<b>Sample Category</b>	<b>No. of Samples</b>	<b>Data Source</b>	<b>Filters</b>
<i>Reception Center</i>				
MITs 12.001–007	RC	N/A at this institution	SOMS	<ul style="list-style-type: none"> <li>Arrival date (2–8 months)</li> <li>Arrived from (county jail, return from parole, etc.)</li> <li>Randomize</li> </ul>
<i>Specialized Medical Housing</i>				
MITs 13.001–003	Specialized Health Care Housing Unit	10	CADDIS	<ul style="list-style-type: none"> <li>Admit date (2–8 months)</li> <li>Type of stay (no MH beds)</li> <li>Length of stay (minimum of 5 days)</li> <li>Rx count</li> <li>Randomize</li> </ul>
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	<ul style="list-style-type: none"> <li>Specialized Health Care Housing</li> <li>Review by location</li> </ul>
<i>Specialty Services</i>				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	<ul style="list-style-type: none"> <li>Approval date (3–9 months)</li> <li>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, psychiatry, podiatry, and radiology services</li> <li>Randomize</li> </ul>
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	<ul style="list-style-type: none"> <li>Approval date (3–9 months)</li> <li>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, psychiatry, podiatry, and radiology services</li> <li>Randomize</li> </ul>
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	<ul style="list-style-type: none"> <li>Approval date (3–9 months)</li> <li>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, psychiatry, podiatry, and radiology services</li> <li>Randomize</li> </ul>

<b>Quality Indicator</b>	<b>Sample Category</b>	<b>No. of Samples</b>	<b>Data Source</b>	<b>Filters</b>
<i>Specialty Services (continued)</i>				
MIT 14.010	Specialty Services Arrivals	20	Specialty Services Arrivals	<ul style="list-style-type: none"> <li>Arrived from (other departmental institution)</li> <li>Date of transfer (3–9 months)</li> <li>Randomize</li> </ul>
MITs 14.011–012	Denials	0	InterQual	<ul style="list-style-type: none"> <li>Review date (3–9 months)</li> <li>Randomize</li> </ul>
		N/A	IUMC/MAR Meeting Minutes	<ul style="list-style-type: none"> <li>Meeting date (9 months)</li> <li>Denial upheld</li> <li>Randomize</li> </ul>
<i>Administrative Operations</i>				
MIT 15.001	Adverse/sentinel events	0	Adverse/sentinel events report	<ul style="list-style-type: none"> <li>Adverse/Sentinel events (2–8 months)</li> </ul>
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	<ul style="list-style-type: none"> <li>Meeting minutes (12 months)</li> </ul>
MIT 15.003	EMRRC	12	EMRRC meeting minutes	<ul style="list-style-type: none"> <li>Monthly meeting minutes (6 months)</li> </ul>
MIT 15.004	LGB	4	LGB meeting minutes	<ul style="list-style-type: none"> <li>Quarterly meeting minutes (12 months)</li> </ul>
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	<ul style="list-style-type: none"> <li>Most recent full quarter</li> <li>Each watch</li> </ul>
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	<ul style="list-style-type: none"> <li>Medical grievances closed (6 months)</li> </ul>
MIT 15.103	Death Reports	10	Institution-list of deaths in prior 12 months	<ul style="list-style-type: none"> <li>Most recent 10 deaths</li> <li>Initial death reports</li> </ul>
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	<ul style="list-style-type: none"> <li>On duty one or more years</li> <li>Nurse administers medications</li> <li>Randomize</li> </ul>
MIT 15.105	Provider Annual Evaluation Packets	8	On-site provider evaluation files	<ul style="list-style-type: none"> <li>All required performance evaluation documents</li> </ul>
MIT 15.106	Provider Licenses	17	Current provider listing (at start of inspection)	<ul style="list-style-type: none"> <li>Review all</li> </ul>
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	<ul style="list-style-type: none"> <li>All staff</li> <li>Providers (ACLS)</li> <li>Nursing (BLS/CPR)</li> <li>Custody (CPR/BLS)</li> </ul>

<b>Quality Indicator</b>	<b>Sample Category</b>	<b>No. of Samples</b>	<b>Data Source</b>	<b>Filters</b>
<i>Administrative Operations (continued)</i>				
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	<ul style="list-style-type: none"> <li>• All required licenses and certifications</li> </ul>
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	<ul style="list-style-type: none"> <li>• All DEA registrations</li> </ul>
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	<ul style="list-style-type: none"> <li>• New employees (hired within last 12 months)</li> </ul>
MIT 15.998	CCHCS Mortality Case Review	10	OIG summary log: deaths	<ul style="list-style-type: none"> <li>• Between 35 business days &amp; 12 months prior</li> <li>• California Correctional Health Care Services mortality reviews</li> </ul>

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# California Correctional Health Care Services' Response

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November 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 California State Prison, Los Angeles County (LAC) conducted by the Office of the Inspector General (OIG) from May 2022 to October 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) 691-3747.

Sincerely,

DocuSigned by:

*DeAnna Gouley*

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DeAnna Gouley  
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 III, CCHCS  
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CALIFORNIA CORRECTIONAL  
HEALTH CARE SERVICES

P.O. Box 588500  
Elk Grove, CA 95758



**Cycle 7**

**Medical Inspection Report**

*for*

**California State Prison**

**Los Angeles County**

OFFICE *of the*  
**INSPECTOR GENERAL**

*Amarik K. Singh*  
Inspector General

*Neil Robertson*  
Chief Deputy Inspector General

STATE *of CALIFORNIA*  
December 2023

**OIG**