



Amarik K. Singh, Inspector General

Neil Robertson, Chief Deputy Inspector General

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Independent Prison Oversight

November 2024

Cycle 7

Medical Inspection Report

*North Kern
State Prison*



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Introduction

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

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

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

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

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

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

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

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

As we did during Cycle 6, our office continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 7 inspection of North Kern State Prison (NKSP), the institution had not been delegated back to the department by the receiver. However, on January 12, 2024, the Receiver delegated this institution back to the department.

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 November 2022 to April 2023.⁴

⁴ Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between May 2022 and November 2022, emergency cardiopulmonary resuscitation reviews between June 2022 and April 2023, and transfer reviews between October 2022 and April 2023.

Summary: Ratings and Scores

We completed the Cycle 7 inspection of NKSP in September 2023. OIG inspectors monitored the institution's delivery of medical care that occurred between November 1, 2022, and April 30, 2023.



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



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

The OIG clinicians (a team of physicians and nurse consultants) reviewed 55 cases, which contained 723 patient-related events. They performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our OIG clinicians acknowledged institutional structures that catch and resolve mistakes that may occur throughout the delivery of care. After examining the medical records, our clinicians completed a follow-up on-site inspection in September 2023 to verify their initial findings. The OIG physicians rated the quality of care for 20 comprehensive case reviews. Of these 20 cases, our physicians rated 18 *adequate*, and two *inadequate*.

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 454 patient records and 1,335 data points and used the data to answer 101 policy questions. In addition, we observed NKSP's processes during an on-site inspection in July 2023.

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

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

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

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

MIT Number	Health Care Indicators	Ratings			Scoring Ranges		
		Proficient	Adequate	Inadequate	100% – 85.0%	84.9% – 75.0%	74.9% – 0
		Case Review		Compliance			
		Cycle 7	Change Since Cycle 6*	Cycle 7	Cycle 6	Change Since Cycle 6*	
1	Access to Care	Adequate	↓	84.7%	84.6%	=	
2	Diagnostic Services	Adequate	=	61.7%	55.8%	=	
3	Emergency Services	Inadequate	↓	N/A	N/A	N/A	
4	Health Information Management	Adequate	↓	92.0%	85.5%	=	
5	Health Care Environment†	N/A	N/A	55.5%	56.9%	=	
6	Transfers	Adequate	=	87.1%	60.7%	↑↑	
7	Medication Management	Adequate	=	61.8%	68.2%	=	
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A	
9	Preventive Services	N/A	N/A	74.5%	61.1%	=	
10	Nursing Performance	Adequate	=	N/A	N/A	N/A	
11	Provider Performance	Adequate	=	N/A	N/A	N/A	
12	Reception Center	Adequate	=	71.7%	34.0%	=	
13	Specialized Medical Housing	Adequate	=	48.0%	85.0%	↓↓	
14	Specialty Services	Adequate	=	87.4%	82.1%	↑	
15	Administrative Operations†	N/A	N/A	71.0%	77.9%	↓	

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

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

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

Medical Inspection Results

Deficiencies Identified During Case Review

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

The OIG found one adverse event at NKSP during the Cycle 7 inspection as follows:

- In case 9, the previously healthy patient arrived at the triage and treatment area (TTA) with symptoms of fever, body aches, chills, coughing up blood, and shortness of breath. The patient was placed in COVID-19 isolation for 22 days without appropriate nursing assessments or being evaluated by a provider. On Day 22, the patient was found unresponsive in his cell and could not be revived. The coroner determined the patient died of pneumonia, a generally treatable medical condition. Had the patient received appropriate medical care, he would not have died.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 11 of the 14 indicators applicable to NKSP. Of these 11 indicators, OIG clinicians rated 10 **adequate** and one **inadequate**. The OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 18 were **adequate** and two were **inadequate**. In the 723 events reviewed, we found 267 deficiencies, 43 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 NKSP:

- Provider initial health assessments and treatments on patients newly arrived to NKSP were usually appropriate and thorough.
- Patients had good access to outpatient and specialized medical housing providers.
- The supervising registered nurse (SRN) who oversaw the TTA, the receiving and release (R&R) area, and the specialty services area conducted daily huddles with the specialty team to ensure all new transfers or patients returning from the hospital had the appropriate

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

follow-up care, and staff timely reconciled medications and specialty referrals.

Our clinicians found the following weaknesses at NKSP:

- NKSP leadership and staff had different understandings of urgent and emergency transport time frames.
- Providers sometimes ordered inappropriate time frames for specialty referrals.
- NKSP staff did not immediately activate emergency medical services (EMS) when medically indicated or when a provider ordered a patient to be transferred to the hospital.
- The emergency response clinical reviews by the SRN, the chief medical executive (CME), and the chief nursing executive (CNE) often did not identify assessments, interventions, or documentation deficiencies that the OIG found.

Compliance Testing Results

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

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

- Medical staff performed proficiently in scanning request for health care services forms and hospital discharge reports into patients' electronic medical records within required time frames.
- The institution completed high-priority, medium-priority, and routine-priority specialty services within required time frames. The institution retrieved specialists' reports, and providers reviewed these reports timely.
- Nursing staff thoroughly completed initial health screening forms for newly arrived patients at NKSP. In addition, for patients transferring out of NKSP, nursing staff ensured all required medications, durable medical equipment, and documentation were processed completely and timely.
- Providers performed well in evaluating patients with chronic care conditions, patients returning from community hospitals, and patients returning from specialty service appointments within specified time frames. Moreover, NKSP referred patients timely to their providers upon arrival at the institution.

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

- The institution did not consistently provide routine and STAT (immediate) laboratory services within required time frames.
- Providers did not often communicate results of diagnostic services timely. Most patient notification letters communicating these results were missing information as to whether the results were within normal limits.
- Health care staff did not consistently follow universal hand hygiene precautions during patient encounters or medication preparation and administration.
- Patients did not always receive their chronic care medications within required time frames. We found poor medication continuity for patients returning from hospitalization, for patients admitted to specialized medical housing, and for patients transferring into and laying over at NKSP.

Institution-Specific Metrics

North Kern State Prison (NKSP) is a medium-security prison located in Delano in Kern County. As a reception center, its mission is to process and classify incoming patients received from county jails by evaluating their medical and mental health needs, evaluating their security levels and program requirements, and determining appropriate institutional placement prior to their transfer to other State facilities. NKSP operates multiple clinics in which staff members handle nonurgent requests for medical services. The institution also treats patients who need urgent or emergent care in its TTA and provides inpatient care in its correctional treatment center (CTC). NKSP has been designated a basic care institution by California Correctional Health Care Services (CCHCS); basic facilities are typically located in rural areas, far away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk medical patients. Due to the institution's remote location and its basic health care status, in general, healthier patients are placed in this institution. As of September 17, 2024, the department reports on its public tracker that 50 percent of NKSP's incarcerated population is fully vaccinated for COVID-19 while 63 percent of NKSP's staff is fully vaccinated for COVID-19.⁷

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

In June 2023, the Health Care Services Master Registry showed that NKSP had a total population of 4,117. A breakdown of the medical risk level of the NKSP population as determined by the department is set forth in Table 2 below.⁸

Table 2. NKSP Master Registry Data as of June 2023

Medical Risk Level	Number of Patients	Percentage*
High 1	53	1.3%
High 2	170	4.1%
Medium	1,546	37.6%
Low	2,348	57.0%
Total	4,117	100.0%

* Percentages may not total 100% due to rounding.

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 6-19-23.

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

According to staffing data the OIG obtained from CCHCS, as identified in Table 3 below, NKSP had zero vacant executive leadership positions, 0.5 primary care provider vacancies, 0.2 nursing supervisor vacancies, and 17.8 nursing staff vacancies.

Table 3. NKSP Health Care Staffing Resources as of June 2023

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	12.5	13.2	145.4	176.1
Filled by Civil Service	5.0	12.0	13.0	127.6	157.6
Vacant	0	0.5	0.2	17.8	18.5
Percentage Filled by Civil Service	100%	100%	100%	88.0%	89.5%
Filled by Telemedicine	0	1.0	0	0	1.0
Percentage Filled by Telemedicine	0	8.0%	0	0	0.6%
Filled by Registry	0	0	0	10.0	10.0
Percentage Filled by Registry	0	0	0	7.6%	5.7%
Total Filled Positions	5.0	12.0	13.0	137.6	167.6
Total Percentage Filled	100%	96.0%	98.5%	94.6%	95.2%
Appointments in Last 12 Months	0	2.0	3.0	16.0	21.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave ‡	0	0	0	6.0	6.0
Adjusted Total: Filled Positions	5.0	12.0	13.0	131.6	161.6
Adjusted Total: Percentage Filled	100%	96.0%	98.5%	90.5%	91.7%

* 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 June 19, 2023, from California Correctional Health Care Services.

Population-Based Metrics

In addition to our own compliance testing and case reviews, as noted above, the OIG presents selected measures from the Healthcare Effectiveness Data and Information Set (HEDIS) for comparison purposes. The HEDIS is a set of standardized quantitative performance measures designed by the National Committee for Quality Assurance to ensure 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 to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

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

Comprehensive Diabetes Care

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

Immunizations

Statewide comparative data were not available for immunization measures; however, we include these data for informational purposes. NKSP had a 23 percent influenza immunization rate for adults 18 to 64 years old and an influenza immunization rate of zero for adults 65 years of age and older.⁹ The pneumococcal vaccination rate was not applicable.¹⁰

Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. NKSP had a 54 percent colorectal cancer screening rate.

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

¹⁰ The pneumococcal vaccines administered are the 13, 15, and 20 valent pneumococcal vaccines (PCV13, PCV15, and PCV20), or 23 valent pneumococcal vaccine (PPSV23), depending on the patient's medical conditions. For the adult population, the influenza or pneumococcal vaccine may have been administered at a different institution other than where the patient was currently housed during the inspection period. For this institution, our sample size for this test was insufficient, leading to a rate of "not applicable."

Table 4. NKSP Results Compared With State HEDIS Scores

HEDIS Measure	NKSP Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	-	-	-
Poor HbA1c Control (> 9.0%) ‡,§	10%	38%	28%	20%
HbA1c Control (< 8.0%) ‡	66%	-	-	-
Blood Pressure Control (< 140/90) ‡	94%	-	-	-
Eye Examinations	85%	-	-	-
Influenza - Adults (18-64)	23%	-	-	-
Influenza - Adults (65+)	0	-	-	-
Pneumococcal - Adults (65+)	0	-	-	-
Colorectal Cancer Screening	54%	-	-	-

Notes and Sources

* Unless otherwise stated, data were collected in July 2023 by reviewing medical records from a sample of NKSP’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 NKSP population was tested.

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

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

Recommendations

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

Diagnostic Services

- Medical leadership should determine the root cause(s) of challenges encountered when collecting, receiving, and notifying providers of STAT and routine laboratory results timely and implement remedial measures as appropriate.
- The department should consider developing strategies to ensure that providers create patient letters when they endorse tests results and that patient letters contain all elements required by CCHCS policy.

Emergency Services

- Nursing leadership should determine the challenges that prevent staff from immediately initiating EMS when indicated or when the provider orders the patient to be transported to the community hospital. Leadership should implement remedial measures as indicated.
- Nursing leadership should determine the root cause(s) of challenges that prevent nurses from performing complete assessments, timely interventions, and thorough documentation. Leadership should implement remedial measures as indicated.
- Nursing leadership should determine the root cause(s) of challenges SRNs face in completing thorough reviews of urgent and emergent events in which patients transfer to the community hospital and implement remedial measures as indicated.
- Executive leadership should determine the challenges preventing the EMRRC from reviewing all unscheduled transports to off-site hospitals and properly identifying all deficiencies in the quality of nursing or provider performance, policy, procedures, and form completion. Executive leadership should implement remedial measures as indicated.

Health Care Environment

- Medical leadership should analyze the root cause(s) of staff not following all required universal hand hygiene precautions and should implement necessary remedial measures.
- Executive leadership should analyze the root cause(s) of staff not following equipment and medical supply management protocols and should implement necessary remedial measures.

- Nursing leadership should determine the root cause(s) of staff not ensuring the EMRBs are regularly inventoried and sealed, and of staff failing to properly complete the monthly logs and should implement necessary remedial measures.
- Executive leadership should determine the root cause(s) of unclean clinics, medical storage rooms, and restrooms and should implement necessary remedial measures.

Medication Management

- The institution should develop and implement measures to ensure staff timely make available and administer medications to patients and document the medication administration record (MAR) summaries, as described in CCHCS policy and procedures.
- Nursing leadership should determine the challenges for nursing staff in documenting patient refusals in the MAR, as described in CCHCS policy and procedures, and implement remedial measures as appropriate.

Preventive Services

- Nursing leadership should develop and implement measures to ensure nursing staff consistently perform patient monitoring as described in CCHCS Care Guides, and nursing staff completely address TB signs and symptoms in their patient monitoring.
- Medical leadership should determine the challenges to timely providing immunizations to chronic care patients and implement remedial measures as appropriate.
- Medical leadership should develop strategies to ensure patients at the highest risk of coccidioidomycosis (Valley Fever) are transferred in a timely manner and implement remedial measures as appropriate.

Nursing Performance

- Nursing leadership should determine the challenges that prevent outpatient nurses from performing complete assessments and implement remedial measures as indicated, such as training staff.

Provider Performance

- Medical leadership must familiarize themselves with the different time frames associated with emergency transport versus urgent transport as established in state and local policy. Medical leadership should also develop and implement strategies to educate and train providers on the differences in these time frames to ensure orders designation appropriate transport levels.

- Medical leadership should determine the cause(s) of challenges to providers ordering specialty services for medically appropriate priorities and time frames and implement remedial measures as appropriate.
- Medical leadership should determine the cause(s) of challenges to providers completing appropriate medical documentation, including on-call progress notes and updated patient medical problem lists and implement remedial measures as appropriate.

Reception Center

- Medical leadership should determine the challenges providers encounter when completing H&P examinations within required time frames, as required by CCHCS policy, and implement remedial measures as appropriate.
- NKSP leadership should determine the root cause(s) of patients not receiving Reception Center laboratory services timely and implement remedial measures as appropriate.

Specialized Medical Housing

- Nursing leadership should determine the challenges preventing CTC nursing staff from completing thorough patient assessments, including PICC line care, and from completing thorough documentation. Nursing leadership should implement remedial measures as appropriate.
- Nursing leadership should determine the challenges preventing CTC nursing staff from completing the call light system rounding checklist every 15 minutes as per the local operating procedures and should implement remedial measures as appropriate.
- The institution should ascertain the root cause(s) related to why medications are not consistently available and administered in a timely manner to specialized medical housing patients and should implement remedial measures as appropriate.

Specialty Services

- Medical leadership should determine the root cause(s) of providers not ordering specialty services within medically appropriate time frames and should implement remedial measures as appropriate.

Access to Care

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

Ratings and Results Overview

Case Review Rating
Adequate

Compliance Rating and Score
Adequate (84.7%)

Case review found NKSP's access to care was good. Nursing often assessed patients timely. Outpatient and specialized medical housing provider access was excellent. Provider follow-up after high-priority specialty services, hospitalization, and receiving emergent or urgent care in the TTA was also very good. However, we identified deficiencies with providers ordering inappropriate time frames for specialty services. In addition, we found nearly one half of transfer-in patients were not seen by a provider within the required time frames. Overall, the OIG rated the case review component of this indicator **adequate**.

Compliance testing showed NKSP performed satisfactorily in this indicator. Staff performed excellently in reviewing patient sick call requests and in timely completing provider follow-up appointments for patients returning from specialty services and hospitalizations. Nurses performed satisfactorily in completing face-to-face encounters, offering provider follow-up appointments for patients transferring into the institution, delivering follow-up appointments for patients with chronic care conditions, and completing provider follow-up sick call appointments. However, NKSP scored low in maintaining patient sick call forms in housing units. Based on the overall compliance score result, the OIG rated the compliance component of this indicator **adequate**.

Case Review and Compliance Testing Results

OIG clinicians reviewed 156 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events that required the institution to generate appointments. We identified 19 deficiencies relating to **Access to Care**, five of which were significant.¹¹

Access to Care Providers

Compliance testing showed NKSP performed satisfactorily in providing both chronic care face-to-face follow-up appointments (MIT 1.001, 80.0%) and nursing-to-provider sick

¹¹ Deficiencies occurred in cases 2, 8, 18, 21, 23-27, 32, 33, 37, 39, 46, 48, 54, and 55. Significant deficiencies occurred in cases 8, 24, 27, 32, and 54.

call referrals (MIT 1.005, 85.7%). Case review found only one minor deficiency related to provider access in the outpatient setting.¹²

Access to Specialized Medical Housing Providers

NKSP provided excellent access to specialized medical housing providers. Compliance testing showed NKSP's specialized medical housing patients always received written history and physical (H&P) exams within required time frames (MIT 13.002, 100%). Case review similarly did not identify any deficiencies.

Access to Clinic Nurses

NKSP performed well in patient access to nurse sick calls and provider-to-nurse referrals. Compliance testing showed nurses often reviewed patient requests for medical services the day of receipt (MIT 1.003, 93.3%), and assessed patients within one business day for symptomatic health care requests (MIT 1.004, 83.3%). Our clinicians reviewed 40 nursing sick call requests in 32 cases. We identified nine deficiencies related to delayed or missing nurse appointments, two of which were significant.¹³

- In case 24, the patient submitted a sick call request for a suspected arm infection. Instead of being seen the same day, the patient was scheduled and seen by the nurse two business days later, placing the patient's health at risk.
- In case 50, the nurse triaged a sick call request for a patient who complained of falling in the shower and experiencing decreased sensation in the lower part of his body. The nurses did not see the patient the same day to assess his symptoms and possible injuries.

Access to Specialty Services

NKSP's performance in patient access to specialists was mixed. Compliance testing determined a satisfactory completion rate of high-priority appointments (MIT 14.001, 80.0%), good completion rate of medium-priority appointments (MIT 14.004, 86.7%), and excellent completion rate of routine-priority appointments (MIT 14.007, 100%). NKSP performed satisfactorily in scheduling high-priority follow-up appointments with specialists (MIT 14.003, 83.3%) and excellently in scheduling medium- and routine-priority follow-up specialty appointments (MIT 14.006, 100%, and MIT 14.009, 100%).

Case review clinicians reviewed 64 specialty services events and found 13 deficiencies related to specialty access.¹⁴ Only four deficiencies directly related to appointment scheduling, one of which was significant.¹⁵ The deficiency is discussed further in the **Specialty Services** indicator.

¹² A deficiency occurred in case 18.

¹³ Deficiencies occurred in cases 17, 23, 24, 37, 39, 46, 48, and 50.

¹⁴ Deficiencies occurred in cases 1, 16, 21, 25, 53–55. Significant deficiencies occurred in cases 16, 25, 54, and 55.

¹⁵ Access to care scheduling deficiencies occurred in cases 21, 25, 54, and 55. A significant deficiency occurred in case 54.

Our clinicians identified nine deficiencies related to providers ordering specialty services outside medically necessary time frames or ordering the incorrect type of service. Five of those deficiencies were significant and are discussed further in the **Provider Performance** and **Specialty Services** Indicator.

Follow-Up After Specialty Services

Compliance testing revealed nearly all provider follow-up appointments after high-priority specialty services occurred within the required time frames (MIT 1.008, 93.3%). Case review did not identify any deficiencies in this area.

Follow-Up After Hospitalization

NKSP performed excellently in ensuring providers saw patients after hospitalizations (MIT 1.007, 92.0%). Case review did not identify any deficiencies in this area.

Follow-Up After Urgent or Emergent Care (TTA)

Providers generally saw their patients following a TTA event as ordered. OIG clinicians assessed 23 TTA events and providers always saw the patients in follow up as ordered.

Follow-Up After Transferring Into NKSP

Compliance testing showed satisfactory performance in access to intake appointments for newly arrived patients (MIT 1.002, 83.3%). Case reviewers, however, found NKSP performed poorly with provider access. We reviewed 12 reception center and transfer-in cases and identified six deficiencies, three of which were significant.¹⁶ Examples include the following:

- In case 8, the high-risk patient with an intracranial shunt arrived to NKSP from a county jail and was evaluated by a provider 13 days late.
- In case 27, the high-risk medical transfer-in patient did not receive the initial provider evaluation until 25 days after arrival.
- In case 32, the high-risk medical reception center patient was evaluated by a provider 18 days late.

Clinician On-Site Inspection

Our case review clinicians spoke with NKSP's executive leadership and schedulers regarding the institution's access to care.

NKSP had six main clinics, designated as A, B, C, D, D6, and M, in addition to the diagnostic reception center. NKSP also operated a TTA and a CTC. Staffing included four midlevel providers and eight physicians. A midlevel provider was assigned to the CTC and TTA and overseen by a provider, who also performed rounds one time a week. Leadership discussed the new reception center, called "diagnostics," which processed 350 to 400 new patients per week. At the time of our inspections, we were informed this new

¹⁶ Deficiencies occurred in cases 2, 8, 26, 27, 32, and 33. Significant deficiencies occurred in cases 8, 27, and 32.

area was expected to house nurses, providers, dental, mental health, radiology, and custody staff and was nearing completion. It was also expected to streamline and expedite the new intake, transfer-in, and transfer-out processes.

At the on-site case review, some providers mentioned they were assigned to the new diagnostics center and had been performing initial provider appointments within the first 24 hours of patient arrival as part of intake streamlining. Some expressed concern this placed them at risk of COVID-19 infection because incoming patients were just beginning COVID-19 quarantine upon arrival. We did not observe either patients or providers using personal protective equipment (PPE).

During the OIG case review, we identified several delays in provider initial patient assessments. Those delays were often due to providers not seeing patients who were in the initial 10- to 14-day COVID-19 quarantine. However, nurses performed their respective patient care duties on quarantine patients during this same time frame.

The schedulers reported a backlog in both provider episodic and chronic care appointments during the review period, with only 68 percent completed by compliance dates. This was similar to the OIG compliance testing results. The backlog was due to an increase in urgent care appointments, a shortage of providers, COVID-19 concerns, and patient class compatibility. Medical leadership confirmed NKSP was short one to two providers during our review period. Two additional providers had been appointed over the previous 12 months.

Furthermore, in response to the backlog, medical leadership had increased the number of patients each provider was scheduled to see each day and added as-needed weekend and evening provider clinics. Physician providers were assigned to see 12 patients per eight-hour schedule and 16 patients per 10-hour schedule plus nurse co-consultations. Mid-level providers were scheduled for 10 patients in eight-hour workdays and 14 patients in 10-hour workdays. The physician providers stated they often also completed several co-consultations a day as well as at least two add-on patients on their schedules, and they expressed concern about the sustainability of this schedule. Regarding the add-on clinics, providers from NKSP and other institutions could volunteer for these extra shifts and were given hourly shift compensation. The providers expressed appreciation for the financial incentive of the additional work hours. They reported this had reduced the backlog and improved access since the review period.

Scheduling also discussed the backlog of ISUDT evaluations and appointments due to an increase in patients arriving on medication assisted treatment (MAT) from the county jails and CCHCS's full expansion of the program. Despite full expansion, a backlog of over 1,200 licensed clinical social worker initial ISUDT assessments existed as of September 2023. In addition, per the new arrival on MAT workflow, providers from CCHCS headquarters addiction medicine team were supposed to manage the new arrivals on MAT; however, they were short on providers and new arrivals on MAT were not being seen within compliance time frames. The responsibility for seeing these patients, whose care was already out of compliance, then became the responsibility of NKSP primary care providers when these patients were added to their schedules.

Compliance On-Site Inspection

Four of six housing units randomly tested at the time of inspection had access to health care services request forms (CDCR 7362) (MIT 1.101, 66.7%). In two housing units, custody officers did not have a system in place for restocking the forms. The custody officers reported reliance on medical staff to replenish the forms in the housing units. In addition, we found an unsecured designated health care services request form collection box in one of the two housing units.

Compliance Score Results

Table 5. Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient’s most recent chronic care visit within the health care guideline’s maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001)	20	5	0	80.0%
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)	20	4	1	83.3%
Clinical appointments: Did a registered nurse review the patient’s request for service the same day it was received? (1.003)	28	2	0	93.3%
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)	25	5	0	83.3%
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)	6	1	23	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)	0	0	30	N/A
Upon the patient’s discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007)	23	2	0	92.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	42	3	0	93.3%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	4	2	0	66.7%
Overall percentage (MIT 1): 84.7%				

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

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

Table 6. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003)	0	0	20	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)	12	8	0	60.0%
Was a written history and physical examination completed within the required time frame? (13.002)	10	0	0	100%
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	5	1	9	83.3%
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)	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	8	0	7	100%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	15	0	0	100%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	2	0	13	100%

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

Recommendations

We offer no specific recommendations for this indicator.

Diagnostic Services

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

Ratings and Results Overview

Case Review Rating
Adequate

Compliance Rating and Score
Inadequate (61.7%)

Case review found NKSP performed well in diagnostic services. Staff generally completed radiology and laboratory tests timely. Providers endorsed results within required time frames. However, providers often did not send patient results notification letters, or the letters were missing the required elements. After reviewing all aspects, the OIG rated the case review component of this indicator **adequate**.

NKSP's overall compliance testing scored low for this indicator. Staff performed excellently in providing radiology services as well as retrieving and reviewing radiology, laboratory, and pathology results. However, testing showed providers needed improvement in generating patient notification letters with all required key elements for diagnostic results. Based on the overall compliance score result, the OIG rated the compliance component of this indicator **inadequate**.

Case Review and Compliance Testing Results

OIG clinicians reviewed 150 diagnostic events and found 59 deficiencies, none of which were significant. Of these 59 deficiencies, we found 55 related to health information management (HIM) including patient results notification letters not being sent to the patient, letters missing required components, or late provider endorsements. Only four deficiencies were due to late or missed test completion.¹⁷

Test Completion

Compliance testing showed NKSP performed excellently in completing radiology tests within the required time frames (MIT 2.001, 100%). In contrast, NKSP performance in completing routine laboratory testing worsened from 100 percent in Cycle 6 to half that score in Cycle 7 (MIT 2.004, 50%). Additionally, the institution continued to perform poorly in STAT laboratory test completion and results receipt (MIT 2.007, 20.0%). Nursing staff also performed poorly in notifying the provider within 30 minutes of receiving STAT laboratory test results (MIT 2.008, 20.0%). Case review identified four deficiencies in laboratory test completion, none of which were significant, and one STAT radiology test

¹⁷ Deficiencies occurred in cases 1, 2, 8-18, 20, 22-25, and 53-55.

that was completed timely.¹⁸ This is discussed further in **Clinician On-Site Inspection** below.

Health Information Management

Both case review and the compliance team found NKSP staff retrieved routine laboratory and diagnostic results promptly and sent them to providers for review. Providers performed very well in endorsing both radiology (MIT 2.002, 90.0%) and laboratory (MIT 2.005, 90.0%) results timely.¹⁹

The providers always endorsed STAT laboratory test results within the required time frames (MIT 2.009, 100%). However, compliance testing showed, as in Cycle 6, nurses continued to perform poorly in timely notifying providers of STAT laboratory studies (MIT 2.008, 20.0%). Our clinicians did not find any deficiencies in the two STAT events in case review.

Compliance testing showed NKSP performed excellently in pathology results retrieval (MIT 2.010, 100%) and in provider review (MIT 2.011, 100%). However, providers rarely communicated pathology results to patients timely (MIT 2.012, 20.0%). Case reviewers identified two pathology results in their samples and found, in both cases, the providers timely retrieved, reviewed, and informed patients of the results. However, we found one minor deficiency for missing letter components.²⁰

NKSP performed poorly in communicating test results to patients. Compliance testing showed providers scored low in communicating radiology and laboratory test results to the patients (MIT 2.003, 50.0% and MIT 2.006, 0.0%). Case review identified 50 deficiencies related to patient notification letters. Of these, 28 deficiencies related to providers failing to notify patients of their test results within policy time frames. All but three of the missing notification letter deficiencies were due to one provider. Several providers were involved in the 22 additional deficiencies with patient notification letters missing at least one of the required elements.²¹

Clinician On-Site Inspection

OIG clinicians met with medical leadership and available laboratory and radiology staff. The relatively new chief support executive (CSE) met with us in lieu of the diagnostic services supervisor, who was out on long-term leave.

The NKSP radiology equipment was replaced in January 2023 and had been in good working order since that time. The X-ray services were available each weekday. During several months of the case review period, NKSP was short one radiology technician, but no backlog of services resulted. NKSP radiology technicians scheduled both the on-site and off-site specialty radiology appointments and were responsible for obtaining those reports.

¹⁸ Deficiencies occurred in cases 8, 17, 23, and 53.

¹⁹ Five deficiencies occurred in cases 18, 23, 53, and 54.

²⁰ Case review identified pathology events requiring follow up in cases 18 and 25.

²¹ Deficiencies occurred in cases 1, 9-18, 20, 22-25, and 55.

The new reception center, also called “diagnostics center,” planned to offer X-ray services for intake and screening assessments on newly arrived patients. The physical space for X-ray was built at the time of our inspection; however, equipment installation was pending.

On-site specialty imaging services were offered by outside vendors. Ultrasound and MRI clinics were offered once a month, while CT scans were offered every other week.²² Leadership discussed requiring more frequent on-site specialty imaging services than were currently available, but they did their best to work within these limitations.

Both on-site and specialty imaging radiology as well as laboratory test results interfaced directly with the EHRS.²³ Once received, the results automatically routed to the providers for review and endorsement. Diagnostics staff reported they were not responsible for monitoring provider endorsement of laboratory studies or ensuring patient results notification letters were complete and sent.

Laboratory testing completion rates varied between OIG compliance and case review. This may be due to slightly different sample periods. Compliance testing case samples for this indicator ranged from September 2022 through January 2023 and resulted in lower completion rates than case review. The case review inspection period was November 1, 2022, to April 30, 2023. NKSP reported a significant backlog of more than 2,600 laboratory studies involving more than 290 patients in November and December 2022. By January and February 2023, which were included in the case review period, laboratory testing completion rates improved to 50 percent with no backlog. Completion rates continued to improve to 94 percent by the end of the case review period.

Diagnostics leadership described many challenges to meeting compliance time frames:

- NKSP had a large number of new intake patients: 300 to 400 per week. New intake patients required intake screening laboratory tests and multiple COVID-19 tests be completed before release from quarantine.
- COVID-19 quarantine and class restrictions made it difficult for laboratory services to access patients and complete tests timely.
- A shortage of laboratory staff during the period contributed to a significant backlog and overtime continued to be utilized to meet compliance time frames.

When asked about staffing shortages and sustainability of continued overtime assignments for existing staff, leadership mentioned difficulty hiring lower-level administrative and technical staff, such as laboratory technicians, due to multiple factors. These factors included a high crime rate in NKSP’s location, regular periods of inclement weather, and lack of close institutions of higher education and professional schools. In

²² An MRI is a magnetic resonance imaging scan. A CT scan is a computed, or computerized, tomography imaging scan.

²³ EHRS is the Electronic Health Records System. The department’s electronic health record system is used for storing the patient’s medical history, and health care staff use the system to communicate with one another.

addition, leadership reported pay rates offered by CCHCS were not competitive; potential candidates could make more money in a more desirable environment, and several competing employers also offered telework options.

Since June 2023, a laboratory technician had been housed within the new diagnostics center and could process patient intake laboratory tests during the intake process, reducing the obstacles presented by COVID-19 quarantine and transport issues.

Compliance Score Results

Table 7. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001)	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	9	1	0	90.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	5	5	0	50.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	5	5	0	50.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	9	1	0	90.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	0	10	0	0
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	2	8	0	20.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	2	8	0	20.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	10	0	0	100%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	2	8	0	20.0%
Overall percentage (MIT 2): 61.7%				

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

Recommendations

- Medical leadership should determine the root cause(s) of challenges encountered when collecting, receiving, and notifying providers of STAT and routine laboratory results timely and implement remedial measures as appropriate.
- The department should consider developing strategies to ensure that providers create patient letters when they endorse tests results and that patient letters contain all elements required by CCHCS policy.

Emergency Services

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

Ratings and Results Overview

Case Review Rating
Inadequate

Compliance Rating and Score
Not Applicable

NKSP performed poorly in emergency services. In Cycle 7, OIG clinicians identified more deficiencies than in Cycle 6. A pattern continued from Cycle 6 to Cycle 7 with delays in emergency medical services (EMS) notification. NKSP nurses did not perform well during emergency events. Nursing staff generally responded promptly to emergent events. However, the nurses did not always perform an initial thorough assessment and did not always reassess patient vital signs and symptoms. Providers generally performed well in urgent and emergent care. Compliance testing showed the institution's EMRRC meetings were not held timely, incident packages were incomplete, and the CME and CNE or designee did not complete clinical reviews of the unscheduled transports. Our clinicians reached similar findings with the CNE and CME not completing clinical reviews in all the urgent and emergent cases. We identified further opportunities for improvement in the institution's ability to identify assessment, intervention, and documentation deficiencies. Factoring all aspects, the OIG rated this indicator *inadequate*.

Case Review Results

OIG clinicians reviewed 16 cases with 26 urgent or emergent events. We found 32 deficiencies, 11 of which were significant.²⁴

Emergency Medical Response

NKSP staff generally responded promptly to emergencies throughout the institution. OIG clinicians reviewed seven cases that required CPR.²⁵ Staff initiated CPR and notified

²⁴ Deficiencies occurred in cases 1, 2, 4, 8, 9, 19–21, 23, and 24. Significant deficiencies occurred in cases 1, 4, 9, 19, 20, 23, and 24.

²⁵ CPR events occurred in cases 3–9.

TTA staff timely. However, we identified a pattern of delays in activating EMS, ranging from 12 minutes to an hour.²⁶ The following are examples:

- In case 4, the patient reported snorting another patient's Suboxone and shortly became lethargic.²⁷ Nursing staff administered two doses of Narcan out in the field and transported the patient to the TTA. While in the TTA the patient required CPR. However, nursing staff did not activate EMS until 12 minutes after administering the initial dose of Narcan.
- In case 9, staff activated a medical alarm for an unresponsive patient. The registered nurse (RN) attempted to respond via the emergency response vehicle but documented the vehicle's engine would not start. Subsequently, the RN walked and arrived at the patient 14 minutes after the medical alarm was activated.
- In case 24, the patient sustained facial and head trauma including bleeding in the mouth. Nursing staff called for EMS an hour after the provider ordered the patient to be transferred urgently via ambulance to the community hospital. The ambulance arrived 23 minutes after the nursing staff called for EMS.

Provider Performance

Providers generally performed well in urgent and emergent situations. They usually were available to nursing staff, made accurate diagnoses, and completed documentation. Of the 26 emergency events, the OIG clinicians identified four deficiencies, two of which were significant:²⁸

- In case 19, the patient presented with chest tightness and low heart rate. The provider ordered the patient sent to the hospital urgently by ambulance instead of emergently. This led to a delay in patient care and placed the patient at risk.
- In case 20, the patient presented with severe abdominal pain, nausea, and vomiting. The provider ordered the patient sent to the hospital urgently via ambulance to rule out appendicitis, rather than emergently. Due to this order, the patient was not transported to the hospital until over 1.5 hours after the emergency event occurred.

Nursing Performance

NKSP nurses did not perform well during emergency events. The nurses did not always assess and monitor their patients to include reassessing vital signs and reassessing the patients' symptoms.

²⁶ The pattern of delays in activating EMS occurred in cases 1, 4, and 24.

²⁷ Suboxone is a medication to treat narcotic dependence.

²⁸ Deficiencies occurred in cases 1, 19, 20, and 23. Significant deficiencies occurred in cases 19 and 20.

- In case 1, the patient arrived at NKSP from the county jail. During the reception center intake process, the patient reported experiencing chest pain. The patient was immediately transported to the TTA for further evaluation. However, the TTA nursing staff did not assess chest pain onset, reassess the chest pain severity for more than an hour after the initial assessment, or reassess the pulse. In addition, the nursing staff activated EMS 12 minutes after the provider ordered the patient to be transported emergently via ambulance to the community hospital.
- In case 19, staff provided emergency services for the patient with complaints of chest tightness and a low heart rate with symptoms. The TTA nursing staff did not reassess the vital signs for approximately an hour while the patient was in the TTA. In addition, the nursing staff did not reassess chest tightness severity or chest pain for two hours while waiting for EMS to arrive in TTA.
- In case 23, the patient was evaluated in the TTA with an elevated blood pressure, severe headache, and moderate chest pain. The TTA RN did not initiate nitroglycerin per the chest pain protocol. Secondly, the TTA RN consulted with the provider 25 minutes after the patient arrived to the TTA for a further care plan. Lastly, the TTA RN, did not reassess the chest pain and headache severity after the initial assessment in the TTA.
- In case 24, the patient sustained facial trauma including bleeding in the mouth. The LVN responded to the patient and documented active bleeding in the mouth. The LVN did not initiate bleeding control measures and did not inquire about or document how the injury occurred. Additionally, the record was unclear on whether, prior to transporting the patient to the TTA, nursing appropriately assessed the patient to determine if the patient should have had cervical/lumbar spine immobilization and alternative transportation to the TTA, instead of via wheelchair, to prevent further injuries.

Nursing Documentation

TTA nurses usually documented sufficiently for emergent events, although documentation was lacking for the timeline of emergency events, the times EMS was requested, and the gauge of intravenous (IV) needles used.²⁹ These deficiencies did not affect overall patient care.

Emergency Medical Response Review Committee

Compliance testing showed NKSP's EMRRC performed poorly. In most cases, NKSP did not review cases timely, the incident package was incomplete, or the institution did not complete the clinical review portion for the CNE and CME or designee (MIT 15.003, 16.7%). Our clinicians found the EMRRC met monthly; however, the EMRR audits the SRNs performed usually did not identify training issues. In addition, our clinicians

²⁹ Deficiencies in TTA nursing documentation occurred in cases 1, 2, 9, 20, 21, and 24.

reached similar findings to the compliance team with the CNE and CME or designees not completing the clinical review portion of the EMRR checklist in all the urgent and emergent cases reviewed. Finally, none of the clinical reviews conducted by NKSP SRNs captured any of the multiple opportunities for improvement identified by our clinicians. Our clinicians reviewed 16 cases with urgent and emergent events and found 10 deficiencies, three of which were significant involving the EMRR checklist or the EMRRC.³⁰ The significant cases are provided below.

- In case 4, the SRN performed a clinical review for a patient who reported snorting another patient's Suboxone, became unresponsive requiring multiple doses of Narcan and CPR, and died at the institution. Nurses did not initiate EMS until 12 minutes after administering the initial dose of Narcan. In addition, the CME and the CNE did not perform a clinical review of the event. However, neither the SRN nor the EMRRC identified any training issues with this emergency event.
- In case 19, staff provided emergency services to a patient with chest pain and a low heart rate, who was transported to the community hospital. The SRN performed a clinical review on this patient and identified no training issues. TTA nursing staff did not reassess the vital signs for approximately an hour while the patient was in the TTA, and they did not reassess chest tightness severity or pain for two hours while waiting for EMS to arrive in the TTA. In addition, neither the CME nor CNE performed a clinical review and the EMRRC identified no training issues with this emergency event.
- In case 24, the patient was found bleeding in the mouth with facial injuries and was transferred to the community hospital. The CNE and CME did not perform a clinical review. In addition, the SRN who performed the review did not identify any concerns with the LVN failing to initiate bleeding control measures and inquire about or document how the injury occurred at the scene. In addition, the record was unclear on whether, prior to transport, nursing staff appropriately assessed the patient to determine if he should have had cervical/lumbar spine immobilization and alternative transportation to the TTA due to the injuries. Lastly, nursing staff did not notify EMS until approximately an hour after the provider ordered the transfer to the community hospital.

Clinician On-Site Inspection

OIG clinicians interviewed RNs, an SRN, MDs, the CNE, and the CME. The TTA had three bays and was staffed with two RNs on each shift. A provider for TTA was available on-site from 7:00 a.m. to 9:00 p.m., and available via phone from 9:00 p.m. to 7:00 a.m.

During the on-site inspection, the clinicians were informed the institution had one emergency response vehicle (ERV). During our review period, one case involved a delay of

³⁰ The EMRR and EMRRC deficiencies occurred in cases 1, 2, 4, 8, 19-21, 23, and 24. Significant deficiencies occurred in cases 4, 19, and 24.

14 minutes for TTA nursing response to an unresponsive patient due to the ERV not working. The CNE reported, after this emergency event, the ERV was taken for repairs and, the EMR coordinator and healthcare captain consulted with NKSP fire department to respond to medical emergencies until the ERV was repaired. In the interim, the ERV cart was used pending ERV repair. The ERV failure prompted a change in the ERV operational procedure. The TTA custody officer would drive the ERV around the facility at the start of each shift to ensure functionality and complete the monthly travel log. The TTA RNs were responsible for checking the ERV for cleanliness.

OIG clinicians identified a pattern of delays with notifying EMS after providers ordered a higher level of care transport. Both medical leadership and providers stated their belief that no difference occurs in urgent versus emergency ambulance time frames. However, the CNE informed our clinicians, for urgent transfers, they wait for custody to assemble their team prior to calling for the ambulance to prevent the ambulance staff arriving before custody has their team assembled. The CNE further noted the urgent ambulance transfers can take up to two hours to arrive at the institution. The TTA RN reported the custody team normally takes 20 minutes to assemble, and the ambulance arrives approximately 30 minutes after notification. The CNE reported she would address this current practice with a new policy because the staff should not wait for either the Request for Authorization of Temporary Removal for Medical Treatment form to be completed or for custody to have their team available and assembled prior to contacting the ambulance to prevent potential delay of interventions from the ambulance staff.

The CNE also reported the new EMR training had started the third week of August 2023 and the EMR was to be implemented at the end of January 2024.

The clinicians informed the CNE and TTA RN that the EMRR checklist provided during the reviews was a one-page form, which had an area for the CNE and the CME or designee's clinical review, but the form contained no designated area for a summary of the event, as required. The TTA SRN reported the EMRR checklist only had one page, the staff documented the summary of the events as needed, and they emailed the EMR checklist to the CME and CNE for review and confirmation but did not obtain their signatures.

The TTA SRN reported having recently started using the Emergency Medical Response and Unscheduled Transport Event Checklist to document the summary of events. NKSP also shifted to using DocuSign for the clinical reviews from the CME and CNE or designee for the EMR checklist.

Recommendations

- Nursing leadership should determine the challenges that prevent staff from immediately initiating EMS when indicated or when the provider orders the patient to be transported to the community hospital. Leadership should implement remedial measures as indicated.
- Nursing leadership should determine the root cause(s) of challenges that prevent nurses from performing complete assessments, timely interventions, and thorough documentation. Leadership should implement remedial measures as indicated.
- Nursing leadership should determine the root cause(s) of challenges SRNs face in completing thorough reviews of urgent and emergent events in which patients transfer to the community hospital and implement remedial measures as indicated.
- Executive leadership should determine the challenges preventing the EMRRC from reviewing all unscheduled transports to off-site hospitals and properly identifying all deficiencies in the quality of nursing or provider performance, policy, procedures, and form completion. Executive leadership should implement remedial measures as indicated.

Health Information Management

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

Ratings and Results Overview

Case Review Rating
Adequate

Compliance Rating and Score
Proficient (92.0%)

Case review found NKSP performed well in health information management this cycle. However, NKSP had performed better in Cycle 6. Although staff performed well in emergency documentation, we found deficiencies such as incomplete hospital discharge reports, late endorsement of specialty reports, illegible signatures, and lack of continuity of care. After reviewing all aspects, the OIG rated the case review component of this indicator **adequate**.

NKSP performed exceptionally well overall in compliance testing for this indicator. Staff excelled in scanning patient sick call requests and endorsing hospital records. The institution also performed well in retrieving and scanning hospital records, labeling, scanning medical records into the correct patient files, and scanning specialty documents. Based on the overall compliance score result, the OIG rated the compliance component of this indicator **proficient**.

Case Review and Compliance Testing Results

We reviewed 723 events and found 79 deficiencies related to health information management. Of these 79 deficiencies, only one was significant.³¹

Hospital Discharge Reports

Compliance testing showed NKSP staff retrieved hospital records and satisfactorily scanned them into the medical record (MIT 4.003, 85.0%). Providers always reviewed the hospital reports properly (MIT 4.005, 100%). Case review found similar results with the hospital records scanning and review. However, our clinicians found some hospital documents were scanned timely but were missing important diagnostic test results.³²

³¹ Deficiencies occurred in cases 9–18, 20, 22–25, and 54. A significant deficiency occurred in case 32.

³² The deficiencies occurred in cases 19 and 24.

Specialty Reports

NKSP performed satisfactorily in retrieving specialty reports (MIT 4.002, 83.3%). Providers performed excellently in endorsing high-priority specialty reports (MIT 14.002, 100%); however, provider endorsements of medium- and routine-priority specialty reports were only satisfactory (MIT 14.005, 80.0% and MIT 14.008, 80.0%).

Our clinicians reviewed 43 specialty reports and identified 10 deficiencies, none of which were significant.³³ The 10 deficiencies ranged from late specialty record retrieval to late provider endorsements. We discuss these findings further in the **Specialty Services** and **Provider Performance** indicators.

Diagnostic Reports

As in Cycle 6, staff performed excellently in this cycle with retrieving, and with providers reviewing, laboratory and diagnostic results. However, in Cycle 7, compliance testing showed NKSP performed poorly in notifying providers of STAT laboratory results and notifying patients of pathology and diagnostic results. Additional details can be found in the **Diagnostic Services** and **Provider Performance** indicators.

Urgent and Emergent Records

OIG clinicians reviewed 26 emergency care events and found both NKSP nurses and providers documented these events excellently. Case reviewers did not identify any documentation deficiencies.

Scanning Performance

NKSP performed well in scanning. Compliance testing showed medical records were properly scanned, labelled, and included in the correct patients' files (MIT 4.004, 91.7%). The OIG clinicians identified three deficiencies related to mislabeled or misfiled medical documents and four documents that were not scanned timely. None of these deficiencies were clinically significant.³⁴

OIG clinicians found nine deficiencies for illegible nursing signatures on several health care services request forms, which hindered identifying which nurse made each triage decision.³⁵ These signatures should have been identified before scanning.

Continuity of Care

OIG clinicians identified a significant deficiency in which the management of health information affected the continuity of care:

- In case 32, a new patient, who identified as transgender, arrived at the reception center with incomplete medical records. However, staff did not request the previous records needed to complete the patient's

³³ Deficiencies occurred in cases 15, 16, 18, and 54.

³⁴ Deficiencies occurred in cases 2, 15, 18, and 54.

³⁵ Deficiencies occurred in cases 23, 35, 39, 42, 43, 47, 48, and 50.

medical history. Therefore, they did not continue the patient's transgender care timely.

Clinician On-Site Inspection

We discussed health information management processes with NKSP health information management (HIM) supervisors, office technicians, ancillary staff, diagnostic staff, nurses, and providers. HIM staff said they were fully staffed during the review period. They did not identify any significant obstacles to completing their mission including no significant COVID-19 impact.

HIM staff had access to one local hospital system's electronic medical records, which expedited receipt of those records. However, they did not have direct access to any medical records systems—electronic or otherwise—belonging to the county jails from which some 300 to 400 incarcerated people per week were transported to NKSP. NKSP staff relied on paper documentation provided upon transfer for new patients arriving from county facilities. Medical leadership reported county jail transfer records were often unreliable and incomplete. HIM management stated the reception center nurses were responsible for reviewing the transfer documentation and, if it appeared incomplete, they would attempt to obtain additional records. HIM staff then would collect those paper records reviewed in reception and scan them in the next business day. In emergent situations, HIM staff would obtain and scan the records as quickly as necessary.

Leadership reported the on-site specialty nurses obtained the on-site specialty reports, forwarded them to providers for hardcopy endorsement, then sent them to HIM for scanning. HIM staff scanned the documents then forwarded the electronic versions for provider endorsement in the EHRS. Health record technicians monitored this process and sent follow up messages to the providers and leadership if specialty reports were not endorsed timely.

In our case reviews, we found many incomplete or missing patient results notification letters. HIM staff stated they do not train the providers on the requirements of these letters or monitor completion. They believe the CME and the chief physician and surgeon (CP&S) manage this process. This is discussed further in the **Provider Performance** and **Diagnostic Services** indicators.

HIM supervisors stated the medical schedulers were responsible for scanning health care services request forms and ensuring nurses' signatures were legible on the scanned versions. The supervisors told us staff would receive training to rectify this problem.

Compliance Score Results

Table 8. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient’s electronic health record within three calendar days of the encounter date? (4.001)	20	0	10	100%
Are specialty documents scanned into the patient’s electronic health record within five calendar days of the encounter date? (4.002)	25	5	15	83.3%
Are community hospital discharge documents scanned into the patient’s electronic health record within three calendar days of hospital discharge? (4.003)	17	3	5	85.0%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients’ files? (4.004)	22	2	0	91.7%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	25	0	0	100%
Overall percentage (MIT 4): 92.0%				

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

Table 9. Other Tests Related to Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	9	1	0	90.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	9	1	0	90.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	2	8	0	20.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	2	8	0	20.0%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	15	0	0	100%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	12	3	0	80.0%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	12	3	0	80.0%

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

Recommendations

We offer no specific recommendations for this indicator.

Health Care Environment

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

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

Ratings and Results Overview

<p>Case Review Rating Not Applicable</p>	<p>Compliance Rating and Score Inadequate (55.5%)</p>
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Overall, NKSP performed poorly with health care environment. In this cycle, multiple aspects of NKSP’s health care environment were poor: medical supply storage areas inside of the clinics either contained expired medical supplies or medical supplies stored directly on the floor; several areas of the examination rooms were unsanitary; emergency medical response bag (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 examining patients. Based on the overall compliance score result, the OIG rated the compliance component of this indicator *inadequate*.

Compliance Testing Results

Patient Waiting Areas

We inspected only indoor waiting areas as NKSP had no outdoor waiting areas. Health care and custody staff reported existing waiting areas contained sufficient seating capacity. Depending on the population, patients were either placed in the clinic waiting area or held in individual treatment modules (see Photo 1). During our inspection, we did not observe overcrowding in any of the clinics’ indoor waiting areas.

Photo 1. Indoor waiting area with individual treatment modules (photographed on 7-5-23).



Clinic Environment

Nine of 11 clinic environments were sufficiently conducive for medical care. They provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 81.8%). In one clinic, the vital signs check station was set up in the clinic hallway, and in the other clinic, the triage stations were within close proximity to each other. Both setups hindered auditory privacy.

Of the 11 clinics we observed, seven contained appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations (MIT 5.110, 63.6%). In the remaining four clinics, we observed one or more of the following deficiencies: examination room was cluttered (see Photo 2); examination room lacked visual privacy for conducting clinical examinations; clinics had unsecured confidential medical records; the examination room’s wall mounted oto-ophthalmoscope did not allow clinicians to examine the patient while lying on the examination table; examination chair was torn; and the clinic lacked auditory privacy during clinical encounters (see Photo 3, below).

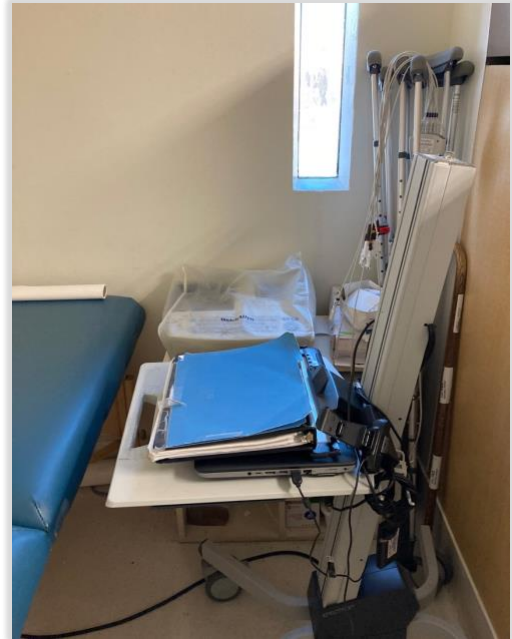


Photo 2. Cluttered examination room (photographed on 7-6-23).



Photo 3. The clinic lacked auditory privacy during clinical encounters (photographed on 7-6-23).

Clinic Supplies

Only two of the 11 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 18.2%). We found one or more of the following deficiencies in nine clinics: expired medical supplies (see Photo 4); unorganized or unidentified medical supplies; cleaning materials or medications stored with medical supplies; and medical supplies directly stored on the floor (see Photo 5).

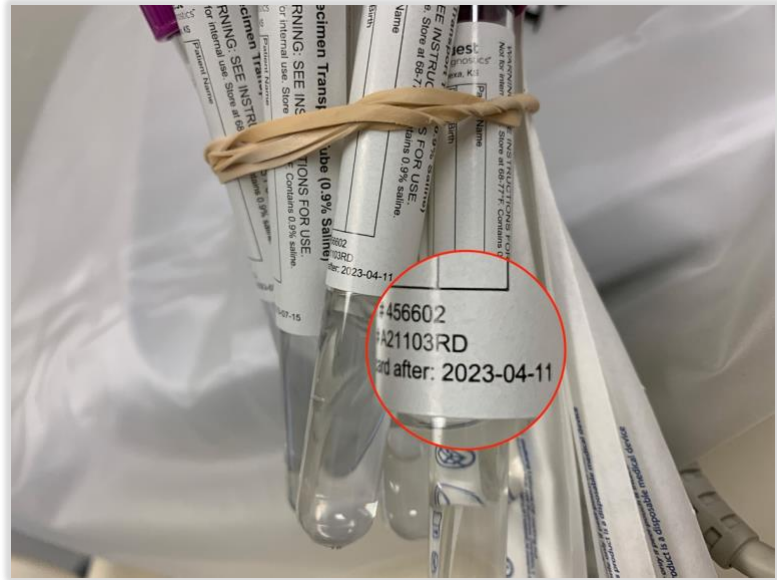


Photo 4. Expired medical supply dated April 11, 2023 (photographed on 7-5-23).

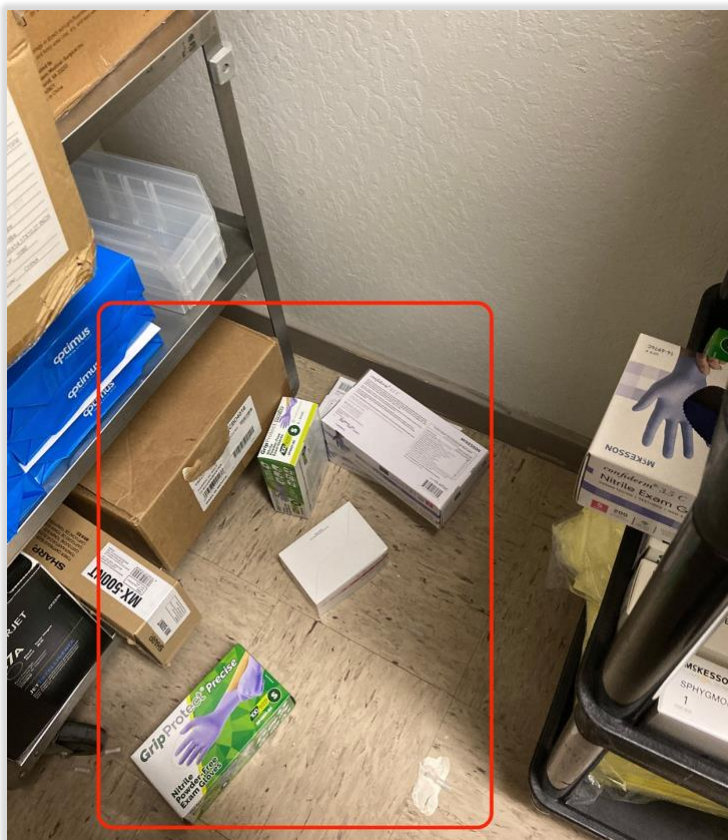


Photo 5. Medical supplies stored directly on the floor (photographed on 7-5-23).

None of the 11 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, zero). All 11 clinics lacked medical supplies or had nonfunctional equipment. The missing items included examination table paper, lubricating jelly, and a nebulization unit. Several clinics contained a nonfunctional oto-ophthalmoscope. In addition, staff had not completed the automated external defibrillator performance test log documentation within the previous 30 days, and several clinic daily glucometer quality control logs were either inaccurate or incomplete.

We examined EMRBs to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only six of the 10 EMRBs passed our test (MIT 5.111, 60.0%). In nine EMRBs we found one or more of the following deficiencies: staff failed to ensure the EMRB's compartments were sealed and intact; staff had not inventoried the EMRBs when the seal tags were replaced; EMRBs contained compromised medical supplies; or staff had not checked whether the EMRB oxygen tank was properly pressurized every shift.

In addition to the above findings, our compliance inspectors found the following in the clinics or examination rooms when they conducted their on-site inspection:

- Staff in Facility B had prefilled the clinic's tool control inventory report a day early (see Photo 6).

NORTH KERN STATE PRISON

DIVISION: CORRECTIONS MONTH July 2023
 SECTION: FACILITY
 UNIT: MEDICAL **TOOL CONTROL INVENTORY REPORT** PAGE 1 OF 1

TOOL DESCRIPTION	QTY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
PERCUSSION HAMMER	1	1	1	1	1	1	1	1																								
SCREW DRIVER	1	1	1	1	1	1	1	1																								
PILL CUTTER	1	1	1	1	1	1	1	1																								
THERMOMETER	2	2	2	2	2	2	2	2																								
PILL CRUSHER	1	1	1	1	1	1	1	1																								
PORTABLE SCALE	1	1	1	1	1	1	1	1																								
BP MACHINE	1	1	1	1	1	1	1	1																								
STRYKER GURNEY	1	1	1	1	1	1	1	1																								
GURNEY STRAP BUCKLE	8	8	8	8	8	8	8	8																								
STRYKER BATTERY	2	2	2	2	2	2	2	2																								
STRYKER BASE CHARGER	1	1	1	1	1	1	1	1																								
CLINIC WHEELCHAIR	1	1	1	1	1	1	1	1																								
AED HCP 195285	1	1	1	1	1	1	1	1																								
VISUAL CHECK (Y/N)	Y/N	Y	Y	Y	Y	Y	Y	Y																								
STAFF INITIALS																																
2ND WATCH (IN)																																
2ND WATCH (OUT)																																
3RD WATCH (IN)																																
3RD WATCH (OUT)																																
2W SRN II INITIALS																																
3W SRN II INITIALS																																

COMMENTS: _____ COLOR CODE: _____
 SCRIBE CODE: _____ SUPERVISOR SIGNATURE: _____
UNIT FILES TO BE MAINTAINED FOR SIX (6) MONTHS

Photo 6. Staff prefilled the clinic's tool control inventory report one day early (photographed on 7-6-23).

Medical Supply Management

Staff proficiently stored clinic medical supplies in the medical supply storage areas outside the clinics (e.g., warehouse, Conex containers, etc.) (MIT 5.106, 100%). According to the chief executive officer (CEO), the institution did not have any issues with the medical supply process. Health care and warehouse managers expressed no concerns about the medical supply chain or their communication process with the existing system in place.

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected five of 11 clinics (MIT 5.101, 45.5%). In seven clinics, we found one or more of the following deficiencies: the cleaning logs were not maintained; the clinic’s sink, cabinet under the sink, examination room floor, stretcher (see Photo 7), patient restroom, and staff restroom were unsanitary; an insect was in a drawer (see Photo 8); and a used glove was improperly disposed of in the shred bin.



Photo 7. Dusty stretcher (photographed on 7-6-23).



Photo 8. An insect found in a clinic drawer (photographed on 7-7-23).

Staff in seven of 11 clinics (MIT 5.102, 63.6%) properly sterilized or disinfected medical equipment. For three clinics, staff did not mention disinfecting the exam table as part of their daily start-up protocol. For one clinic, the staff did not remove and replace the examination table paper after each patient encounter.

We found operating sinks and hand hygiene supplies in the examination rooms in four of 11 clinics (MIT 5.103, 36.7%). In seven clinics, the patient restroom lacked antiseptic soap and disposable hand towels.

We observed patient encounters in six applicable clinics. In three clinics, clinicians did not wash their hands before examining their patients (MIT 5.104, 50.0%).

Health care staff in 10 of 11 clinics followed proper protocols to mitigate exposure to bloodborne pathogens and contaminated waste (MIT 5.105, 90.9%). In one clinic, we found a sharps container was overfilled, and biohazardous waste was not stored in the clinic's secured and labeled area.

Physical Infrastructure

At the time of our medical inspection, the institution reported the Health Care Facility Improvement Program (HCFIP) project had ongoing construction to renovate the pharmacy. The institution estimated the projects would be completed by the end of July 2023. In addition, the institution reported a construction delay for the pharmacy renovation due to code issues pending fire marshal approval.

Despite the pharmacy renovation delay, the CEO did not believe it negatively impacted the institution's current ability to provide good patient care (MIT 5.999).

Compliance Score Results

Table 10. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	5	6	0	45.5%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	7	4	0	63.6%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	4	7	0	36.4%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	3	3	5	50.0%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	10	1	0	90.9%
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)	1	0	0	100%
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	2	9	0	18.2%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	0	11	0	0
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	9	2	0	81.8%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	7	4	0	63.6%
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)	6	4	1	60.0%
Does the institution’s health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
Overall percentage (MIT 5): 55.5%				

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

Recommendations

- Medical leadership should analyze the root cause(s) of staff not following all required universal hand hygiene precautions and should implement necessary remedial measures.
- Executive leadership should analyze the root cause(s) of staff not following equipment and medical supply management protocols and should implement necessary remedial measures.
- Nursing leadership should determine the root cause(s) of staff not ensuring the EMRBs are regularly inventoried and sealed, and of staff failing to properly complete the monthly logs and should implement necessary remedial measures.
- Executive leadership should determine the root cause(s) of unclean clinics, medical storage rooms, and restrooms and should implement necessary remedial measures.

Transfers

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

Ratings and Results Overview

Case Review Rating
Adequate

Compliance Rating and Score
Proficient (87.1%)

NKSP's case review performance for this indicator was satisfactory. Compared to Cycle 6, our clinicians reviewed a similar number of events and deficiencies. NKSP's nursing staff showed significant improvement in thoroughly completing the initial health screening forms compared to Cycle 6. However, OIG clinicians found opportunities for improvement in documentation of vital signs and pending specialty service referrals for transfer-out patients. NKSP performed very well both in providing follow-up appointments within required time frames to patients returning from hospitalization and emergency room encounters as well as in retrieving and scanning hospital records timely. After reviewing all aspects, the OIG rated the case review component of this indicator **adequate**.

Compared with Cycle 6, NKSP's compliance performance greatly improved for this indicator. While compliance testing resulted in low scores for medication continuity for newly transferred patients, the institution performed excellently in completing the assessment and disposition section of the screening process. The institution also showed good performance in ensuring transfer packets for departing patients included the required documents and medications and in completing initial health screening forms for newly arrived patients. Based on the overall compliance score result, the OIG rated the compliance component of this indicator **proficient**.

Case Review and Compliance Testing Results

We reviewed 25 events in 15 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 15 deficiencies, two of which were significant.³⁶

Transfers In

OIG clinicians reviewed eight events in four cases in which patients transferred into the facility from other institutions.³⁷ The OIG clinicians found nurses evaluated patients appropriately, provided appropriate interventions, and requested provider appointments within required time frames in all cases reviewed.

Compliance testing showed nurses performed satisfactorily in completing the initial health screening forms thoroughly (MIT 6.001, 84.0%) and always completed the assessment and disposition sections of the initial health screening form (MIT 6.002, 100%). Compliance testing showed providers generally evaluated transfer-in patients within the required time frame (MIT 1.002, 83.3%).

Compliance testing revealed NKSP needed improvement in providing timely medications for transfer-in patients (MIT 6.003, 64.3%). The compliance team found NKSP performed poorly with medication continuity for patients laying over at the institution (MIT 7.006, 30.0%). However, patients who transferred from one housing unit to another frequently received medications without interruption (MIT 7.005, 80.0%). The case review clinicians identified one deficiency in medication continuity that was not significant. Please refer to the **Medication Management** indicator for further details.

Compliance testing showed patients who transferred into NKSP with preapproved specialty service appointments were usually scheduled timely (MIT 14.001, 80.0%). Please refer to the **Specialty Services** indicator for further details.

Transfers Out

NKSP's performance in the transfer-out process was fair. OIG clinicians reviewed five transfer-out cases and found five deficiencies, none of which were significant.³⁸ In compliance testing, nurses performed excellently with ensuring transfer packages included required medications and documents (MIT 6.101, 100%). However, our clinicians identified missing documentation and vital signs as described in the following cases:

- In cases 22 and 30, prior to the patients' transfer, nurses did not obtain a complete set of vital signs.
- In cases 2, 29, 30 and 31, nurses did not accurately complete the interfacility documentation to include all pending specialist appointments, such as a colonoscopy, EMG, TTE, and GI specialty

³⁶ Deficiencies occurred in cases 2, 19, 22, 24, 25, 27–31, and 55. Significant deficiencies occurred in cases 27 and 55.

³⁷ Transfer-in deficiencies occurred in cases 25, 27, and 28. A significant deficiency occurred in case 27.

³⁸ Transfer-out deficiencies occurred in cases 2, 22, and 29–31. No significant deficiencies occurred.

consultation.³⁹ Fortunately, the receiving institutions reconciled the pending specialty appointments.

Hospitalizations

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

NKSP performed very well in providing follow-up appointments within required time frames to patients returning from hospitalizations and emergency room encounters (MIT 1.007, 92.0%). NKSP's performance was good in retrieving and scanning hospital records (MIT 4.003, 85.0%). Compliance testing showed providers always reviewed and endorsed documents timely (MIT 4.005, 100%). Please refer to the **Health Information Management** indicator for further details.

The OIG clinicians reviewed 10 events that occurred in nine cases for patients who were treated at a community hospital.⁴⁰ We identified seven deficiencies, one of which was significant.⁴¹

- In case 55, the patient with a bone infection returned from the hospital after the hospital staff was unable to reestablish the PICC line.⁴² The hospital recommended the patient return the following day. In the interim, the hospital placed a right-arm peripheral IV to administer antibiotics. The patient was returned to the CTC housing unit. The nurses did not assess or document the left-arm PICC line site or document the antibiotic should only be administered through the new peripheral IV in the right arm per the hospital recommendations. Fortunately, the patient received the antibiotic as ordered.

Compliance testing showed NKSP performed poorly in medication continuity for patients discharging from the hospital to the institution (MIT 7.003, 44.0%). Case reviewers identified one medication deficiency, which was not significant.⁴³ Please refer to the **Medication Management** indicator for further details.

Patients almost always received timely provider follow-up appointments (MIT 1.007, 92.0%). Similarly, case review found no deficiencies for delays in provider follow-up appointments. Providers always reviewed hospital discharge documentation within the required time frame (MIT 4.005, 100%). Hospital or emergency room summary reports

³⁹ Electromyography (EMG) measures muscle response or electrical activity in response to a nerve's stimulation to the muscle. Transthoracic echocardiogram (TTE) is an ultrasound of the heart. Gastrointestinal (GI) specialist evaluates the digestive system.

⁴⁰ Hospitalization events occurred in cases 1, 2, 19–24, and 55.

⁴¹ Deficiencies occurred in cases 2, 19, 22, 24, and 55. A significant deficiency occurred in case 55.

⁴² PICC line is a peripherally inserted central catheter used to administer medications or obtain blood tests.

⁴³ Deficiencies occurred in case 2.

were generally scanned into EHRS and made available within required time frames (MIT 4.003, 85.0%). Please refer to the **Health Information Management** indicator for further details.

Clinician On-Site Inspection

During the OIG clinician on-site inspection, the reception center (RC) RNs conducted all RC intake transfers and intake screening for patients arriving from another institution. The RC RNs were assigned to the morning and evening shifts. The receiving and release (R&R) RN performed the transfer-out process. One R&R RN is assigned on each morning and evening shift. On the graveyard shifts, two R&R RNs and one LVN are assigned.

NKSP had between 60 to 120 transfer-out patients per day. The nurse reported, three months prior to the clinician on-site inspection, they had added one LVN to R&R for the early morning medication administration, and this new process had helped the RNs tremendously with the large number of patients requiring medications prior to transfer. The nurses reported one office technician was assigned to assist the nurses with the transfer packets. In the R&R, one medication cart had LCC medications so the nurses could administer medications timely during patient arrivals and departures.⁴⁴ The R&R had no Omnicell, so if additional medication was needed, they would obtain medications from the TTA Omnicell, which was in close proximity.⁴⁵

The TTA, R&R, and specialty areas were supervised by the same SRN. OIG clinicians identified a best practice at NKSP wherein this SRN performed daily huddles with the specialty team to ensure all new transfers or patients returning from the hospital had appropriate follow-up appointments and medications. In addition, this SRN ensured specialty referrals were timely reconciled.

⁴⁴ The licensed correctional clinic (LCC) stock are stock medications provided by the pharmacy for the medical staff to administer that are not patient specific.

⁴⁵ An Omnicell is an automated medication dispensing machine.

Compliance Score Results

Table 11. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001)	21	4	0	84.0%
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)	21	0	4	100%
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	9	5	11	64.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	10	0	0	100%
Overall percentage (MIT 6): 87.1%				

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

Table 12. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient’s clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	20	4	1	83.3%
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)	23	2	0	92.0%
Are community hospital discharge documents scanned into the patient’s electronic health record within three calendar days of hospital discharge? (4.003)	17	3	5	85.0%
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)	25	0	0	100%
Upon the patient’s discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003)	11	14	0	44.0%
Upon the patient’s transfer from one housing unit to another: Were medications continued without interruption? (7.005)	20	5	0	80.0%
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	7	0	30.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	7	4	0	63.6%

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

Recommendations

We offer no specific recommendations for this indicator.

Medication Management

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

Ratings and Results Overview

Case Review Rating
Adequate

Compliance Rating and Score
Inadequate (61.8%)

Case review found NKSP performed well in providing medications timely for transfer-out, transfer-in, reception center, hospital discharge, and specialized medical housing patients. However, NKSP needed improvement in medication continuity for chronic care medications. Overall, the OIG rated the case review component of this indicator **adequate**.

Compliance testing showed NKSP had a mixed performance for this indicator. The institution's pharmacy performed exceptionally in employing general security and storing medications in its main pharmacy. Compliance testing showed NKSP staff were proficient in medication continuity for transfer-out patients, and staff performed well in medication continuity for patients newly arrived to the reception center and patients transferring from one housing unit to another. Conversely, the institution still requires great improvement in timely providing chronic care medications, newly prescribed medication orders, hospital discharge medications, and medications for patients temporarily housed at NKSP. Based on the overall compliance score result, the OIG rated the compliance component of this indicator **inadequate**.

Case Review and Compliance Testing Results

We reviewed 120 events in 29 cases related to medications and found 16 medication deficiencies, six of which were significant.⁴⁶

New Medication Prescriptions

Compliance testing showed new medications were available or administered without delay a majority of the time (MIT 7.002, 75.0%). Compliance testing showed five samples of medications that either were not made available or were delivered to the patient up to

⁴⁶ Deficiencies occurred in cases 1, 2, 9, 12–14, 17, 18, 23, 25, 28, 34, and 55. Significant deficiencies occurred in cases 12–14, 17, and 23.

two days late. Our clinicians found four deficiencies related to new medications not being timely administered, one of which was significant.⁴⁷ Two examples follow:

- In case 1, the patient underwent an off-site surgical procedure and an antibiotic, Keflex, was ordered; however, the patient received the keep-on-person (KOP) antibiotic one day late.
- In case 23, the patient with a nasal skin infection received his newly ordered KOP amoxicillin medication two days late.

Chronic Medication Continuity

NKSP needed improvement in ensuring medication continuity for patients with chronic conditions. Compliance testing showed patients intermittently received their chronic care medications within required time frames (MIT 7.001, 52.2%). Compliance testing showed patients on medications for high blood pressure, cholesterol, or asthma received medication one day late or not at all. In addition, compliance testing revealed a patient refused insulin as scheduled multiple times; however, we found no documentation of counseling from the patient care team for refusing three or more consecutive days of insulin. In case review, our clinicians found patients did not receive their chronic care medications timely or did not receive them at all.⁴⁸

- In case 12, during the month of January 2023, the diabetic patient did not receive the KOP diabetic medications Jardiance and metformin. The patient received the KOP diabetic medications in February 2023, one month later.
- In case 13, during the month of January 2023, the diabetic patient did not receive the scheduled monthly KOP metformin. The KOP metformin was given in December 2022 and the next dose was given February 2023, almost two months later.
- In case 14, during the month of December 2022, the patient did not receive the KOP medications metformin and atorvastatin (cholesterol medication).
- In case 17, the patient was scheduled to receive the KOP lisinopril to treat high blood pressure. The patient did not receive the medication until three weeks later.
- In case 23, in the month of February 2023, the patient did not receive KOP medications for high blood pressure: amlodipine, furosemide, and hydralazine. The patient did not receive all the medications until they were nurse administered in March 2023, more than two months after the last administration of the KOP medication.

⁴⁷ New medication not received timely occurred in cases 1, 9, 18, and 23. A significant deficiency occurred in case 23.

⁴⁸ Chronic care medications not received timely occurred in cases 12–14, 17, 23, and 25. Significant deficiencies occurred in cases 12–14, 17, and 23.

Hospital Discharge Medications

Compliance testing showed NKSP performed poorly in ensuring patients received needed medications when they returned from an off-site hospital or emergency room (MIT 7.003, 44.0%). Testing similarly showed patients returning from the hospital did not receive their high blood pressure, antibiotic, cholesterol, diabetes, or seizure medications timely. In contrast, our clinicians found patients almost always received hospital discharge medications timely.⁴⁹

Transfer Medications

Compliance testing showed NKSP needed improvement in ensuring medication continuity for patients transferring into the institution (MIT 6.003, 64.3%). Compliance testing found a patient on high cholesterol medication received the medication 13 days late. Compliance testing also showed staff documented patients' refusals or no show/no barriers in the MAR; however, we found no documentation of the reason for the refusal or no show/no barriers. In contrast, OIG clinicians found the majority of the patients reviewed received their medications within the required time frame.

OIG clinicians and compliance testing found patients who transferred out of NKSP to another institution had all their transfer medications (MIT 6.101, 100%). Compliance testing showed patients who transferred from one housing unit to another generally received their medications timely (MIT 7.005, 80.0%). However, NKSP performed poorly in medication continuity for patients laying over at the institution (MIT 7.006, 30.0%).

Reception Center Medications

OIG clinicians and compliance testing found NKSP performed very well in ensuring patients arriving from the county jail received medications timely (MIT 7.004, 90.0%).

Specialized Medical Housing Medications

Medication continuity performance for patients admitted to the CTC was mixed. Compliance testing showed few patients admitted to the CTC received their medications timely (MIT 13.003, 40.0%). In contrast, our clinicians found only one deficiency related to medication management, which was not significant.⁵⁰

Medication Administration

NKSP performed very well in administering tuberculosis (TB) medications (MIT 9.001, 88.0%). However, nurses performed poorly in monitoring patients' prescribed TB medications (MIT 9.002, 28.0%). OIG clinicians did not identify any cases with lapses in administering TB medication.

Clinician On-Site Inspection

At the on-site inspection, the clinicians met with the pharmacist and nursing leadership to discuss case findings. During our discussion, the pharmacist informed us the

⁴⁹ Hospital discharge medication deficiency occurred in case 2.

⁵⁰ CTC medication deficiency occurred in case 55.

pharmacy department moved into their newly renovated location on Labor Day. Plans for the new space, drafted in 2009, originally intended to allow all pharmacy staff to work alongside the pharmacist. Unfortunately, due to the increase in pharmacy staff since 2009, the pharmacy department's workspace limitations did not improve.

The CEO indicated the pharmacy was short staffed between November 2022 and April 2023, which caused challenges with meeting the medication demands. These challenges were further exacerbated because NKSP is a reception center institution and has a high volume of patients in the integrated substance use disorder treatment program. They continued to provide the medications by offering overtime to the pharmacy staff.

OIG clinicians also toured the medication areas and interviewed medication nurses. We found the nurses were knowledgeable about the medication process. The medication nurses attended clinic huddles and notified the providers of expiring medications and other medication-related concerns.

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in six of nine applicable clinic and medication line locations (MIT 7.101, 66.7%). In two locations, narcotic medications were not properly and securely stored as required by CCHCS policy. In the remaining clinic, the nursing supervisor did not accurately describe the narcotic medication discrepancy reporting process.

NKSP appropriately stored and secured nonnarcotic medications in five of 11 clinic and medication line locations (MIT 7.102, 45.5%). In three locations, the medication area either lacked a clearly labeled designated area for refrigerated medication returns to the pharmacy, or the designated bin for returns to the pharmacy was unsanitary. In two locations, nurses did not maintain unissued medication in its original labeled packaging. In one location, the treatment cart log was missing daily security check entries.

Staff kept medications protected from physical, chemical, and temperature contamination in four of the 11 clinic and medication line locations (MIT 7.103, 36.4%). In seven locations, we found one or more of the following deficiencies: staff did not consistently record the room temperature; staff did not store internal and external medications separately; staff stored medications with disinfectants; staff stored medications directly on the floor; and the medication refrigerator was unsanitary.

Staff successfully stored valid, unexpired medications in eight of the 11 applicable medication line locations (MIT 7.104, 72.7%). In three locations, nurses did not label multi-use medications as required by CCHCS policy. In one of the three locations, we found expired medication vials.

Nurses exercised proper hand hygiene and contamination control protocols in one of seven applicable locations (MIT 7.105, 14.3%). In six locations, some nurses neglected to wash or sanitize their hands before preparing and administering medications, before donning gloves, or before each subsequent regloving. In two of the six locations, the medication nurses did not change gloves when the integrity of the gloves was compromised.

Staff in six of seven applicable medication preparation and administration areas had appropriate administrative controls and protocols (MIT 7.106, 85.7%). In one location,

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 two of seven applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 28.6%). In five locations, we observed one or more of the following deficiencies: medication nurses did not distribute medications to patients within the required time frames; medication nurses did not always verify patients' identification using a secondary identifier; medication nurses did not consistently observe patients while they swallowed direct observation therapy medications; and medication nurses did not follow CCHCS care guide when administering Suboxone medication.

Pharmacy Protocols

NKSP always followed general security, organization, and cleanliness management protocols for nonrefrigerated and refrigerated medications stored in its pharmacy (MITs 7.108, 7.109, and 7.110, 100%).

The pharmacist-in-charge (PIC) did not thoroughly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the nurse present at the time of the medication area inspection did not correctly complete the medication area inspection checklist (CDCR Form 7477) in one location. This error resulted in a score of zero for this test (MIT 7.111).

We examined 12 medication error reports. The PIC timely and correctly processed 11 of these 12 reports (MIT 7.112, 91.7%). The PIC did not provide a pharmacy error follow-up review form for one medication error.

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 NKSP, the OIG did not find any applicable medication errors (MIT 7.998).

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

Compliance Score Results

Table 13. Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001)	12	11	2	52.2%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	18	6	1	75.0%
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)	11	14	0	44.0%
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)	9	1	10	90.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	20	5	0	80.0%
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	7	0	30.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	6	3	3	66.7%
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	6	1	45.5%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	4	7	1	36.4%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	8	3	1	72.7%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	1	6	5	14.3%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	6	1	5	85.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	2	5	5	28.6%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	11	1	0	91.7%
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): 61.8%				

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

Table 14. Other Tests Related to Specialized Services

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)	9	5	11	64.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	10	0	0	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	22	3	0	88.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	7	18	0	28.0%
Upon the patient’s admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	4	6	0	40.0%

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

Recommendations

- The institution should develop and implement measures to ensure staff timely make available and administer medications to patients and document the medication administration record (MAR) summaries, as described in CCHCS policy and procedures.
- Nursing leadership should determine the challenges for nursing staff in documenting patient refusals in the MAR, as described in CCHCS policy and procedures, and implement remedial measures as appropriate.

Preventive Services

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

Ratings and Results Overview

Case Review Rating
Not Applicable

Compliance Rating and Score
Inadequate (74.5%)

NKSP showed a mixed performance in providing preventive services. Staff performed well in administering medications to patients who were prescribed TB medications, screening patients annually for TB, offering patients an influenza vaccine for the most recent influenza season, and offering colorectal cancer screening for patients from ages 45 through 75. However, NKSP performed poorly in monitoring patients taking prescribed TB medications, needed improvement in offering required immunizations to chronic care patients, and did not always timely transfer patients at the highest risk for coccidioidomycosis (Valley Fever). Based on the overall compliance score result, the OIG rated the compliance component of this indicator *inadequate*.

Compliance Score Results

Table 15. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	22	3	0	88.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	7	18	0	28.0%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	25	0	0	100%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	21	4	0	84.0%
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)	9	8	8	52.9%
Are patients at the highest risk of coccidioidomycosis (Valley Fever) infection transferred out of the facility in a timely manner? (9.009)	13	6	0	68.4%
Overall percentage (MIT 9): 74.5%				

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

Recommendations

- Nursing leadership should develop and implement measures to ensure nursing staff consistently perform patient monitoring as described in CCHCS Care Guides, and nursing staff completely address TB signs and symptoms in their patient monitoring.
- Medical leadership should determine the challenges to timely providing immunizations to chronic care patients and implement remedial measures as appropriate.
- Medical leadership should develop strategies to ensure patients at the highest risk of coccidioidomycosis (Valley Fever) are transferred in a timely manner and implement remedial measures as appropriate.

Nursing Performance

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

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

Ratings and Results Overview

Case Review Rating Adequate	Compliance Rating and Score Not Applicable
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NKSP nurses generally delivered good care, documented appropriately most of the time, and did well with providing timely face-to-face appointments. However, OIG clinicians found opportunities for improvement in nursing assessments, which did not increase risk of harm to patients. The OIG rated this indicator *adequate*.

Case Review Results

We reviewed 168 nursing encounters in 48 cases. Of the nursing encounters we reviewed, 67 occurred in the outpatient setting. We identified 85 nursing performance deficiencies, 12 of which were significant.⁵¹

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.

Nurses frequently provided timely and appropriate nursing care. Our clinicians identified 39 sick call events in 32 cases. In those events, our clinicians identified 31 outpatient

⁵¹ Deficiencies occurred in case 1, 2, 4, 8, 9, 15, 17–24, 29–31, 33, 34, 40, 44, 46–51, and 53–55. Significant deficiencies occurred in cases 1, 4, 9, 19, 23, 24, 50, and 55.

nursing deficiencies, three of which were considered significant.⁵² Of the 32 deficiencies, 17 were sick call deficiencies, one of which was significant.⁵³ These deficiencies occurred when the nursing staff did not always perform complete assessments. Examples of incomplete assessments are as follows:

- Our clinicians found a pattern of NKSP nursing staff not performing a set of vital signs or missing components to include a full set of vital signs in cases 1, 9, 17, 23, 46, 47, and 48.
- In case 9, the patient was in COVID-19 isolation during the review period. The patient had flu-like symptoms with fever, pain, and an elevated heart rate. However, the nursing staff frequently did not complete a full set of vital signs to include blood pressure readings and frequently did not address whether previous symptoms were worsening or resolving. Secondly, on several occasions, nursing staff did not perform COVID-19 isolation rounding twice per day as ordered. Lastly, the patient's oxygen saturation had decreased to 94% on three occasions; however, the nurses did not reassess the oxygen saturation, auscultate lung sounds, or obtain a blood pressure reading and did not consult a provider.
- In case 49, the RN evaluated the patient for an infection to the right arm. However, the sick call nurse did not assess right arm range of motion. In addition, the nurse did not document the measurements of the infection and did not document if the patient was compliant with the KOP doxycycline medication that was provided the day prior for the arm infection.
- In case 50, nursing staff triaged a sick call request for a hospital checkup due to pain that had caused loss of feeling to the lower body, trouble sleeping, and a report of falling once in the shower. The patient was not evaluated the same day of the sick call triage for the report of falling in the shower. The sick call RN evaluated the patient the next day and documented the patient had chronic lower back pain with spinal stenosis and had a pending back surgery appointment. However, the nurse did not assess extremity strength, sensation, and range of motion. In addition, the nurse did not obtain information regarding the fall in the shower to include the date and time of the incident, how the patient landed, if it was witnessed, and whether the patient sustained any injuries at the time of the fall.

⁵² Deficiencies occurred in cases 1, 2, 8, 9, 15, 17–19, 22–24, 40, 44, and 46–51. Significant deficiencies occurred in cases 9 and 50.

⁵³ Sick call deficiencies occurred in cases 1, 2, 8, 17, 19, 23, 24, 40, 44, and 46–51. A significant deficiency occurred in case 50.

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. NKSP nursing staff frequently documented care appropriately.

However, emergency services, transfers, and specialized medical housing showed room for improvement in documentation. Please refer to the **Emergency Services, Transfers, and Specialized Medical Housing** indicators for further details.

Case Management

Care managers evaluated patients with chronic conditions such as diabetes, hypertension, hepatitis C, and asthma. OIG clinicians reviewed two cases in which patients were evaluated by a care manager and identified one deficiency, which was not significant.⁵⁴ During the clinician on-site inspection, we were informed the care managers evaluated approximately 12 patients per day.

Wound Care

We reviewed three cases in which wound care was provided to the patients.⁵⁵ In two cases, the patients were in the CTC with a PICC line.⁵⁶ The clinicians identified opportunities for improvement in assessing the PICC line care as well as dressing changes. Please refer to the **Specialized Medical Housing** indicator for further details.

At the clinician on-site inspection, nursing staff informed us the licensed vocational nurse and psychiatric technicians performed wound care, which included documenting the measurement of the wound, documenting the wound drainage color, and noting any infection. In addition, they were to document if the wound was improving and to check whether the dressing was appropriate or needed reassessment with the RN or primary care physician (PCP).

Emergency Services

We reviewed 16 cases with 26 urgent or emergent events. We found 18 nursing performance deficiencies, six of which were significant.⁵⁷ Nurses generally responded promptly to emergent events. However, we identified a pattern with delays in notifying emergency medical services and with the CME or CNE not conducting clinical reviews of the unscheduled transfers. In addition, the nurses did not always perform an initial thorough assessment or reassess patients while waiting for the ambulance transfer to the hospital. Please refer to the **Emergency Services** indicator for further details.

⁵⁴ Patients evaluated by the care manager occurred in cases 3 and 9.

⁵⁵ Wound care occurred in cases 22, 54, and 55.

⁵⁶ PICC is a peripherally inserted central catheter, which provides intravenous access to administer fluids and medication.

⁵⁷ Nursing performance deficiencies occurred in cases 1, 2, 4, 8, 9, 19–21, 23, and 24. Significant deficiencies occurred in cases 1, 4, 9, 19, 23, and 24.

Hospital Returns

We reviewed 10 events in nine cases that involved returns from off-site hospitals or emergency rooms. We identified four nursing performance deficiencies, one of which was significant.⁵⁸ Please refer to the **Transfers** indicator for further details.

Transfers

We reviewed 15 cases that involved transfer-in and transfer-out processes. The nurses evaluated patients appropriately and initiated provider appointments within appropriate time frames. However, OIG clinicians found opportunities for improvement in documenting vital signs as well as pending specialty service referrals for transfer-out patients. Please refer to the **Transfers** indicator for further details.

Reception Center

We reviewed eight reception center cases with 27 events. The clinicians identified five nursing performance deficiencies, none of which were significant. OIG clinicians found nurses generally completed the initial health screening forms and performed thorough assessments. Please refer to the **Reception Center** indicator for further details.

Specialized Medical Housing

We reviewed four CTC cases with a total of 88 events that included 32 provider events and 20 nursing events. We identified 33 deficiencies, four of which were significant.⁵⁹ The clinicians found 17 of the deficiencies related to nursing performance, two of which were significant.⁶⁰ The clinicians found opportunities for improvement in nursing assessments, documentation, and PICC line care. Please refer to the **Specialized Medical Housing** indicator for further details.

Specialty Services

We reviewed 24 events in 10 cases in which nurses evaluated patients after returning from off-site specialist appointments or procedures. The clinicians identified five deficiencies, none of which were significant.⁶¹ The nursing staff provided good assessments, reviewed specialists' findings and recommendations, and communicated those results to the provider. The clinicians found opportunities for improvement in nursing documentation in four cases; however, it did not affect overall patient care.

⁵⁸ Nursing performance deficiencies occurred in cases 2, 19, 22, and 55. A significant deficiency occurred in case 55.

⁵⁹ Deficiencies occurred in cases 24 and 53-55. Significant deficiencies occurred in cases 53 and 55.

⁶⁰ Nursing performance deficiencies occurred in cases 24 and 53-55. Two significant deficiencies occurred in case 55.

⁶¹ Deficiencies occurred in cases 17, 18, 20, and 53.

Medication Management

OIG clinicians reviewed 120 events in 29 cases involving medication management. The OIG clinicians and compliance testing had mixed reviews. Please refer to the **Medication Management** indicator for further details.

Clinician On-Site Inspection

At the OIG clinician on-site inspection, our clinicians interviewed nurses in the TTA, CTC, Reception Center, specialty services, outpatient clinics, and medication areas. We attended well organized huddles in the clinics and the CTC and found staff were knowledgeable and familiar with their patient population. The nurses reported both the medication nurses and medication administration provided wound care, vaccines, and NIDA screenings.⁶²

The ISUDT SRN reported approximately 400 patients were in the ISUDT program and on Suboxone. The SRN reported the challenges for patients in the ISUDT program were the short-term stay, custody level, and limits on where patients who need methadone treatment could transfer. Only eight institutions are set up for methadone delivery (Substance Abuse Treatment Facility, California State Prison - Corcoran, Mule Creek State Prison, Valley State Prison, Wasco State Prison, North Kern State Prison, San Quentin Rehabilitation Center, and California Institution for Men).

NKSP C Yard had a population of 1,500 patients in a dorm setting that housed patients in general population and sensitive needs yard (SNY) as well as housing northerners. Nursing staff reported, normally, they have two primary RNs and two case manager RNs, but filling one primary RN vacancy position had been difficult. As a result, one case manager was frequently redirected to assist with sick call face-to-face (FTF) appointments. The case managers evaluated approximately 15 patients per day. The RNs would triage approximately 50 to 70 sick call requests per day and evaluate approximately 25 to 50 sick call FTF appointments a day. To help with the large volume, the case manager RN would assist and volunteer to stay after hours. This yard had a minimal backlog (three RN, one LVN) for the nursing staff at the time of our inspection, and all the backlog patients were scheduled that day. In contrast, the providers had a large backlog (159 requests). Newly arrived patients who were cleared after COVID-19 quarantine from B and D Yards were transferred to C Yard until they could transfer to the main yard, which contributed to the backlog in C Yard. The SRN reported challenges with patients being seen timely for their scheduled appointments in the clinic due to patients in the sensitive needs yard or the patient's gang affiliation, which required those patients not be housed or grouped together. Therefore, some patients were not seen as scheduled, and custody staff would work with medical staff the best they could. Staff also reported the challenge that telemedicine MAT appointments with social workers were time sensitive, which slowed the process for getting patients to the RN and provider lines.

D Yard had a population of 580 patients and housed 16 patients in COVID-19 isolation. We were informed the LVNs completed the isolation rounding, and if they found any abnormalities, they would contact the RN or PCP. LVNs also completed the low risk COVID scoring on the registry. This yard had two primary RNs and one care manager

⁶² National Institute on Drug Abuse (NIDA) is a screening tool utilized to identify substance use.

RN. NKSP staff reported RNs triaged approximately 35 sick calls per day and had 15 patients on the RN line per day.

Clinic SRNs reported they conducted 10 sick call face-to-face (FTF) audits per month per RN, and the testing was chosen randomly. In addition, SRNs reported they performed spot audits of both the primary and case manager charting, and provided training as needed. Staff reported, during huddles and population management meetings, they discussed patient care and any issues with orders, interventions, or medications. They also discussed if patients needed follow up care was needed and whether the care was appropriately ordered.

We met with the CNE, who addressed our findings and acknowledged several opportunities for improvements in nursing assessment, interventions, and documentation.

The CNE reported the RN clinic in B and C Yards have the largest sick call lines, from 30 to 45 patients per day. The CNE reported challenges with scheduling appointments. The large volume of appointments, approximately 250 bed moves per day, and patients frequently transferring in and out of the institution contributed to the difficulty in scheduling the patients timely. Even with the challenges the CNE reported, NKSP performed well (at 90 percent) in providing RN FTF appointment triage in one day for August 2023 in the Master Registry.

The CNE expressed challenges with implementing CCHCS programs and projects due to the institution being a reception center institution, decrease in staffing, and staff not staying more than three months. The CNE reported staff were leaving for higher education, better jobs, and greater work-life balance.

Recommendations

- Nursing leadership should determine the challenges that prevent outpatient nurses from performing complete assessments and implement remedial measures as indicated, such as training staff.

Provider Performance

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

Ratings and Results Overview

Case Review Rating Adequate	Compliance Rating and Score Not Applicable
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OIG case review found provider performance was mixed. Providers generally completed proper assessments and made sound medical decisions for their patients; however, we found some deficiencies. Providers performed well reviewing medical records carefully. Chronic care and continuity of provider care were good. Usually, providers gave appropriate emergency care while at the institution; however, the mode of emergency transport and associated times were sometimes inappropriate for patients' medical conditions. We identified a pattern of providers ordering specialty services for inappropriate time frames. In addition, providers did not always document progress notes, update patient medical record problem lists, or send complete patient test results notification letters. Factoring all performance aspects, the OIG rated this indicator **adequate**.

Case Review Results

OIG clinicians reviewed 102 medical provider encounters and identified 81 deficiencies, 16 of which were significant.⁶³ We identified 28 deficiencies due to missing patient results notification letters. In addition, our OIG physicians examined the quality of care in 20 comprehensive case reviews. Of these 20 cases, we found 18 **adequate** and two **inadequate**.⁶⁴

Outpatient Assessment and Decision-making

Providers generally completed proper assessments and made sound medical decisions for their patients. Being a reception center, we recognize the significant challenges associated with the large volume of patients coming into and going out of the facility. Most of the time, the providers took good histories, formulated differential diagnoses,

⁶³ Deficiencies occurred in cases 1, 2, 8, 9–20, 22–25, and 53–55. Significant deficiencies occurred in cases 1, 8, 9, 16, 19, 20, 23, 25, 53, and 55.

⁶⁴ We rated cases 9 and 25 **inadequate**.

ordered appropriate tests, provided care with the correct diagnosis, and referred patients to proper specialists when needed.

We identified 17 provider assessment and decision-making deficiencies, eight of which were significant and led to the death of one patient.⁶⁵ The following are examples:

- In case 1, the patient arrived from county jail with medical complaints consistent with a heart attack. The TTA provider did not order prophylactic nitroglycerin, which is standard care, despite being aware of the patient's history of a heart attack one month prior. This increased the patient's risk of injury and death.
- In case 9, an RN documented seeing a previously healthy patient with fever, body aches, shortness of breath, hemoptysis (coughing up blood), and chest pain with deep breathing. The provider was called and ordered Tylenol, COVID-19 RNA testing, and COVID-19 point of care testing. Within minutes, the same RN placed orders from a different provider ordering COVID-19 isolation rounding and contact precautions for 14 days. Neither provider ordered a provider follow-up assessment to ensure the patient improved or the coughing up blood was investigated. When the COVID tests returned negative, indicating the patient's symptoms were not from COVID-19, a provider did not reassess the patient. Neither provider documented the phone call from the nurse explaining the medical reasoning for the orders or the intended plan of care.
- Later in case 9, nursing informed a provider this patient, who had been in isolation for 13 days due to fever, chills, body aches, hemoptysis, and shortness of breath, again had fever, a rapid heart rate, chills, and a persistent cough. Despite this communication, no orders were placed, a provider did not see the patient, and no provider documentation was written. The ill patient was never assessed by a provider and died nine days later. Additional nursing deficiencies also contributed to the patient's demise throughout this case. The coroner determined the patient died of pneumonia.⁶⁶ Had the patient been appropriately evaluated and treated, his outcome could have been different. The OIG considered this patient's death to be an adverse event.

Outpatient Review of Records

Providers usually reviewed medical records carefully. This is especially critical because NKSP is a reception center for incoming patients. Collecting and documenting a

⁶⁵Provider assessment and decision-making deficiencies occurred in cases 1, 2, 8, 9, 15, 23, 24, 34, and 53. Significant deficiencies occurred in cases 1, 8, 9, and 23. We identified deficiencies that contributed to an adverse event (death) in case 9.

⁶⁶ Pneumonia is a generally treatable medical condition.

patient's outside medical data is critical to ensure adequate continuity of care. We identified only three deficiencies, none of which were significant.⁶⁷

Emergency Care

Providers usually managed patients in the TTA with urgent or emergent conditions appropriately. However, we found providers may not have sent patients to the hospital by the appropriate ambulance designation.⁶⁸ Of the 10 emergency cases where the patient required emergent transport, we identified two instances where the patients should have been sent emergently but were sent urgently, which led to delays in care. Both deficiencies were significant and are discussed further in the **Emergency Services** indicator and **Clinician On-Site Inspection** area below.

Chronic Care

In most instances, providers appropriately managed patients' chronic health conditions, were familiar with their patients, and provided appropriate care. We identified five deficiencies with quality of patient care, two of which were significant and are described below:⁶⁹

- In case 8, the provider performed a new intake H&P on a patient with a history of brain injury, intracranial shunt, and only one kidney. The provider did not perform a complete baseline neurologic exam, documented an inaccurate assessment of the cranial nerves, did not order outside medical records to ensure accurate medical history was obtained, and did not assess the patient's remaining kidney function.
- In case 23, the provider did not recognize the patient had critically elevated blood pressure requiring immediate treatment. This placed the patient at risk of possible stroke or heart injury.

Specialty Services

Providers usually reviewed high-priority specialty reports timely, but as discussed in the **Health Information Management** indicator, compliance testing revealed medium- and high-priority specialty report endorsements were sometimes delayed. Once specialty reports were reviewed, however, providers usually acted upon the specialist's recommendations and referred patients for specialty consultations. Case review identified a pattern of providers ordering referrals in inappropriate priority time frames or for incorrect locations of specialty services (e.g., ordered telemedicine provider but required an on-site provider assessment). We found eight deficiencies, five of which were significant. Examples of significant deficiencies include:⁷⁰

⁶⁷ Poor record review deficiencies occurred in cases 1, 53, and 55.

⁶⁸ Emergency events requiring a higher level of care transport occurred in cases 1, 2, 19–24, and 55. Emergency transport deficiencies occurred in cases 19 and 20; both were significant.

⁶⁹ Chronic care deficiencies occurred in cases 8, 15, 23, 34, and 54. Significant deficiencies occurred in cases 8 and 23.

⁷⁰ Deficiencies occurred in cases 1, 16, 25, 53, and 55. Significant deficiencies occurred in cases 16, 25, and 55.

- In case 16, the patient's prostate biopsy was positive for intermediate risk prostate cancer with perineural invasion. The specialist requested additional studies to determine if the patient's cancer had spread. The provider ordered a medium-priority nuclear medicine bone scan to evaluate for possible metastatic cancer due 1.5 months later. The specialty follow-up appointments to determine cancer treatment were pending completion of this and other studies; therefore, the provider should have ordered the scan urgently as high priority.
- More than 1.5 months later, also in case 16, an oncology specialist saw the patient for an initial prostate cancer evaluation. The oncologist requested the patient have an in-person specialty follow-up appointment, but the provider ordered a telemedicine appointment instead, delaying care to the patient.
- In case 25, on a colonoscopy, the specialist found the patient had a large rectal mass, likely to be cancerous, and needed an urgent colorectal surgery referral. The provider ordered the referral for a slower priority than medically indicated, ordered the wrong location (telemedicine instead of an in-person appointment), and selected the wrong type of specialist (general surgeon instead of colorectal surgeon). Because of these errors, the much-needed colorectal surgery evaluation did not occur until almost five months later.
- In case 55, the provider ordered a follow-up appointment for a patient with a spinal infection with neurology instead of neurosurgery. Staff did not discover the error until approximately 1.5 months later, two days before the incorrect neurology appointment was scheduled to occur. This delayed the patient's assessment by the proper specialist.

Outpatient Documentation Quality

Providers did not always document provider progress notes. We found 15 deficiencies, nine of which related to nurse communication and were the result of one provider.⁷¹ The remaining six related to orders without documented medical reasoning.

In the EHRS, a patient's documented problem list provides healthcare staff a snapshot of the patient's medical health and should be consistent with a patient's medical problems. We identified a pattern of providers not keeping problem lists up to date. Examples include:

- In case 13, throughout the review period, the provider did not update the patient's medical problem list to include sleep apnea and seizure disorder, both significant medical issues.

⁷¹ Deficiencies for missing provider progress notes occurred in cases 14, 15, 17, 18, 24, 54, and 55.

- In case 14, throughout the review period, the provider did not update the patient’s diagnoses of diabetes, hypertension, and hyperlipidemia in the patient’s medical record problem list.
- In case 15, throughout the review period, the provider did not update the patient’s medical concerns of anemia, history of congestive heart failure, hypothyroidism, and history of thoracic aorta aneurysm stent graft repair to the patient’s medical problem list.

Patient Notification Letters

After providers interpret laboratory results, they send test result notification letters. Most providers performed well in sending letters; however, NKSP had a high rate of deficiencies, mostly due to one provider. This is discussed further in **Clinician On-Site Inspection** area below. Also, when providers sent patient notification letters, the letters often did not include the four elements as required by policy.⁷² We found 22 deficiencies, none of which were significant.

Outpatient Provider Continuity

Generally, the institution offered good provider continuity. Providers were assigned to specific clinics and specialized medical housing units to ensure continuity of care. We found one deficiency, which was significant:

- In case 53, the specialized medical housing patient was seen by eight different providers in a span of 13 appointments. This increased the risk of medical error.

Clinician On-Site Inspection

OIG clinicians met with medical leadership, providers, and nursing staff. The providers covered the CTC, the TTA, diagnostics (reception center), restrictive housing unit, and five clinics. At the time of our inspection, NKSP employed five physicians and four advanced practice providers (nurse practitioners and physician assistants).

Medical leadership discussed provider staffing challenges. Two providers were on chronic intermittent illness leave and NKSP had no coverage for provider regularly accrued time off. In addition, NKSP had one more physician allotment they had given to headquarters telemedicine with the understanding the telemedicine provider would support NKSP clinics. However, that telemedicine provider was reassigned, and headquarters telemedicine had not returned the physician position to NKSP. Therefore, they were short one provider but did not have an open physician position for recruitment.

To reduce appointment backlogs, medical leadership increased the providers’ daily appointment schedules to 16 patients per 10-hour workday and 12 patients per eight-hour workday, including nursing co-consultations. In addition, medical leadership had added weekend and evening clinics to reduce the backlog.

⁷² Providers did not send letters in cases 9–18, and 20–25. Letters missing necessary components occurred in cases 1, 15, 16, 18, 23–25, and 55.

Several providers mentioned the increase in number of patients was challenging; however, most were very happy with their leadership, fellow providers, and nursing support. NKSP was one of the institutions able to offer the 15% increase pay differential to attract providers. NKSP also offered a ten-hour workday, which most providers took advantage of, citing the benefits of decreased commuting time and reduced stress overall.

NKSP leadership and staff had differing views on the emergency process. Medical leadership and providers stated urgent and emergent transports took the same transport time to the emergency department. However, custody and nursing leadership mentioned the transport times were not the same. The ambulance may travel at the same speed regardless of emergency designation; however, custody was expected to have a transport team assembled for emergency transport immediately, whereas the expectation for urgent transport was assembly within 20 minutes.

Medical leadership mentioned specialty schedulers did not schedule specialty appointments based on the priority time frame ordered. Rather, they placed the patient in the next available specialty appointment regardless of the priority time frame. In light of this, they felt the actual priority ordered was not important. The OIG case review team disagrees. As NKSP is a reception center, most patients would transfer to another institution, sometimes before the specialty appointment occurs. CCHCS policy states, when a patient transfers to another institution, the receiving institution must schedule that appointment within the originally ordered compliance time frame, not the scheduled appointment date. The practice of ordering specialty referrals with a delayed compliance date places patients at risk of delayed specialty medical care.

Notably, the provider with the most deficiencies for missing patient notification letters stated he was not aware patient notification letters were required or that letters had required components. Also, the provider with the most deficiencies for missing progress notes was the physician who would oversee the CTC patients but round on them only one day a week.⁷³ This CTC physician also worked full-time in other NKSP clinics, and nursing staff frequently contacted this physician for CTC patient orders in the evenings while he was working in other clinics. These factors made completing appropriate documentation difficult.

⁷³ An advanced practice provider was present daily.

Recommendations

- Medical leadership must familiarize themselves with the different time frames associated with emergency transport versus urgent transport as established in state and local policy. Medical leadership should also develop and implement strategies to educate and train providers on the differences in these time frames to ensure orders designation appropriate transport levels.
- Medical leadership should determine the cause(s) of challenges to providers ordering specialty services for medically appropriate priorities and time frames and implement remedial measures as appropriate.
- Medical leadership should determine the cause(s) of challenges to providers completing appropriate medical documentation, including on-call progress notes and updated patient medical problem lists and implement remedial measures as appropriate.

Reception Center

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

Ratings and Results Overview

Case Review Rating
Adequate

Compliance Rating and Score
Inadequate (71.7%)

In case review, NKSP generally delivered good reception center medical care. We found nurses generally completed the initial health screening forms and performed thorough assessments. In addition, staff performed well in medication continuity and provided timely specialty service appointments. In contrast, providers needed improvement in completing timely provider H&P examinations. After reviewing all aspects, the OIG rated the case review component of this indicator **adequate**.

Compliance testing showed NKSP staff performed well in completing the initial health screening form and maintaining medication continuity for patients arriving from the county jails. However, NKSP staff needs improvement with timely completing screening intake tests. Based on the overall compliance score result, the OIG rated the compliance component of this indicator **inadequate**.

Case Review and Compliance Testing Results

Our clinicians reviewed eight reception center cases with 27 events. The clinicians identified 17 deficiencies, five of which were significant.⁷⁴

Provider Access

Both compliance testing and case reviewers revealed reception center provider access needed improvement. New patients from county jails intermittently received the required provider performed physical examinations, including H&Ps, within seven days (MIT 12.004, 60.0%). Similarly, OIG clinicians found, in four out of eight reception center cases, the provider did not timely evaluate the patients for an H&P.⁷⁵ Please refer to the **Access to Care** indicator for further details.

⁷⁴ Deficiencies occurred in cases 1, 2, 8, 23, 24, and 32–34. Significant deficiencies occurred in cases 1, 8, and 32.

⁷⁵ Provider access deficiencies occurred in cases 2, 8, 32, and 33. Significant deficiencies occurred in cases 8 and 32.

Nursing Performance

OIG clinicians found nurses generally completed the initial health screening forms and performed thorough assessments. Compliance testing showed nurses performed very well in completing the initial health screening forms thoroughly (MIT 12.001, 90.0%) and performed perfectly in completing the assessment and disposition sections (MIT 12.002, 100%). However, we reviewed eight cases of patients who arrived via the reception center and identified five nursing performance deficiencies, none of which were significant. The following are examples:

- In case 34, the RN assessed a patient newly arrived from the county jail with multiple chronic conditions and a colostomy bag. The nurse did not assess the patient's abdominal area for a skin assessment or ensure the patient had wound care supplies for the colostomy bag changes. Fortunately, the provider saw the patient the following day and ordered colostomy supplies as well as a LVN follow-up for wound care.
- Also in case 34, the nurse incorrectly documented the patient did not have any pending medical appointments. However, the patient arrived with pending specialty referrals to cardiology, gastroenterology, neurology, and radiology.

Compliance testing showed staff offered screening intake tests; however, staff only intermittently completed the tests timely (MIT 12.005, 65.0%). In contrast, our OIG clinicians found staff generally completed the screening intake tests on time. Compliance testing further showed the institution performed very well in maintaining medication continuity for patients arriving from the county jail (MIT 7.004, 90.0%) and ensuring specialty service appointments occurred timely (MIT 1.008, 93.3%). Our case review clinicians reached similar findings.

Clinician On-Site Inspection

During the clinician on-site inspection, we toured the new diagnostics area that opened in June 2023. The diagnostics area connected to the R&R area and allowed for same day RC processing of new arrivals by nursing, medical, dental, laboratory, and mental health services. The diagnostics area did not contain an Omnicell, but if medications were needed, the nursing staff could obtain those medications from the TTA Omnicell, which was in close proximity.

The RC nursing staff were knowledgeable about their job duties and the reception intake process. The RC had two RNs and two nurse practitioners. An RC RN was assigned both in the morning and evening shift. In addition, another RC RN was assigned during the swing shift.

The CNE reported challenges with constant RC movement of approximately 300 RC patients weekly. The nursing staff reported between 60 to 220 RC departures to other institutions per day. Additionally, according to policy, one week prior to a patient's transfer from county jail to a RC, custody notifies the RC by email of the patients who would be arriving. However, the nursing staff reported they frequently did not receive a

bus list from the county jail in advance for the new arrivals. Instead, they usually learned of incoming new patients when the patient arrived at NKSP.

Compliance Score Results

Table 16. Reception Center

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: Did nursing staff complete the initial health screening and answer all screening questions upon arrival of the patient at the reception center? (12.001) *	18	2	0	90.0%
For patients received from a county jail: Did the RN complete the assessment and disposition section, and sign and date the completed health screening form upon patient’s arrival at the reception center? (12.002) *	19	0	1	100%
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003) *	0	0	20	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) *	12	8	0	60.0%
For patients received from a county jail: Were all screening tests offered or completed within specified timelines? (12.005) *	13	7	0	65.0%
For patients received from a county jail: Did the primary care provider review and communicate the intake test results to the patient within specified timelines? (12.006)	6	14	0	30.0%
For patients received from a county jail: Was a coccidioidomycosis (Valley Fever) skin test offered, administered, read, or refused timely? (12.007)	17	3	0	85.0%
Overall percentage (MIT 12): 71.7%				

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

Table 17. Other Tests Related to Reception Center

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: Were all medications ordered by the institution’s reception center provider made available, administered, or delivered to the patient within the required time frames? (7.004) *	9	1	10	90.0%

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

Recommendations

- Medical leadership should determine the challenges providers encounter when completing H&P examinations within required time frames, as required by CCHCS policy, and implement remedial measures as appropriate.
- NKSP leadership should determine the root cause(s) of patients not receiving Reception Center laboratory services timely and implement remedial measures as appropriate.

Specialized Medical Housing

In this indicator, OIG inspectors evaluated the quality of care in the specialized medical housing units. We evaluated the performance of the medical staff in assessing, monitoring, and intervening for medically complex patients requiring close medical supervision. Our inspectors also evaluated the timeliness and quality of provider and nursing intake assessments and care plans. We assessed staff members' performance in responding promptly when patients' conditions deteriorated, and we 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, NKSP's specialized medical housing consisted of a correctional treatment center (CTC).

Ratings and Results Overview

Case Review Rating
Adequate

Compliance Rating and Score
Inadequate (48.0%)

Case review found NKSP performed satisfactorily in this indicator. Compared to Cycle 6, we reviewed a greater number of provider and nursing events. Similar to Cycle 6, we found providers evaluated their patients within the required time frames and delivered good care. The nurses rounded on patients routinely and generally notified the provider when they identified abnormal findings. However, we found opportunities for improvement in nursing assessments, documentation, and peripherally inserted central catheter (PICC) line care. Overall, the OIG rated the case review component of this indicator **adequate**.

Compared with Cycle 6, compliance testing showed NKSP needed improvement in this indicator. NKSP performed excellently in completing initial assessments and in completing H&P examinations within required time frames. However, records contained poor medication continuity for patients newly admitted to specialized medical housing. Compliance testing also revealed the CTC did not maintain an operational call system to ensure patients have access to care, and the CTC staff did not perform patient safety checks timely. Based on the overall compliance score result, the OIG rated the compliance component of this indicator **inadequate**.

Case Review and Compliance Testing Results

We reviewed four CTC cases with 88 events that included 32 provider events and 20 nursing events. Due to the frequency of nursing and provider contacts in the specialized medical housing, we bundled up to two weeks of patient care into a single event. We identified 33 deficiencies, four of which were significant.⁷⁶

⁷⁶ Deficiencies occurred in cases 24 and 53-55. Significant deficiencies occurred in cases 53 and 55.

Provider Performance

Providers delivered good care to the specialized medical housing patients. Compliance testing showed providers performed excellently in obtaining timely admission H&P (MIT 13.002, 100%). OIG clinicians reviewed 32 specialized medical housing provider events in four cases and did not identify any delays in admission H&Ps. Providers completed their rounds at clinically appropriate intervals, generally developed good care plans, and made sound medical decisions. We found a pattern of seven missing provider progress notes omitted by one provider, but none were significant. In addition, we identified one significant deficiency related to incorrect specialty services orders, which is discussed in the **Provider Performance** indicator.⁷⁷

Nursing Performance

Compliance testing showed CTC nurses performed excellently in providing timely admission assessments (MIT 13.001, 100%). The OIG clinicians reached similar findings.

OIG clinicians concluded, of the 33 deficiencies identified in the CTC cases, 17 deficiencies related to nursing performance, two of which were significant.⁷⁸ CTC nurses conducted regular rounds and generally provided satisfactory care. However, our clinicians found opportunities for improvement in performing thorough nursing assessments, documentation, and PICC line care.

- In case 53, the RN obtained the patient’s vital signs during CTC rounds, and the patient had an abnormally elevated heart rate. However, the RN did not recheck the patient’s heart rate or notify the provider. In another event, an RN evaluated the patient for abdominal cramping. The RN did not describe the abdomen appearance or palpate the abdomen. Additionally, the nurse documented “unable to assess” bowel sounds; however, we found no signed refusal form on file.
- In case 54, the patient with disseminated cocci had a PICC line for IV fluids and IV antibiotics. The CTC nurses performed daily assessments, provided wound care to the left chest, and communicated well with the laboratory staff to ensure they received STAT laboratory results and notified the PCP. However, we identified opportunities for improvement in assessments of intake and output, PICC line care, and skin assessments. For example, the CTC nurses did not always change the PICC line caps with weekly dressing changes and did not always flush the PICC line after administering IV antibiotics.
- In case 55, the patient had osteomyelitis (bone infection causing inflammation) and had a PICC line for antibiotics. During the review period, the nurses frequently did not document assessments of the

⁷⁷ Provider performance deficiencies occurred in cases 53–55. The two significant deficiencies occurred in cases 53 and 55. The documentation deficiencies occurred in cases 54 and 55.

⁷⁸ Nursing performance deficiencies occurred in cases 24 and 53–55. Two significant deficiencies occurred in case 55.

PICC line for appearance or signs of infection and did not measure the external line to ensure proper placement when administering IV antibiotics. We identified opportunities for improvement in PICC line care; however, they did not impact the care provided. The patient completed the antibiotics, discharged to outpatient housing, and was followed closely by the infectious disease and neurosurgery specialists.

Compliance testing showed NKSP performed poorly in maintaining an operational call system to ensure CTC patients have access to care, and the CTC staff performed poorly in conducting patient safety checks timely (MIT 13.101 and 13.102, zero). At the time of the compliance team's on-site inspection, the CTC call light system was in disrepair. In addition, although rounding checks must be completed every 15 minutes, during the compliance testing on-site, we discovered the nursing service call light system rounds checklist was missing documentation of rounding checks for more than three hours.

Medication Administration

Compliance testing showed NKSP performed poorly in ensuring patients admitted to the CTC received their medications timely (MIT 13.003, 40.0%). Our clinicians identified one deficiency related to medication management, which was not significant.⁷⁹ Please refer to the **Medication Management** indicator for further details.

Clinician On-Site Inspection

The institution had six medical CTC beds and ten CTC mental health beds. NKSP had two designated negative pressure rooms, which are designed to minimize the spread of airborne infection. During the OIG clinician on-site inspection, patients occupied six medical beds and eight patients occupied the mental health beds.

The CTC had 24-hour nursing staff. The CTC nursing staff informed the OIG clinicians they were assigned on the morning shift with a lead RN, one medical RN, one mental health RN, one psychiatric technician, one LVN, and one CNA as needed. On the evening shift, they had one lead RN, a medical and mental health RN, and one psychiatric technician. On graveyard shift, staffing included one lead RN, one medical RN, and one mental health RN. The lead RNs conducted audits on every shift and performed a random sample audit with new admissions after three days to ensure documentation was complete.

Our clinicians observed the CTC huddle, which was well attended and included the nurses, medical and mental health providers, recreational therapist, dietician, utilization management nurse, SRN, and custody staff. They discussed pertinent patient information including on-site/off-site specialty appointments, admissions, discharges, refusals of vital signs, and medication compliance.

The OIG clinicians interviewed the CTC RNs and found they were knowledgeable regarding the PICC line care, flushes, assessment, and documentation. The nurses stated the RNs on every shift completed a head-to-toe assessment and vital signs. The nursing staff reported PICC line flush orders could be confusing; however, they would contact the

⁷⁹ A medication management deficiency occurred in case 55.

provider if they found discrepancies in the orders. The nursing staff also reported, for patients who were on continuous IV fluids, they did not measure the urine output but only documented the patient's report of the number of times they urinated. However, the CTC nurses acknowledged, under their local operating procedures, they should have been documenting the measurement of fluid intake or urine output, not the number of times the patient reported urinating.

Compliance On-Site Inspection

At the time of on-site inspection, the CTC had a nonfunctional call light system (MIT 13.101, zero), and the CTC patients' safety check log had several missing entries. Thorough completion of the safety check log is required in the institution's local operating procedure in the event the call light system is inoperable (MIT 13.102, zero).

Compliance Score Results

Table 18. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission? (13.001)	10	0	0	100%
Was a written history and physical examination completed within the required time frame? (13.002)	10	0	0	100%
Upon the patient’s admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	4	6	0	40.0%
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101)	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)	0	1	0	0
Overall percentage (MIT 13): 48.0%				

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

Recommendations

- Nursing leadership should determine the challenges preventing CTC nursing staff from completing thorough patient assessments, including PICC line care, and from completing thorough documentation. Nursing leadership should implement remedial measures as appropriate.
- Nursing leadership should determine the challenges preventing CTC nursing staff from completing the call light system rounding checklist every 15 minutes as per the local operating procedures and should implement remedial measures as appropriate.
- The institution should ascertain the root cause(s) related to why medications are not consistently available and administered in a timely manner to specialized medical housing patients and should implement remedial measures as appropriate.

Specialty Services

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

Ratings and Results Overview

Case Review Rating Adequate	Compliance Rating and Score Proficient (87.4%)
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OIG case review found NKSP's performance in specialty services was good. Specialty services usually occurred as ordered; however, we found providers often ordered specialty services for inappropriate priority time frames. Nurses performed satisfactorily with patient assessments when patients returned from off-site specialty appointments. We found specialty reports were not always scanned timely, but once scanned, providers usually endorsed them within the required time frames. Overall, the OIG rated the case review component of this indicator **adequate**.

Compliance testing showed NKSP performed excellently in specialty services. Staff almost always timely provided initial routine-priority specialty services and subsequent follow-up appointments for medium- and routine-priority specialty services. Staff also timely retrieved and endorsed high-priority specialty reports. However, compliance testing resulted in low scores for providing preapproved specialty services. Based on the overall compliance score result, the OIG rated the compliance component of this indicator **proficient**.

Case Review and Compliance Testing Results

The OIG clinicians reviewed 85 specialty services events, including 55 specialty encounters, 24 nursing encounters, and six provider encounters. We found 26 deficiencies in this category, five of which were significant.⁸⁰

Access to Specialty Services

NKSP performed very well in meeting specialty referral compliance dates. Compliance testing showed staff performed satisfactorily in completing most high-priority appointments (MIT 14.001, 80.0%), performed well in completing medium-priority appointments (MIT 14.004, 86.7%), and performed excellently in completing routine specialty appointments within required time frames (MIT 14.007, 100%). Case reviewers

⁸⁰ Deficiencies occurred in cases 1, 15–18, 20, 21, 23, 25, 53, and 55. Significant deficiencies occurred in cases 16, 23, 25, and 54.

identified four access to specialty care deficiencies related to missed compliance dates, one of which was significant:⁸¹

- In case 54, the provider ordered a follow-up GI specialty appointment for a patient with severe iron deficiency anemia and possible gastrointestinal bleeding. The specialty appointment occurred almost one month late.

Compliance testing showed NKSP needed improvement in ensuring specialty access for patients who transferred into the institution with a preapproved specialty request (MIT 14.010, 63.6%).

Provider Performance

Provider performance in specialty services was mixed. Compliance testing showed patients almost always saw their providers or nurses promptly after specialty services (MIT 1.008, 93.3%). Case review did not identify any deficiencies in follow up after specialty services.

Case review identified nine deficiencies in which providers ordered specialty appointments with medically inappropriate time frames, five of which were significant.⁸² High-priority referrals have a two-week compliance time frame, medium-priority referrals have up to a 45-day compliance time frame and routine-priority referrals have up to a 90-day compliance time frame. Several referrals ordered for medium or routine priority should have been ordered as high priority. Ordering referrals for a medically inappropriate, delayed time frame artificially increases the appearance of compliance with the CCHCS compliance dashboards but increases risks to the patients.

We also identified provider errors in the location or type of specialty appointments ordered which also delayed care to the patients. These issues are discussed in more detail in the **Provider Performance** indicator.

Nursing Performance

NKSP nurses performed adequately in assessing patients who returned to the institution from off-site appointments. The specialty nurses provided pertinent patient records for the off-site specialists to review and generally communicated specialist recommendations to the providers. Case review identified five deficiencies, none of which were significant.⁸³

Health Information Management

Compliance testing showed staff performed satisfactorily in scanning specialty reports within required time frames (MIT 4.002, 83.3%). Provider performance was excellent for retrieving and endorsing high-priority specialty reports (MIT 14.002, 100%) and was

⁸¹ Deficiencies occurred in cases 21, 25, 54, and 55.

⁸² Provider specialty deficiencies occurred in cases 1, 16, 25, and 55. Significant deficiencies occurred in cases 16, 25, and 55.

⁸³ Deficiencies occurred in cases 17, 18, 20, and 53. None were significant.

satisfactory for retrieving and endorsing medium- and routine-priority specialty reports (MIT 14.005, 80.0% and MIT 14.008, 80.0%).

Of the 55 specialty services appointments in case review samples, clinicians found nine deficiencies related to HIM, with a pattern of specialty reports scanned late. The following are examples:

- In case 15, a cardiologist saw the patient; however, staff scanned the specialty report late.
- In case 18, the patient had an EGD and colonoscopy.⁸⁴ Staff only scanned preliminary reports into the EHRS and did not scan the final reports.
- In case 54, an infectious disease specialist saw the patient; however, staff scanned the specialty report two weeks late.

Clinician On-Site Inspection

We discussed specialty services processes with specialty services staff, office technicians, health information management supervisors, ancillary staff, diagnostic staff, nurses, and providers. Staff reported no significant staffing shortages among specialty services staff during the review period.

The medical records supervisor and specialty services RNs described the process of retrieving on-site and off-site reports. The off-site specialty RN was responsible for obtaining final off-site specialty reports. NKSP had access to their local hospital medical record system, which expedited specialty report receipt from appointments occurring within that system. Upon return from an off-site appointment, the TTA RN would assess the patient and collect any specialty paperwork returned with the patient. HIM staff picked up the specialty paperwork the next morning and scanned it into the medical record.

The on-site specialty RN obtained the on-site specialist's reports and obtained handwritten provider endorsement signatures, if possible. HIM staff then would scan the paper reports into the EHRS. After scanning into the EHRS, staff electronically sent the specialty reports to the patient's primary care provider for review and endorsement.

Specialty services staff discussed intermittent backlogs during the review period. NKSP had difficulty obtaining transgender evaluation appointments (which occurred through telemedicine), speech therapy evaluations, and orthopedic appointments. Orthopedic appointments could be problematic because they often occurred in batches of multiple patients at one time.

To ensure staff scheduled patients for telemedicine appointments within their compliance dates, NKSP developed a process where staff would forward high-priority, medium-priority, and routine-priority telemedicine appointment requests that were

⁸⁴ An EGD is an esophagogastroduodenoscopy. In this procedure, the specialist uses a camera to examine the esophagus and the stomach.

within 10, 14, and 30 days of compliance, respectively, to the off-site specialty RN to schedule with an off-site specialist.

Compliance Score Results

Table 19. Specialized Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	12	3	0	80.0%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	15	0	0	100%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	5	1	9	83.3%
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)	13	2	0	86.7%
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)	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	8	0	7	100%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	15	0	0	100%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	2	0	13	100%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	7	4	0	63.6%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	10	0	0	100%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	6	2	2	75.0%
Overall percentage (MIT 14): 87.4%				

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

Table 20. Other Tests Related to Specialized 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) *	42	3	0	93.3%
Are specialty documents scanned into the patient’s electronic health record within five calendar days of the encounter date? (4.002)	25	5	15	83.3%

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

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

Recommendations

- Medical leadership should determine the root cause(s) of providers not ordering specialty services within medically appropriate time frames and should implement remedial measures as appropriate.

Administrative Operations

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

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

Ratings and Results Overview

<p>Case Review Rating Not Applicable</p>	<p>Compliance Rating and Score Inadequate (71.0%)</p>
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NKSP’s performance was mixed in this indicator. While NKSP scored well in some applicable tests, performance needed improvement in several areas. The EMRRC did not always complete the required checklists and review cases within required time frames. The local governing body did not timely complete documentation. While staff conducted medical emergency response drills, the nursing education department emergency response drill forms were all either incomplete or missing. In addition, the nursing department did not ensure newly hired nurses timely received the required onboarding training. These findings are set forth in the table on the next page. Based on the overall compliance score result, the OIG rated the compliance component of this indicator *inadequate*.

Compliance Testing Results

Nonscored Results

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

We obtained CCHCS Mortality Case Review reporting data. At the time of our inspection, for eight patients, we found no evidence in the submitted documentation that preliminary mortality reports were completed. These reports were overdue at the time of the OIG’s inspection (MIT 15.998).

Compliance Score Results

Table 21. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	This is a nonscored test. Please refer to the discussion in this indicator.			
Did the institution’s Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	2	10	0	16.7%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	1	3	0	25.0%
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)	7	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	9	2	0	81.8%
Did the providers maintain valid state medical licenses? (15.106)	13	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates, and did the pharmacy maintain valid Automated Drug Delivery System (ADDS) licenses? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? Effective 05/2022: Did the Headquarters Mortality Case Review process mortality review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution’s health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 3 for CCHCS-provided staffing information.			
Overall percentage (MIT 15): 71.0%				

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

Recommendations

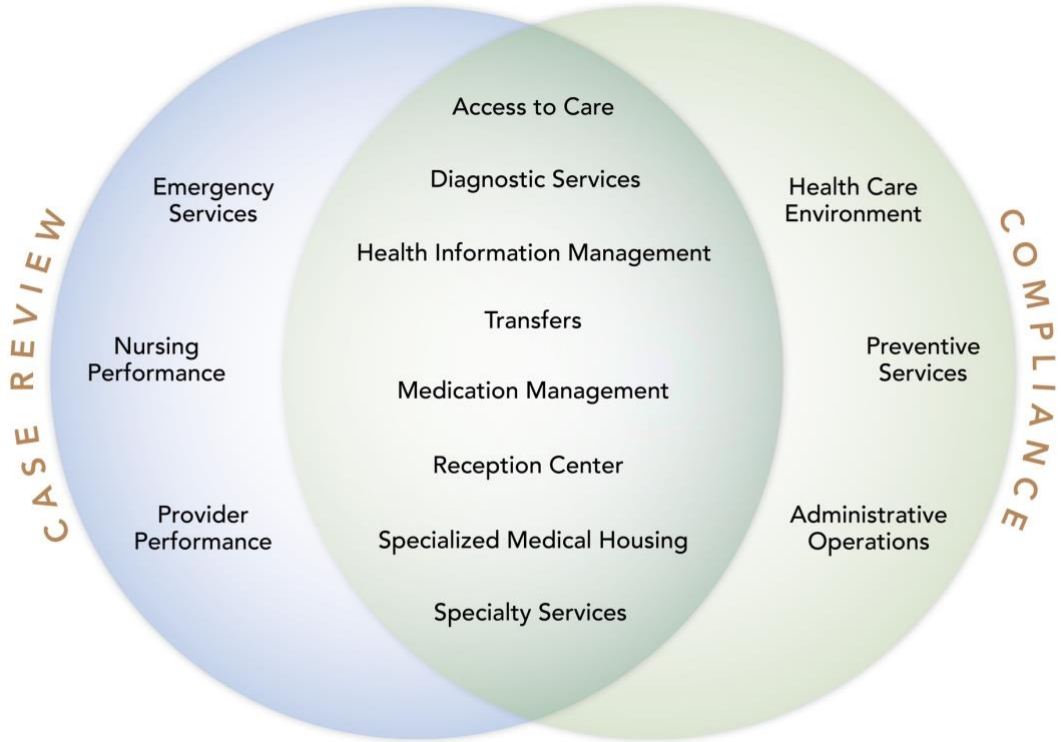
The OIG offers no recommendations for this indicator.

Appendix A: Methodology

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

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

Figure A-1. Inspection Indicator Review Distribution for NKSP



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

Case Reviews

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

Table A-1. Case Review Definitions

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

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

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

Case Review Sampling Methodology

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

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

Case Review Testing Methodology

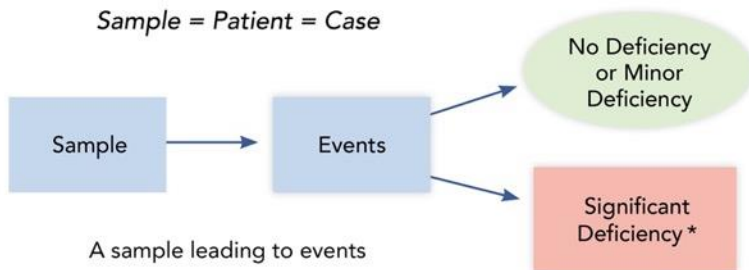
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review **events**. Our clinicians also record medical errors, which we refer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

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

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

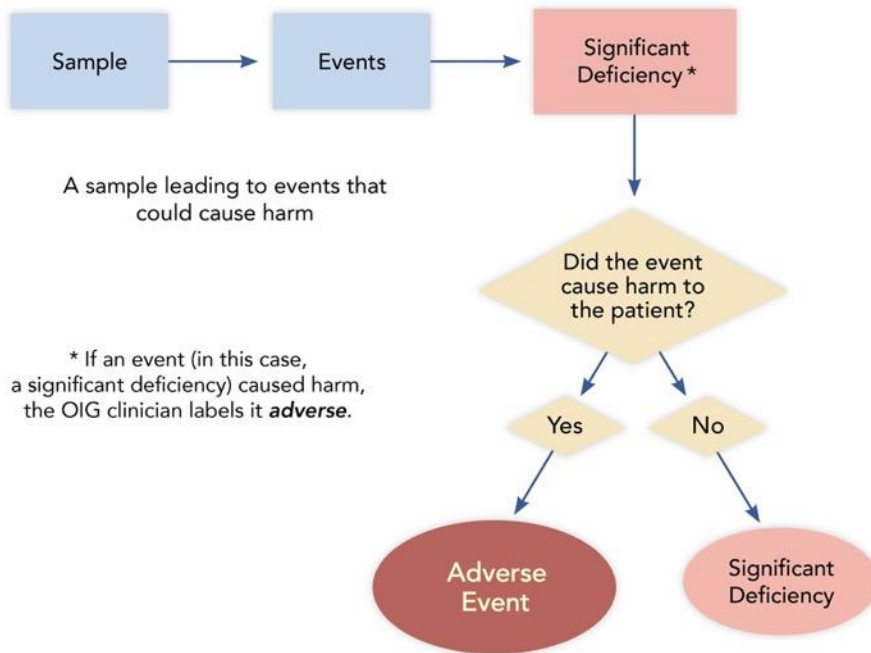
Figure A-2. Case Review Testing

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



Deficiencies

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



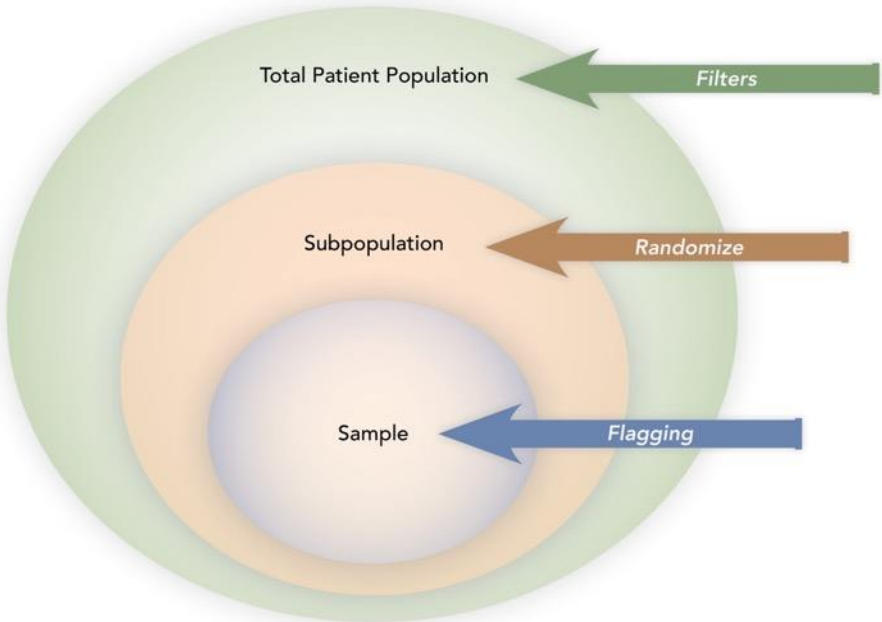
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

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

Figure A-3. Compliance Sampling Methodology



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

Compliance Testing Methodology

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

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

Scoring Methodology

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

Indicator Ratings and the Overall Medical Quality Rating

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

Appendix B: Case Review Data

Table B-1. NKSP Case Review Sample Sets

Sample Set	Total
CTC/OHU	3
Death Review/Sentinel Events	2
Diabetes	5
Emergency Services - CPR	5
Emergency Services - Non-CPR	2
High Risk	4
Hospitalization	6
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	18
Reception Center Transfers	3
Specialty Services	1
	55

Table B–2. NKSP Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	3
Anticoagulation	1
Arthritis/Degenerative Joint Disease	3
Asthma	11
Cancer	4
Cardiovascular Disease	1
Chronic Kidney Disease	3
Chronic Pain	6
Cirrhosis/End-Stage Liver Disease	2
Coccidioidomycosis	2
COPD	1
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	5
Gastroesophageal Reflux Disease	4
HIV	1
Hepatitis C	14
Hyperlipidemia	14
Hypertension	17
Mental Health	23
Seizure Disorder	2
Sleep Apnea	3
Substance Abuse	16
Thyroid Disease	1
	138

Table B–3. NKSP Case Review Events by Program

Diagnosis	Total
Diagnostic Services	161
Emergency Care	43
Hospitalization	19
Intrasystem Transfers In	8
Intrasystem Transfers Out	7
Outpatient Care	267
Reception Center Care	27
Specialized Medical Housing	88
Specialty Services	103
	723

Table B–4. NKSP Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	20
MD Reviews Focused	5
RN Reviews Detailed	14
RN Reviews Focused	35
Total Reviews	73
Total Unique Cases	55
Overlapping Reviews (MD & RN)	19

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Appendix C: Compliance Sampling Methodology

North Kern State Prison

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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	<ul style="list-style-type: none"> • Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	<ul style="list-style-type: none"> • Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	25	OIG Q: 4.005	<ul style="list-style-type: none"> • Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested incarcerated person	<ul style="list-style-type: none"> • Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	25	CADDIS off-site admissions	<ul style="list-style-type: none"> • Date (2-8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101-105 MITs 5.107-111	Clinical Areas	11	OIG inspector on-site review	<ul style="list-style-type: none"> • Identify and inspect all on-site clinical areas
Transfers				
MITs 6.001-003	Intrasystem Transfers	25	SOMS	<ul style="list-style-type: none"> • Arrival date (3-9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	10	OIG inspector on-site review	<ul style="list-style-type: none"> • R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	<ul style="list-style-type: none"> • See Access to Care • At least one condition per patient – any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	<ul style="list-style-type: none"> • Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	25	OIG Q: 4.005	<ul style="list-style-type: none"> • See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals – Medication Orders	20	OIG Q: 12.001	<ul style="list-style-type: none"> • See Reception Center
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	<ul style="list-style-type: none"> • Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	10	SOMS	<ul style="list-style-type: none"> • Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	<ul style="list-style-type: none"> • Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	<ul style="list-style-type: none"> • Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	<ul style="list-style-type: none"> • Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	12	Medication error reports	<ul style="list-style-type: none"> • All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	9	On-site active medication listing	<ul style="list-style-type: none"> • KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001-007	Recent Deliveries	N/A at this institution	OB Roster	<ul style="list-style-type: none"> Delivery date (2-12 months) Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	<ul style="list-style-type: none"> Arrival date (2-12 months) Earliest arrivals (within date range)
Preventive Services				
MITs 9.001-002	TB Medications	25	Maxor	<ul style="list-style-type: none"> Dispense date (past 9 months) Time period on TB meds (3 months or 12 weeks) Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	<ul style="list-style-type: none"> Arrival date (at least 1 year prior to inspection) Birth month Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	<ul style="list-style-type: none"> Arrival date (at least 1 year prior to inspection) Randomize Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	<ul style="list-style-type: none"> Arrival date (at least 1 year prior to inspection) Date of birth (45 or older) Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	<ul style="list-style-type: none"> Arrival date (at least 2 yrs. prior to inspection) Date of birth (age 52-74) Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	<ul style="list-style-type: none"> Arrival date (at least three yrs. prior to inspection) Date of birth (age 24-53) Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	<ul style="list-style-type: none"> Chronic care conditions (at least 1 condition per IP – any risk level) Randomize Condition must require vaccination(s)
MIT 9.009	Valley Fever	19	Cocci transfer status report	<ul style="list-style-type: none"> Reports from past 2-8 months Institution Ineligibility date (60 days prior to inspection date) All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001-007	RC	20	SOMS	<ul style="list-style-type: none"> • Arrival date (2-8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001-003	Specialized Health Care Housing Unit	10	CADDIS	<ul style="list-style-type: none"> • Admit date (2-8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101-102	Call Buttons	All	OIG inspector on-site review	<ul style="list-style-type: none"> • Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001-003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	<ul style="list-style-type: none"> • Approval date (3-9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.004-006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	<ul style="list-style-type: none"> • Approval date (3-9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Specialty Services (continued)				
MITs 14.007-009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	<ul style="list-style-type: none"> Approval date (3-9 months) Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services Randomize
MIT 14.010	Specialty Services Arrivals	11	Specialty Services Arrivals	<ul style="list-style-type: none"> Arrived from (other departmental institution) Date of transfer (3-9 months) Randomize
MITs 14.011-012	Denials	10	InterQual	<ul style="list-style-type: none"> Review date (3-9 months) Randomize
		N/A	IUMC/MAR Meeting Minutes	<ul style="list-style-type: none"> Meeting date (9 months) Denial upheld Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	0	Adverse/sentinel events report	<ul style="list-style-type: none"> Adverse/Sentinel events (2-8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	<ul style="list-style-type: none"> Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	<ul style="list-style-type: none"> Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	<ul style="list-style-type: none"> Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	<ul style="list-style-type: none"> Most recent full quarter Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	<ul style="list-style-type: none"> Medical grievances closed (6 months)
MIT 15.103	Death Reports	7	Institution-list of deaths in prior 12 months	<ul style="list-style-type: none"> Most recent 10 deaths Initial death reports

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
<i>Administrative Operations (continued)</i>				
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	<ul style="list-style-type: none"> On duty one or more years Nurse administers medications Randomize
MIT 15.105	Provider Annual Evaluation Packets	11	On-site provider evaluation files	<ul style="list-style-type: none"> All required performance evaluation documents
MIT 15.106	Provider Licenses	13	Current provider listing (at start of inspection)	<ul style="list-style-type: none"> Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	<ul style="list-style-type: none"> All staff Providers (ACLS) Nursing (BLS/CPR) Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	<ul style="list-style-type: none"> All required licenses and certifications
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	<ul style="list-style-type: none"> All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	<ul style="list-style-type: none"> New employees (hired within last 12 months)
MIT 15.998	CCHCS Mortality Case Review	8	OIG summary log: deaths	<ul style="list-style-type: none"> Between 35 business days & 12 months prior California Correctional Health Care Services mortality reviews

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California Correctional Health Care Services' Response

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November 18, 2024

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

Dear Ms. Singh:

California Correctional Health Care Services has reviewed the draft Medical Inspection Report for North Kern State Prison (NKSP) conducted by the Office of the Inspector General from November 2022 to April 2023. Thank you for preparing the report. While CCHCS disagrees with the findings for the compliance portion of the OIG Inspection for NKSP, we understand that the OIG is forming a workgroup to revise the Medical Inspection Tool to reduce or eliminate subjectivity and complex, compound questions that make it difficult for CCHCS to determine areas of policy non-compliance. CCHCS looks forward to participating in such efforts and urges the OIG to begin the process as soon as possible.

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

Sincerely,



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

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



CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

November 25, 2024, OIG Response to November 18, 2024, Letter Regarding NKSP Report

STATE of CALIFORNIA
OIG OFFICE of the
INSPECTOR GENERAL
Independent Prison Oversight

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

Regional Offices

Sacramento
Bakersfield
Rancho Cucamonga

November 25, 2024

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

Dear Ms. Gouldy:

OIG RESPONSE TO NOVEMBER 18, 2024, CCHCS LETTER REGARDING NKSP REPORT

The OIG provided CCHCS the Cycle 7 draft report package for North Kern State Prison (NKSP) on September 26, 2024. Following the 30-day dispute period, CCHCS disputed 12 findings relating to the compliance testing component of the draft report. The OIG thoroughly reviewed the evidence in the patient records for each dispute as well as the related requirements in CCHCS’s own published Health Care Department Operations Manual (HCDOM), as it existed at the time we performed our inspection. Based on our review, we accepted one dispute and will be amending the test for our Medical Inspection Tool (MIT) 14.010 to further clarify the scope and intent of that test. We denied the remaining 11 disputes because the action or omission underlying the finding in question did not comply with the related HCDOM requirement as it existed at the time the action occurred. As explained in our November 14, 2024 response to CCHCS’s disputes, we measure compliance with the policies that are in existence at the time of the inspection. We cannot measure compliance with policies or procedures that came into existence after the date of the inspection.

Your formal response also claims the OIG’s Medical Inspection Tool (MIT) contains subjective, complex, and compound questions that are difficult for CCHCS to understand. The MIT, which the OIG amends quarterly in collaboration with CCHCS and other stakeholders, is modeled after the policies CCHCS has formalized in its Health Care Department Operations Manual (HCDOM). The wording and the requirements of each MIT standard are taken directly from the different HCDOM rules and requirements that CCHCS has formulated with the expectation that its own staff can understand and implement. While the OIG’s MIT critical review workgroup is in the process of considering whether to separate its compound testing questions, every

Gavin Newsom, Governor

10111 Old Placerville Road, Suite 110
Sacramento, California 95827
Telephone: (916) 288-4212
www.oig.ca.gov



Ms. DeAnna Gouldy, Deputy Director
November 25, 2024
Page 2

compound question in the MIT was initially vetted for testing in that manner because the HCDOM itself requires each data point of these tests to be true to meet a singular HCDOM requirement. If the testing measures are difficult for CCHCS to comprehend, CCHCS ought to consider HCDOM revisions to clarify the health care rules by which they intend to operate.

If CCHCS has specific concerns with any of our compliance testing findings, we encourage you to raise these issues via our longstanding dispute resolution process so we are able to consider any evidence or information we may have overlooked during the compliance testing process.

Sincerely,


[Amarik Singh](#) (Nov 25, 2024 09:47 PST)

Amarik K. Singh
Inspector General
Office of the Inspector General

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Federal Receiver
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
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Robin Hart, Associate Director, Risk Management Branch, CCHCS
Regional Executives, Region III, CCHCS
Celia Bell, Chief Executive Officer, NKSP
Heather Pool, Chief Assistant Inspector General, OIG
Medical Inspection Unit Management Team, OIG
Shaun Spillane, Chief Counsel, OIG

Cycle 7
Medical Inspection Report
for
North Kern State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
November 2024

OIG