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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

April 2025

Cycle 7

Medical Inspection Report

Central California Women's Facility

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Introduction

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

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

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

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

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

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

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

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

As we did during Cycle 6, our office continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 7 inspection of Central California Women's Facility, the institution had been delegated back to the department by the receiver.

We completed our seventh inspection of the institution, and this report presents our assessment of the health care provided at this institution during the inspection period from May 2023 to October 2023.[4]

[4] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include cardiopulmonary resuscitation reviews between November 2022 and April 2023, and death reviews between February 2023 and September 2023.

Summary: Ratings and Scores

We completed the Cycle 7 inspection of CCWF in May 2024. OIG inspectors monitored the institution's delivery of medical care that occurred between May 2023 and October 2023.

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

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

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 59 cases, which contained 1,285 patient-related events. They performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our OIG clinicians acknowledged institutional structures that catch and resolve mistakes that may occur throughout the delivery of care. After examining the medical records, our clinicians completed a follow-up on-site inspection in May 2024 to verify their initial findings. OIG physicians rated the quality of care for 28 comprehensive case reviews. Of these 28 cases, our physicians rated 24 ***adequate*** and four ***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 437 patient records and 1,382 data points, and used the data to answer 106 policy questions. In addition, we observed CCWF's processes during an on-site inspection in January 2024.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in 15 health care indicators.

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

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

MIT Number	Health Care Indicators	Case Review Ratings: Cycle 7	Case Review: Change Since Cycle 6*	Compliance Scoring Ranges: Cycle 7	Compliance Scoring Ranges: Cycle 6	Compliance: Change Since Cycle 6*
		Ratings: Proficient, Adequate, Inadequate		*Scoring Ranges*: 100%–85.0%, 84.9%–75.0%, 74.9%–0		
		Case Review		Compliance		
1	Access to Care	Adequate	=	75.1%	80.5%	↓
2	Diagnostic Services	Adequate	=	65.0%	75.8%	↓
3	Emergency Services	Inadequate	=	N/A	N/A	N/A
4	Health Information Management	Adequate	=	79.7%	89.3%	↓
5	Health Care Environment†	N/A	N/A	65.6%	79.6%	↓
6	Transfers	Adequate	=	72.4%	61.1%	=
7	Medication Management	Inadequate	=	55.5%	67.8%	=
8	Prenatal and Postpartum Care	Proficient	=	90.0%	100%	=
9	Preventive Services	N/A	N/A	83.8%	76.8%	=
10	Nursing Performance	Adequate	=	N/A	N/A	N/A
11	Provider Performance	Adequate	=	N/A	N/A	N/A
12	Reception Center	Adequate	=	67.9%	75.0%	↓
13	Specialized Medical Housing	Adequate	=	56.0%	77.5%	↓
14	Specialty Services	Adequate	=	77.4%	75.9%	=
15	Administrative Operations†	N/A	N/A	77.9%	71.2%	=

* 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.[5]

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

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 12 of the 15 indicators applicable to CCWF. Of these 12 indicators, OIG clinicians rated one ***proficient***, nine ***adequate***, and two ***inadequate***. OIG physicians also rated the overall adequacy of care for each of the 28 detailed case reviews they conducted. Of these 28 cases, 24 were ***adequate*** and four were ***inadequate***. In the 1,285 events reviewed, we identified 347 deficiencies, 94 of which OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at CCWF:

- Providers offered excellent prenatal and emergency care.
- Providers generally offered good care continuity.
- Staff facilitated good access to providers in the outpatient setting and the specialized medical housing unit.
- Staff frequently completed diagnostic tests within requested time frames.

Our clinicians found the following weaknesses at CCWF:

- Access to nurses and specialists needed improvement.
- Providers needed to improve communication of diagnostic test results to patients through complete patient test result letters.
- Staff needed to improve retrieval of hospital discharge reports and specialty reports.
- CCWF needed improvement in ensuring transport teams are available to provide timely emergent transfers to higher levels of care.

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

- CCWF needed improvement in timely administering keep-on-person (KOP) medications and completing the corresponding documentation in the medication administration record.[6]

Compliance Testing Results

Our compliance inspectors assessed 12 of the 15 indicators applicable to CCWF. Of these 12 indicators, our compliance inspectors rated one ***proficient***, five ***adequate***, and six ***inadequate***. We tested policy compliance in **Health Care Environment**, **Preventive Services**, and **Administrative Operations** as these indicators do not have a case review component.

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

- Staff provided pregnant patients timely provider appointments, and nursing staff documented patients' vital information, such as blood pressure and weight. The institution also offered lower-tier housing and lower-bunk accommodations to these patients and provided them with prenatal screening tests.

- Staff performed well in offering immunizations and providing preventive services for their patients, such as influenza vaccinations, annual testing for tuberculosis (TB), and breast, cervical, and colorectal cancer screenings.

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

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

- Patients did not always receive their chronic care medications within required time frames. In addition, CCWF maintained poor medication continuity for patients returning from hospitalizations, for patients admitted to specialized medical housing, and for patients transferring into and laying over at CCWF.

- Providers often did not communicate results of diagnostic services timely with complete test result letters. At times, providers failed to generate patient letters communicating the results. Other patient letters were missing the date of the diagnostic services, the date of the results, and whether the results were within normal limits.

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

- The institution did not consistently provide STAT laboratory services within specified time frames.

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

- Nursing staff and providers performed poorly in completing nursing and provider assessment of patients admitted to the specialized medical housing unit within the required time frame.

Institution-Specific Metrics

Central California Women's Facility is located in Chowchilla, Madera County. California's largest female institution, CCWF is the only female prison designated as a reception center. In addition, the institution houses the only death row for women in California. The institution's medical clinics provide routine health care services. Patients also receive care at CCWF's on-site specialty clinic, and the restricted housing unit (RHU) maintains a separate clinic for RHU patients. The institution's medical staff screen arriving and departing patients at the receiving and release clinic (R&R) and also treat patients requiring urgent or emergent care at the triage and treatment area (TTA). California Correctional Health Care Services (CCHCS) has designated CCWF as a *reception* health care institution.

As of August 28, 2024, the department reports on its public tracker that 70 percent of CCWF's incarcerated population is fully vaccinated for COVID-19 while 63 percent of CCWF's staff is fully vaccinated for COVID-19.[7]

In December 2023, the Health Care Services Master Registry showed CCWF had a total population of 2,237. A breakdown of the medical risk level of the CCWF population as determined by the department is set forth in Table 2 below.[8]

Table 2. CCWF Master Registry Data as of December 2023

Medical Risk Level	Number of Patients	Percentage*
High 1	175	7.8%
High 2	228	10.2%
Medium	1,323	59.1%
Low	511	22.8%
Total	**2,237**	**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 12-26-23.

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

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

According to staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 3 below, CCWF had one vacant executive leadership position, 2.5 primary care provider vacancies, four nursing supervisor vacancies, and 24.1 nursing staff vacancies.

Table 3. CCWF Health Care Staffing Resources as of December 2023

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	4.0	10.5	1.5	142.0	171.5
Filled by Civil Service	3.0	8.0	11.0	117.9	139.9
Vacant	1.0	2.5	4.0	24.1	31.6
Percentage Filled by Civil Service	75.0%	76.2%	73.3%	83.0%	81.6%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	1.0	0	66.0	67.0
Percentage Filled by Registry	0	9.5%	0	46.5%	39.1%
Total Filled Positions	3.0	9.0	11.0	183.9	206.9
Total Percentage Filled	**75.0%**	**85.7%**	**73.3%**	**129.5%**	**120.6%**
Appointments in Last 12 Months	0	3.0	1.0	50.2	54.2
Redirected Staff	0	0	0	0	0
Staff on Extended Leave ‡	0	0	0	7.0	7.0
Adjusted Total: Filled Positions	**3.0**	**9.0**	**11.0**	**176.9**	**199.9**
Adjusted Total: Percentage Filled	**75.0%**	**85.7%**	**73.3%**	**124.6%**	**116.6%**

* Executive Leadership includes the Chief Physician and Surgeon.

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

‡ In Authorized Positions.

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

Source: Cycle 7 medical inspection preinspection questionnaire received on December 26, 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 CCWF's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. 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)—CCWF'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. CCWF had a 43 percent influenza immunization rate for adults 18 to 64 years old and a 77 percent influenza immunization rate for adults 65 years of age and older.[9] The pneumococcal vaccination rate was 93 percent.[10]

Cancer Screening

Statewide comparative data was available for breast cancer, cervical cancer, and colorectal cancer screening. When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—CCWF had a 97 percent breast cancer screening rate and 90 percent colorectal cancer screening rate, indicating very good performance on these two screening measures. CCWF had a 71 percent cervical cancer screening rate, which was

[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.

better than California Medi-Cal, but worse than Kaiser Northern California (Medi-Cal) and Kaiser Southern California (Medi-Cal).

Prenatal and Postpartum Care

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—CCWF's prenatal care was 100 percent, indicating better performance than the three Medi-Cal programs. Data for CCWF's postpartum care was not available.

Table 4. CCWF Results Compared With State HEDIS Scores

HEDIS Measure	CCWF Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (> 9.0%) ‡,§	**5%**	36%	31%	22%
HbA1c Control (< 8.0%) ‡	92%	–	–	–
Blood Pressure Control (< 140/90) ‡	93%	–	–	–
Eye Examinations	81%	–	–	–
Influenza – Adults (18–64)	43%	–	–	–
Influenza – Adults (65+)	77%	–	–	–
Pneumococcal – Adults (65+)	93%	–	–	–
Breast Cancer Screening (50–74)	**97%**	56%	77%	77%
Cervical Cancer Screening	71%	57%	**75%**	**75%**
Colorectal Cancer Screening	**90%**	37%	68%	70%
Prenatal Care	**100%**	89%	91%	95%
Postpartum Care	N/A	82%	79%	82%

Notes and Sources

* Unless otherwise stated, data were collected in January 2024 by reviewing medical records from a sample of CCWF's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication titled *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2022–June 30, 2023 (published March 2024); **https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Managed-Care-Technical-Report-Volume-1.pdf**.

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

Access to Care

- Medical leadership should determine the root cause(s) of challenges in the timely provision of chronic care follow-up appointments and should implement remedial measures as appropriate.

Diagnostic Services

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

- Medical leadership should determine the root cause of untimely providing and notifying patients of STAT laboratory results and should implement remedial measures as appropriate.

Emergency Services

- Leadership should determine the root cause(s) of challenges to the custody transportation teams arriving timely to the TTA for higher level of care transfers and implement remedial measures as appropriate. In addition, the EMRRC should continue the current performance improvement plan reported during the on-site inspection.

- Nursing leadership should determine the root cause of challenges that prevent nurses from accurately documenting the time and sequence of events during emergency responses and should implement remedial measures as appropriate, such as including these documentation and timeline deficiencies in the clinical review process.

Health Information Management

- HIM should identify the challenges to properly labeling and scanning documents into the electronic health record and should implement appropriate remedial measures.

- HIM should determine the root cause(s) of challenges to staff timely retrieving as well as thoroughly completing hospital discharge reports and should implement appropriate remedial measures.

Health Care Environment

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

- Nursing leadership should determine the root cause(s) for staff not ensuring clinic examination rooms contain essential core medical equipment and verify staff follow equipment and medical supply management protocols. Leadership should take necessary remedial measures.

- Nursing leadership should determine the root cause(s) for staff both not ensuring the EMRBs are regularly inventoried and sealed as well as not properly completing the monthly logs. Leadership should take necessary remedial measures.

Transfers

- Nursing leadership should determine the root cause(s) of challenges that prevent nurses from thoroughly completing the initial health screening process, including documenting last menstrual period, answering all questions, and documenting an explanation for all "Yes" answers before the patient is transferred to the housing unit. Nursing leadership should implement remedial measures as appropriate.

Medication Management

- Nursing leadership should determine the challenges that prevent staff from providing medication continuity for patients prescribed chronic care medications, hospital discharge patients, en route patients, and patients returning from off-site specialty consultations and should implement remedial measures as appropriate.

- Nursing leadership should identify the root cause(s) of nurses not administering insulin medications as ordered and should implement remedial measures as appropriate.

- The institution should consider developing and implementing measures to ensure staff timely make available and administer medications to patients, and staff document the administration of medications in the electronic health record system (EHRS), as described in CCHCS policy and procedures.

- Nursing leadership should assess the root cause(s) for nursing staff failing to document patient refusals in the medication administration record (MAR), as described in CCHCS policy and procedures, and should implement remedial measures as needed.

Preventive Services

- Nursing leadership should develop and implement measures to ensure nursing staff monitor patients who are on TB medications per policy.

- Medical leadership should determine the root cause(s) of challenges to the timely provision of vaccinations for chronic care patients and should implement appropriate remedial measures.

Nursing Performance

- Nursing leadership should determine the challenges preventing nurses from performing complete assessments and interventions and should implement remedial measures as appropriate.

Reception Center

- Nursing leadership should determine the root cause(s) of challenges preventing nursing staff from thoroughly completing the reception initial health screening questions. Leadership should implement remedial measures as appropriate.

Specialized Medical Housing

- Nursing leadership should ascertain the root cause(s) preventing SNF nurses from timely completing admission assessments and should implement remedial measures as appropriate.

- Medical leadership should ascertain the root cause(s) preventing providers from completing history and physicals timely and should implement remedial measures as appropriate.

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

Access to Care

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Adequate* (75.1%)**

Compared with Cycle 6, case review found CCWF performed similarly well with access to care. Staff delivered very good access to outpatient providers and excellent access to CTC providers, but they needed improvement with access to clinic nurses and specialists. Considering all aspects, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed CCWF's performance was mixed in access to care. Access to providers was very good for patients who returned to CCWF after hospitalizations, and nurses performed excellently in timely reviewing patient sick call requests. However, staff needed improvement in completing chronic care appointments, nurse-to-provider referrals, and face-to-face nurse appointments within required time frames. Timely completion of specialty service appointments varied. 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 288 provider, nursing, urgent or emergent care, specialty, and hospital events requiring the institution to generate appointments. We identified 26 deficiencies relating to access to care, 15 of which were significant.[11]

Access to Care Providers

CCWF delivered a mixed performance in access to its providers. Compliance testing showed chronic care face-to-face follow-up appointments occurred within policy time frames only a little more than half the time (MIT 1.001, 64.0%). CCWF also needed improvement in timely provider access from nurse referrals (MIT 1.005, 71.4%). However, case review found providers evaluated patients timely when nurses referred them from their sick-call requests as well as when providers requested subsequent appointments. We identified three deficiencies related to provider access as follows:

[11] Access to care deficiencies occurred in cases 2, 3, 8, 9, 14, 19, 22, 23, 25, 26, 28, 34, and 54. Significant deficiencies occurred in cases 2, 3, 8, 9, 14, 19, 22, 23, 25, 28, 34, and 54.

- Twice, in case 22, the nurse ordered a provider appointment for the patient; however, both appointments occurred one day late.

- In case 28, the provider ordered a MAT follow-up appointment, but this appointment did not occur.[12]

Access to Specialized Medical Housing Providers

CCWF provided excellent access to specialized medical housing providers. Case review did not find any access to provider deficiencies in the CTC. Providers rounded on the patients in the CTC with appropriate frequency and did not have any delays in performing the initial history and physical upon admission.

Access to Clinic Nurses

CCWF had room for improvement for access to clinic nurses. Although compliance testing showed nurses always reviewed sick call requests the same day they were received (MIT 1.003, 100%), staff needed improvement in completing face-to-face appointments timely (MIT 1.004, 73.3%). Case review found CCWF's performance with access to clinic nurses decreased from Cycle 6 as we identified nine deficiencies related to sick-call access in Cycle 7. In these deficiencies, nurses triaged patient health care requests and formulated plans to see the patient. These encounters were delayed by one to four days, except in the following example:

- In case 19, the nurse triaged the patient's request for more treatment and ordered a face-to-face appointment within one day. However, the patient was not seen for this request because the nurse entered the appointment order twice and cancelled it twice.

Case review did not find any access deficiencies with provider-to-RN appointments.

Access to Specialty Services

CCWF performed variably with access to specialists. Compliance testing showed a mixed completion rate of high-priority (MIT 14.001, 73.3%), medium-priority (MIT 14.004, 66.7%), and routine-priority (MIT 14.007, 100%) appointments. Specialty follow-up appointments often occurred timely (MIT 14.009, 85.7%). In this cycle, case review found CCWF had more deficiencies with access to specialty services and procedures compared with Cycle 6. We reviewed 135 specialty consultations and procedures, and identified seven access to specialty services deficiencies. The following are examples:

- In case 2, the patient was hospitalized for an unresolved infection after bowel surgery, which required antibiotics. Upon hospital discharge, the patient was supposed to have a follow-up appointment with the surgeon. The provider

[12] MAT is the Medication Assisted Treatment program for substance use disorder.

mis-ordered the appointment, resulting in a delay of the surgical follow-up appointment by one week.

- In case 8, the patient had a large lung mass, for which the provider ordered a high-priority CT-guided soft tissue biopsy.[13] This procedure occurred after a 16-day delay.

- In case 14, the provider ordered a pulmonology consult for a patient with chronic asthma. This consult was scheduled with a 21-day delay due to a backlog of telemedicine specialists.

- In case 28, the provider ordered an echocardiogram.[14] This specialty appointment was canceled due to a "custody issue" and had to be rescheduled. When the appointment was rescheduled, it was delayed by four weeks.

Follow-Up After Specialty Services

Compliance testing showed most of the required provider appointments after specialty services occurred within the required time frame (MIT 1.008, 86.7%). Case review found good access to CCWF providers after specialty consultations, except in the following example:

- In case 26, the cardiology and endocrine specialists evaluated the patient at separate consultations. The provider follow-up appointments after both of these specialty consultations occurred late; however, both delays were two days with minor consequence.

Follow-Up After Hospitalization

CCWF usually ensured providers evaluated patients after hospitalizations. Compliance testing showed the institution frequently completed provider follow-up appointments within the required time frame after the patients' hospital discharges (MIT 1.007, 88.9%). Case review identified one deficiency as follows:

- In case 3, the patient returned from the emergency department for left-sided weakness and sensory deficits, but the provider did not follow up with the patient for these symptoms. The provider evaluated the patient nine days later to address a headache sick call and did not formally address the stroke-like symptoms.

Follow-Up After Urgent or Emergent Care (TTA)

Case review found providers evaluated their patients following a TTA event as medically indicated. We reviewed 41 TTA events and identified no deficiencies with access to providers after TTA encounters.

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[13] A CT scan is a computed, or computerized, tomography imaging scan.

[14] An echocardiogram is a procedure using an ultrasound to examine and image the heart.

Follow-Up After Transferring Into CCWF

Access to care for patients who had recently transferred into the CCWF was good. In compliance testing, timely intake appointments for newly arrived patients usually occurred (MIT 1.002, 83.3%). Case review identified one deficiency as follows:

- In case 34, the patient transferred in with a pending RN appointment for a laceration that had a compliance due date of the next day. This appointment occurred with a three-day delay.

Clinician On-Site Inspection

We discussed deficiencies with scheduling supervisors, nursing supervisors, and specialty nurses. The supervisors and nurses agreed with most of the deficiencies and provided additional information to explain the delays. As a result, we adjusted some of the deficiencies accordingly.

Compliance On-Site Inspection

Two of six housing units randomly tested at the time of inspection had access to Health Care Services Request Forms (CDCR form 7362) (MIT 1.101, 33.3%). In three 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. The remaining housing unit had no forms available at the time of inspection.

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)	16	9	0	64.0%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	15	3	5	83.3%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	30	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004)	22	8	0	73.3%
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)	10	4	16	71.4%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006)	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)	16	2	0	88.9%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	26	4	15	86.7%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	2	4	0	33.3%
				Overall percentage (MIT 1): **75.1%**

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

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

Table 6. Other Tests Related to Access to Care

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003)	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)	18	1	1	94.7%
Was a written history and physical examination completed within the required time frame? (13.002)	6	4	0	60.0%
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	7	1	7	87.5%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004)	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	8	1	6	88.9%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	15	0	0	100%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	6	1	8	85.7%

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

Recommendations

- Medical leadership should determine the root cause(s) of challenges in the timely provision of chronic care follow-up appointments and should implement remedial measures as appropriate.

Diagnostic Services

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (65.0%)**

Case review found CCWF delivered good performance with diagnostic services. Staff performed excellently with completing diagnostic studies. Health information management with diagnostic services needed improvement as we identified a pattern of late provider endorsements of tests results as well as providers not generating patient notification test result letters or generating letters with missing required information. However, most of the health information management deficiencies were not clinically significant. After careful deliberation, the OIG rated the case review component of this indicator ***adequate***.

CCWF's overall compliance testing scored low for this indicator. Staff performed remarkably well in completing radiology and laboratory tests, but performed poorly in completing STAT tests. Providers promptly endorsed diagnostic results but rarely generated test results letters with all required elements. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 291 diagnostic events and found 81 deficiencies, three of which were significant.[15] Of these 81 deficiencies, we found one related to a delay in obtaining a test and 80 pertained to health information management.

Test Completion

Compliance testing performance was mixed. Compliance scores showed radiology test completion was perfect (MIT 2.001, 100%) and routine laboratory test completion was very good (MIT 2.004, 90.0%). However, STAT laboratory test completion was poor (MIT 2.007, 40.0%).

Case review found excellent access and scheduling of ordered diagnostic tests and procedures. Out of 291 events, we only found one test that was not completed within the time frame ordered by the provider as follows:

[15] Diagnostic deficiencies occurred in cases 1–3, 6, 7, 9, 10–13, 15–18, 20, 22, 23, and 25–30. Significant diagnostic deficiencies occurred in cases 1, 2, and 27.

- In case 9, the provider ordered the beta hCG quantitative test to be completed by a specified date.[16] However, this test was completed one day late.

Health Information Management

Compliance testing showed frequent timely provider review of radiologic studies and laboratory test results (MIT 2.002, 90% and MIT 2.005, 80.0%), but intermittent nurse notification of STAT laboratory tests (MIT 2.008, 50.0%). Staff performed well in retrieving (MIT 2.010, 80.0%) and excellently in reviewing (MIT 2.011, 100%) pathology results. However, providers performed poorly in communicating pathology results with complete notification letters to the patients within specified time frames (MIT 2.012, 20.0%).

Case review identified many deficiencies with the health information management of diagnostic tests and procedures. While CCWF staff retrieved these diagnostic results promptly, providers did not timely endorse 22 results or did not generate 35 patient result letters. Of the generated patient notification test result letters, 27 omitted elements required by policy. In addition, we identified one STAT laboratory test without a patient result letter. While most of the identified deficiencies did not have significant clinical impact, a few affected patient care as follows:

- In case 1, staff scanned the MRI of the patient's abdomen into the chart 10 days late.

- In case 2, the provider endorsed the abdominal CT scan four days late and did not notify the patient of a possible abscess in the abdomen.

- In case 6, the patient's test showed a critically low sodium level. The laboratory staff called and faxed the result to CCWF staff; however, the CCWF nurse did not notify the provider in a reasonable time frame. The patient was transferred to the hospital 22 hours later to treat the low sodium.

- In case 27, the patient had an x-ray of the hand showing a displaced fracture of the fifth digit. The provider did not endorse the result or notify the patient.

Clinician On-Site Inspection

We discussed some of the deficiencies with laboratory supervisors and providers. The laboratory supervisors stated they used reports at regular intervals to monitor for timely retrievals and endorsements. When the laboratory supervisors identified delays, they messaged the responsible staff to compete the retrieval or endorsement.

[16] Beta hCG is a laboratory blood test used to measure human chorionic gonadotropin (hCG) hormone. This test helps diagnose pregnancy, checks for fetal age, assesses miscarriage risk, and evaluates for certain cancers.

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)	3	7	0	30.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	9	1	0	90.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	8	2	0	80.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	2	8	0	20.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	4	6	0	40.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	5	5	0	50.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	8	2	0	80.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	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): **65.0%**

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

Recommendations

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

- Medical leadership should determine the root cause of untimely providing and notifying patients of STAT laboratory results and should implement remedial measures as appropriate.

Emergency Services

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

Ratings and Results Overview

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

In Cycle 7, CCWF continued to struggle with emergency care. In Cycle 7, OIG clinicians reviewed more cases but observed fewer emergency events than in Cycle 6. However, although fewer deficiencies existed in Cycle 7, we identified more significant deficiencies related to delays in transporting patients to a higher level of care and to the EMRRC failing to identify training deficiencies. In addition, nurses had opportunities for improvement in providing appropriate interventions for emergency care and documentation. Taking all aspects into consideration, the OIG rated this indicator ***inadequate***.

Case Review Results

OIG clinicians reviewed 66 events, 42 of which were urgent or emergent. We found 42 deficiencies occurred within various aspects of overall emergency care, 21 of which were significant.[17]

Emergency Medical Response

CCWF custody and health care staff generally responded promptly to medical alarm activations throughout the institution. However, on two occasions, nurses did not respond within required time frames.[18] In addition, in two other events, nurses and custody staff did not activate emergency medical services (EMS) timely.[19] Furthermore, on multiple occasions in two cases, the custody transport team arrived after EMS did, delaying the ambulance transporting patients to a higher level of care.[20] The following are examples of the above-mentioned significant deficiencies:

[17] Deficiencies occurred in cases 1–9, 15, 21, and 24–28. Significant deficiencies occurred in cases 2–6, 15, and 26–28.

[18] Emergency response delay deficiencies occurred in cases 3 and 26.

[19] EMS activation delay deficiencies occurred in cases 3 and 27.

[20] Transport team delay deficiencies occurred in cases 2 and 3.

- In case 2, on four separate occasions, staff ordered the patient transfer to a community hospital. However, the custody transport team arrived after EMS did, delaying the patient's transfer to the hospital. This also occurred in case 3.

- In case 3, custody staff activated a medical alarm at 1:50 p.m.; however, the health care first responder (HCFR) did not arrive to the patient until 2:07 p.m., 17 minutes after the alarm was activated.

- Also in case 3, custody staff activated a medical alarm for the patient with suspected stroke symptoms. At 5:39 p.m., the nurse documented EMS was initiated; however, in documentation explaining the need to redirect the ambulance, at 5:56 p.m. custody staff relayed to the nurse EMS had not yet been initiated, indicating a delay of 19 minutes for EMS initiation after the alarm was activated.

- In case 26, staff activated a medical alarm for the patient with an injury sustained during a fall. However, nurses documented a 15-minute delay in arrival due to another medical alarm. At the clinician on-site inspection, nursing leadership reported they had no written contingency plan in the local operating procedure for multiple-alarm activations.

- In case 27, staff activated a medical alarm for the patient with chest pain, a cardiac pacemaker, and a congestive heart failure diagnosis. At 10:36 a.m., the nurse received orders from the provider to transfer the patient to a higher level of care. However, the nurse did not initiate EMS until 11:00 a.m., a 24-minute delay.

Cardiopulmonary Resuscitation Quality

CCWF custody and medical staff frequently worked collaboratively to provide emergency care. OIG clinicians reviewed three cases in which staff administered CPR and administered naloxone. However, in all three cases, we identified opportunities for improvement as follows:

- In case 4, staff activated a medical alarm for the unresponsive patient, who was later pronounced dead on site. Custody staff did not immediately initiate CPR and instead waited until health care staff arrived two minutes later.

- In case 5, custody staff activated a medical alarm for the unresponsive patient, who was later pronounced dead on site. Although custody staff immediately initiated CPR, nurses did not record vital signs throughout the code period. In addition, the TTA RN documented having used nursing protocol for loss of consciousness but inappropriately administered an intramuscular injection of epinephrine, which is found only in nursing protocol for allergic reactions.[21] Furthermore, nurses did not insert an oral airway device until over 20 minutes after arriving to the patient.[22]

- In case 7, staff provided emergency care for the unresponsive patient, who was later pronounced dead on site. Custody staff immediately initiated both CPR and EMS, while nurses applied an AED and administered Narcan.

[21] Epinephrine is a drug used in cardiac life support treatment.

[22] An oral airway device is a medical device used to maintain or open a patient's airway when the patient is unresponsive and not breathing.

However, nursing documentation of oxygen therapy was inconsistent, and the record did not clearly indicate whether oxygen was provided.

Provider Performance

Case review found CCWF's providers performed well in urgent and emergent situations, and during after-hours care. Providers were available for consultation with nurses when necessary and were involved in treatment decisions. They made accurate diagnoses and generally completed documentation. We reviewed 66 emergency events and identified four deficiencies, one of which was significant.[23] The following are examples:

- In case 1, the provider evaluated the patient for a sore throat and ordered antibiotics for a possible streptococcal infection but did not order a throat culture to diagnose a bacterial infection.[24]

- In case 15, the provider evaluated the patient for an eyelid skin infection and planned on following up with the patient in three days. However, the provider did not place the order; consequently, the patient was not seen.

- In case 26, staff activated a medical alarm for the elderly patient, who sustained a fall and complained of dizziness, symptoms which could have been caused by heart conditions. Staff obtained an EKG; however, the provider did not review the patient's EKG.[25]

Nursing Performance

CCWF's nursing performance in emergent events revealed opportunities for improvement in assessments and interventions. Of the 66 emergency care deficiencies identified, 18 were nursing related.[26] TTA nurses sometimes had incomplete nursing assessments or reassessments, and occasionally did not notify the provider when a patient's condition warranted further evaluation and treatment. In addition, TTA nurses did not always use nursing protocols or used incorrect nursing protocols. The following are examples:

- In case 3, staff activated a medical alarm for the patient with general weakness and dizziness. The patient was positive for stroke-like symptoms and had an altered level of consciousness. The TTA RN first transported the patient to the clinic for assessment and then later transported the patient to the TTA for further care, which contributed to further delays of assessments and interventions. In addition, the TTA RN incorrectly utilized the loss of consciousness nursing protocol and did not contact the provider immediately after identifying positive stroke symptoms. The TTA RN instead waited over 45 minutes to contact the provider.

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[23] Provider deficiencies occurred in cases 1, 6, 15, and 26. A significant deficiency occurred in case 15.

[24] Streptococcal infection, also known as strep infection, is a bacterial infection.

[25] An EKG is an electrocardiogram. This noninvasive test measures and records the electrical impulses from the heart and is used to help diagnose heart problems.

[26] Nursing deficiencies occurred in cases 1, 3–5, 7-9, 21, and 24–28. Significant deficiencies occurred in cases 3, 5, and 26–28.

- In case 26, staff activated a medical alarm for the patient, who sustained a fall with injury. The TTA nurse did not obtain the patient's vital signs and did not perform a reassessment prior to discharging the patient to the housing unit.

- In case 27, staff activated a medical alarm for the patient, who had a cardiac pacemaker, clammy skin, and complained of chest pain, which he rated seven out of 10 on a pain measurement scale. Despite these factors, the nurse allowed the patient to walk to the TTA. In addition, the TTA RN did not assess for the patient's activity at the onset of chest pain or inquire about worsening or relief of pain or about medication compliance.

- In case 28, staff activated a medical alarm for the patient experiencing chest pain. However, the TTA RN did not use the chest pain nursing protocol, which includes inquiring about activity at onset or location of the pain. In addition, the nurse did not obtain a finger-stick blood glucose reading on the diabetic patient, palpate for pulses and chest tenderness, or assess capillary refill. Furthermore, the nurse did not perform an EKG, monitor vital signs at least every 15 minutes, or co-consult with the provider, although the patient had a history of heart failure and an enlarged heart.

Nursing Documentation

CCWF nurses generally performed thorough documentation for emergent events. However, we identified 13 documentation deficiencies related to conflicting nurse reports, unclear timelines, and observation of patient clinical presentation or assessments.[27] The following are examples:

- In case 4, the HCFR did not document the emergency care provided during a medical alarm for the unresponsive patient. In addition, the second HCFR did not document the time or person who initiated the rescue breathing to the patient, or the result of the oxygen saturation taken from the patient's right hand.

- In case 26, staff activated a medical alarm for the patient, who sustained an injury after a fall. However, nurses did not document the time of the alarm activation, the time of the HCFR's arrival, or the time the patient was transported to the TTA. In addition, the HCFR did not document their involvement in the response or initial screening of the patient to include vital signs and blood sugar result, as reported to the TTA RN. The TTA RN also did not document the result of the patient's lower extremity assessment.

- In case 27, the TTA RN provided emergency care for the patient with chest pain and inaccurately documented applying oxygen at 10:30 a.m., despite documentation that, at 10:25 a.m., vital signs indicated oxygen had already been initiated. In addition, the TTA RN did not properly document the time the EKG was performed, as the electronic time stamp was prior to the

[27] Nursing documentation deficiencies occurred in cases 1, 3, 4, 5, 7, 9, 21, and 24–28.

patient's arrival to the TTA. Furthermore, the TTA RN did not document the time of the IV insertion or respiration rates during vital signs checks.

- In case 28, the TTA RN responded to an alarm for the patient with chest pain. However, the TTA RN did not document the nursing activities from the time of arrival to the patient or the patient's subsequent arrival in the TTA. In addition, the nurse did not document the time the patient was discharged from the TTA to the housing unit.

Emergency Medical Response Review Committee

The EMRRC met monthly and discussed emergency responses and unscheduled send-outs. However, compliance testing showed incident packages were deficient due to cases not being reviewed within the required time frame or being incomplete (MIT 15.003, 33.3%). OIG clinicians found CCWF always performed clinical reviews; however, in two emergency cases, the chief nurse executive (CNE) or designee was the same nurse who performed the initial supervising registered nurse II (SRNII) review and was not the intended reviewer. In addition, in 11 of the 16 emergency events or unscheduled send-outs, nursing and medical leadership did not recognize the same opportunities for improvement that we identified.[28]

Clinician On-Site Inspection

At CCWF, one temporary TTA was located in an alternative space, while the intended area for the permanent TTA was under construction. The temporary TTA was one large room with three emergency beds and an additional overflow bed in a smaller room in the same hallway. OIG clinicians learned the TTA staffed two RNs on the night and morning shifts as well as three to five RNs on the afternoon shift. Nurses reported the assigned provider for TTA changed daily, and the provider was responsible to cover the TTA, mental health crisis beds, and skilled nursing facility (SNF) beds. After hours, until 8:00 p.m., the on-call provider was available for consult, and from 8:00 p.m. to 6:00 a.m., the telemedicine provider covered the TTA.

The TTA RN and medication line LVNs reported they were the first responders. Nurses shared challenges with the location of the temporary TTA, such as delayed custody response. Due to the TTA location, when staff activated the "emergency button" on their personal alarms, custody staff could not obtain a direct location. In addition, the TTA nurses shared challenges with staffing, as the positions are considered undesirable due to the volume of emergencies and staff call outs. The TTA RN reported, in one month, they had an average of 450 emergency calls to respond to in addition to their other assignments. Nurses also shared the custody transport team was often delayed when requesting transfers to a higher level of care. Estimated time ranges included up to 20 minutes for emergent transfers and 40 minutes for urgent transfers. Nurses further reported custody staff can take up to four hours to be ready to transport a patient to a higher level of care via a State vehicle. According to nursing leadership, CCWF had already identified these challenges and established a performance improvement plan as well as a plan to monitor the outcome.

[28] CCWF leadership or supervisors conducted clinical reviews in cases 2–8 and 24–27. Deficiencies occurred in cases 2–6, 8, 24, 25, and 27.

Recommendations

- Leadership should determine the root cause(s) of challenges to custody transportation teams arriving timely to the TTA for higher level of care transfers and implement remedial measures as appropriate. In addition, the EMRRC should continue the current performance improvement plan reported during the on-site inspection.

- Nursing leadership should determine the root cause of challenges that prevent nurses from accurately documenting the time and sequence of events during emergency responses, and should implement remedial measures as appropriate, such as including these documentation and timeline deficiencies in the clinical review process.

Health Information Management

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Adequate* (79.7%)**

In case review, CCWF's performance in managing health information for this cycle decreased in comparison with its performance in Cycle 6. CCWF had excellent urgent or emergent information management and did not have many scanning errors. However, we found CCWF needed improvement with hospital discharge records, diagnostic results, and specialty reports. Most deficiencies we found were due either to generating incomplete or not generating patient test result letters, most of which did not impact decision-making or treatment plans. Factoring in all aspects, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed CCWF performed well in managing health information. Staff always scanned patient sick call requests timely. Staff also performed well in retrieving, scanning, and endorsing hospital records, along with scanning specialty documents. However, staff needed to improve in labeling and scanning medical records into the correct patient records. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***adequate***.

Case Review and Compliance Testing Results

We reviewed 1,290 events and found 104 deficiencies related to health information management, 10 of which were significant.[29]

Hospital Discharge Reports

CCWF's performance varied for information management of hospital or emergency department encounters. Compliance testing showed, while staff had excellent timely retrieval and scanning of hospital records (MIT 4.003, 100%), they struggled with obtaining complete hospital discharge reports with key elements (MIT 4.005, 61.1%). OIG clinicians reviewed 16 offsite emergency and hospital encounters and identified six deficiencies. Four of the deficiencies related to missing a hospital discharge summary or

[29] HIM deficiencies occurred in cases 1–3, 6, 7, 9–18, 20, 22–30, and 39. Significant deficiencies occurred in cases 1–3 and 25–27.

an emergency department report, and two of the deficiencies related to incorrectly scanned hospital reports. The following are examples:

- In cases 2 and 27, the patients returned from the emergency department, but CCWF staff did not retrieve the emergency department reports.
- In case 3, the patient returned from the hospital with stroke-like symptoms. While CCWF staff retrieved the hospital reports for the neurology consultation, imaging studies, and discharge instructions, staff did not scan the hospital discharge summary into the EHRS.
- In case 26, the patient returned from the hospital, but CCWF staff did not retrieve the hospital discharge summary.

Specialty Reports

CCWF had a mixed performance with managing specialty health information. Generally, staff timely retrieved specialty reports (MIT 4.002, 83.3%); however, providers' timely endorsements varied for high-priority, (MIT 14.002, 92.9%) medium-priority (MIT 14.005, 60.0%), and routine-priority (MIT 14.008, 57.1%) specialty reports. Case review identified 17 deficiencies, two of which were related to provider endorsement delays.[30] Case review also identified five deficiencies in which providers did not send patient notification letters regarding off-site specialty tests results. Seven of the deficiencies related to late retrieval or late scanning of the reports into the EHRS. The following is an example:

- In case 25, the patient had an appointment at the cancer infusion center. Staff scanned a blank report of this appointment, which was mislabeled as a radiation oncology appointment.

Diagnostic Reports

CCWF's performance also varied with information management of diagnostic reports. Compliance testing showed poor performance in timely STAT laboratory test notification (MIT 2.008, 50.0%). Providers performed excellently in timely reviewing pathology results (MIT 2.011, 100%), but performed poorly in communicating results to the patient with test result letters (MIT 2.012, 20.0%). Case review identified 80 deficiencies concerning test result letters; most of which related to either staff not generating patient test notification letters or patient notification letters missing required elements.

Urgent and Emergent Records

OIG clinicians reviewed 66 emergency care events and found CCWF nurses and providers documented these events excellently. Providers also documented their emergency care sufficiently, including provider on-call (POC) telephone encounters. We did not identify any health information deficiencies with urgent or emergent events. The **Emergency Services** indicator provides additional details.

[30] Specialty HIM deficiencies occurred in cases 2, 10, 14, 23, and 25–29. Significant deficiencies occurred in cases 2 and 25.

Scanning Performance

Compliance testing showed staff needed improvement with scanning, labeling, and filing of patient files (MIT 4.004, 54.2%). Case review identified three scanning errors at CCWF as follows:

- In case 25, the patient's specialty report was mislabeled as a radiation oncology appointment in the EHRS.
- In case 24, the patient had several emergency department encounters within days of each other. Staff scanned some of the patient's records with the wrong date and erroneously combined the different emergency department reports.
- In case 39, the patient arrived from county jail. Staff scanned a document for another patient into this patient's medical record.

Clinician On-Site Inspection

We discussed health information management processes with health information management supervisors, ancillary staff, diagnostic staff, nurses, and providers. The medical records supervisor detailed the process of retrieving on-site and off-site reports and routing them to providers for review and endorsement. Providers reported medical records staff obtained outside reports quickly and routed reports appropriately for review.

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)	13	0	5	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	13	11	0	54.2%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	11	7	0	61.1%
				Overall percentage (MIT 4): **79.7%**

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

Table 9. Other Tests Related to Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	9	1	0	90.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	8	2	0	80.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	5	5	0	50.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	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)	13	1	1	92.9%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	9	6	0	60.0%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	8	6	1	57.1%

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

Recommendations

- HIM should identify the challenges to properly labeling and scanning documents into the electronic health record and should implement appropriate remedial measures.

- HIM should determine the root cause(s) of challenges to staff timely retrieving and thoroughly completing hospital discharge reports and should implement appropriate remedial measures.

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. Case review does not rate this indicator.

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (65.6%)**

Overall, CCWF performed poorly with respect to its health care environment. In this cycle, multiple aspects of CCWF's health care environment needed improvement: medical supply storage areas in the clinics contained expired medical supplies; emergency medical response bag (EMRB) logs were missing staff verification, EMRB inventory was not performed when seal tags changed, or EMRBs contained compromised medical supplies; and staff did not properly wash their hands throughout patient encounters. Based on the overall compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Outdoor Waiting Areas

We inspected outdoor patient waiting areas. Health care and custody staff reported the existing waiting areas contained sufficient seating capacity and ample protection from inclement weather (see Photo 1).

Photo 1. Outdoor wating area (photographed on 1-17-24).

Indoor Waiting Areas

We inspected indoor waiting areas. Health care and custody staff reported existing waiting areas contained sufficient seating capacity (see Photo 2, next page). Dependent on the population, patients were

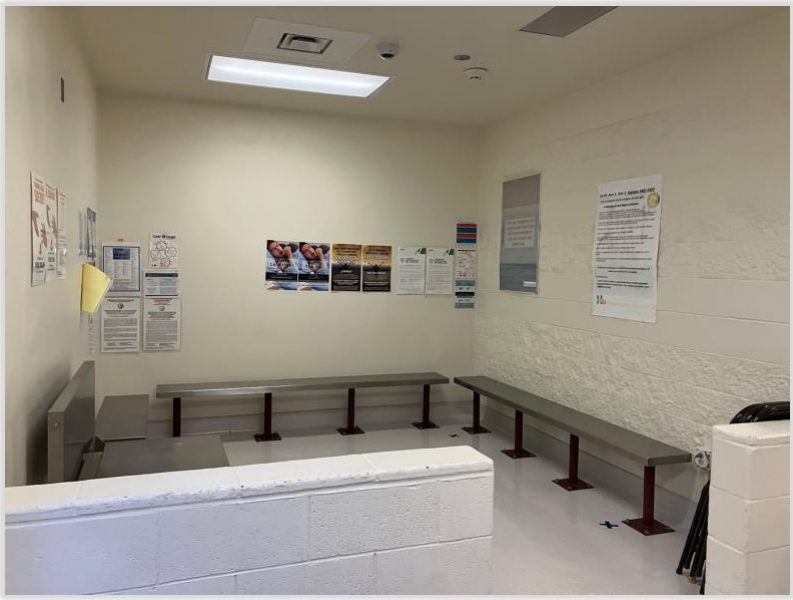

Photo 2. Indoor waiting area (photographed on 1-19-24).

either in the clinic waiting area or in individual modules (see Photo 3, next page). During our inspection, we did not observe overcrowding.

Photo 3. Individual waiting modules (photographed on 1-18-24).

Clinic Environment

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

Eleven of the 12 applicable clinics we observed contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 91.7%). In one clinic, the examination table had a torn cover.

Clinic Supplies

Only two of the 12 applicable clinics followed appropriate medical supply storage and management protocols (MIT 5.107, 16.7%). We found one or more of the following deficiencies in 10 clinics: compromised sterile medical supply packaging; expired medical supplies (see Photos 4 and 5); long-term storage of staff's food in the medical supply storage location (see Photo 6, next page); unorganized, unidentified, or inaccurately labeled medical supplies; cleaning materials stored with medical supplies; and medical supplies stored with medications (see Photo 7, next page).

Photo 4. Expired medical supply, dated November 30, 2023 (photographed 1-17-24).

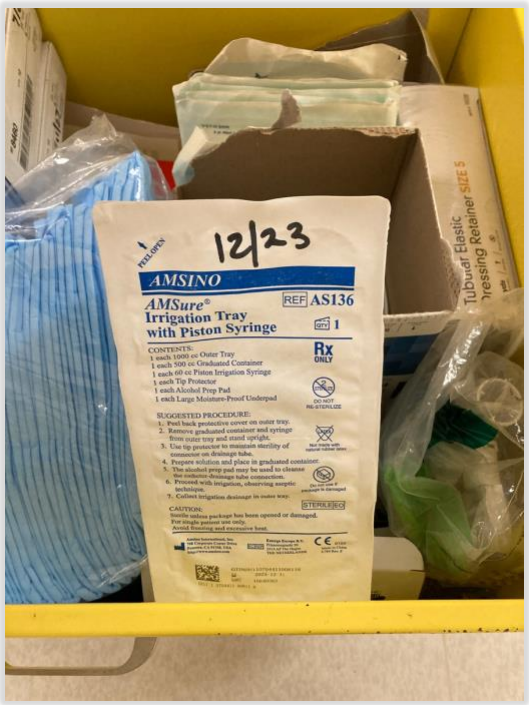

Photo 5. Expired medical supply, dated December 31, 2023 (photographed on 1-17-24).

Photo 6. Bulk food stored long term in the medical supply storage location (photographed on 1-17-24).

Photo 7. Medical supply stored with medication (photographed on 1-18-24).

Eight of the 12 applicable clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 66.7%). In four clinics, we found one or more of the following deficiencies: missing nebulizer or emergency medical response bag (EMRB); the Snellen eye chart was placed at an improper distance; staff did not properly log the results of the defibrillator performance test within the last 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. Six of the 11 EMRBs passed our test (MIT 5.111, 54.6%). We found one or more of the following deficiencies with five EMRBs: staff failed to ensure the EMRB's compartments were sealed and intact; staff had not inventoried the EMRBs when seal tags were replaced; EMRBs contained compromised medical supply packaging; and an EMRB oxygen tank had pressure less than 1,000 per square inch (psi).

Medical Supply Management

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

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

Infection Control and Sanitation

Infection control and sanitation staff appropriately cleaned, sanitized, and disinfected 11 of 12 applicable clinics (MIT 5.101, 91.7%). In one clinic, we found the cabinet under the sink unsanitary.

Staff in 10 of 11 applicable clinics (MIT 5.102, 90.9%) properly sterilized or disinfected medical equipment. In one clinic, we found sterilized reusable invasive medical equipment with compromised packaging.

We found operating sinks and hand hygiene supplies in all examination rooms (MIT 5.103, 100%).

We observed patient encounters in 10 applicable clinics. In nine clinics, staff rarely washed their hands before or after examining their patients, or before each subsequent regloving (MIT 5.104, 10.0%).

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

Physical Infrastructure

We gathered information to determine whether the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely and adequate health care. When we interviewed health care managers, they did not have concerns about the facility's infrastructure or its effect on the staff's ability to

provide adequate health care. At the time of inspection, the institution had three ongoing infrastructure projects and three more infrastructure projects underway, which management felt would improve the delivery of care at CCWF (MIT 5.999):

- Subproject 2.1: Facility A primary care clinic storage and one examination room renovation, which began in November 2020 and was expected to be completed by April 2024.

- Subproject 2.2: Facility A primary care clinic staff restroom and four examination rooms renovation, which was projected to begin in June 2024 and expected to be completed by April 2025.

- Subproject 3.2 B: Facility B primary care clinic staff workstation, examination rooms, and custody staff station renovation, which was projected to begin in February 2025 and expected to be completed by September 2025.

- Subproject 3.2 C: Facility C primary care clinic staff workstation, examination rooms, and custody staff station renovation, which was projected to begin in February 2025 and expected to be completed by October 2025.

- Subproject 3.2 D: Facility D primary care clinic staff workstation, examination rooms, and custody staff station renovation, which was projected to begin in April 2025 and expected to be completed by October 2025.

- Subproject 5.2: Central Health Services storage and examination room renovation, which began in December 2020 and was expected to be completed by December 2024.

Compliance Score Results

Table 10. Health Care Environment

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	11	1	1	91.7%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	10	1	2	90.9%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	12	0	1	100%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	1	9	3	10.0%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	12	0	1	100%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	2	10	1	16.7%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	8	4	1	66.7%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	12	0	1	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	11	1	1	91.7%
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	5	2	54.6%
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): **65.6%**

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

Recommendations

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

- Nursing leadership should determine the root cause(s) for staff not ensuring clinic examination rooms contain essential core medical equipment and verify staff follow equipment and medical supply management protocols. Leadership should take necessary remedial measures.

- Nursing leadership should determine the root cause(s) for staff both not ensuring the EMRBs are regularly inventoried and sealed as well as not properly completing the monthly logs. Leadership should take 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 staff performance in communicating vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals; and inspectors confirmed whether staff sent complete medication transfer packages to receiving institutions. For patients who returned from off-site hospitals or emergency rooms, inspectors reviewed whether staff appropriately implemented recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (72.4%)**

Case review found CCWF performed sufficiently with the transfer process. Compared with Cycle 6, although OIG clinicians reviewed fewer events in fewer cases, we identified both more overall and more significant deficiencies in Cycle 7. OIG clinicians found mostly minor deficiencies related to the transfer-in and transfer-out processes, with most deficiencies related to the hospital return process. We identified a pattern with CCWF staff not always obtaining hospital discharge paperwork. We identified additional opportunities for improvement regarding nursing performance for patients returning from the community hospital. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate.***

Compared with Cycle 6, compliance testing showed CCWF's overall performance improved for this indicator. Nursing staff performed excellently in completing the assessment and disposition section of the screening process for newly arrived patients. Nursing staff also ensured transfer packets for patients departing had the required documents and medications. However, the institution performed poorly in completing the initial health screening forms. Based on the overall compliance score result, the OIG rated the compliance testing component of this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 47 events in 18 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 18 deficiencies, seven of which were significant.[31]

Transfers In

CCWF's transfer-in process had a mixed performance. Compliance testing showed receiving and release (R&R) nurses performed poorly in completing the initial health screening form thoroughly (MIT 6.001, 21.7%). However, nurses almost always completed the assessment and disposition sections of the form in their entirety (MIT 6.002, 95.5%). Compliance testing also found staff intermittently ensured medication continuity occurred at the time of transfer (MIT 6.003, 72.2%) but performed poorly in medication continuity for patient layovers at the institution (MIT 7.006, 30.0%). In addition, compliance testing showed newly arrived patients were generally seen by a provider within necessary time frames (MIT 1.002, 83.3%).

While compliance testing results varied, OIG clinicians found CCWF's transfer-in process to be satisfactory. We reviewed eight events in four cases in which patients transferred into the facility from other institutions. We identified only four deficiencies, one of which was significant.[32] The following is an example:

- In case 34, the nurse assessed the transfer-in patient and noted the patient had a pending RN follow-up appointment for a laceration above the left eyebrow; however, the RN follow-up appointment did not occur timely. In addition, the nurse documented a referral to the provider within seven days, but did not place an order for the appointment. Consequently, the patient was seen three days late.

Transfers Out

CCWF performed well in the transfer-out process. Compliance testing showed patients who transferred out of the institution always had their medications and required documents (MIT 6.101, 100%). OIG clinicians found the same.

OIG clinicians reviewed a total of 14 transfer-out events in six cases in which patients transferred out of the facility to other institutions. We identified two minor deficiencies.[33] One deficiency related to the transfer-out medications and is addressed further in the **Medication Management** indicator. The second deficiency related to nursing staff not documenting communication of pending specialty appointments to the receiving institution.

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high risk for lapses in care quality. These patients typically experience severe illness or injury. They

[31] Deficiencies occurred in cases 2, 3, 11, 23, 24, 26, 27, 33–35, and 60. Significant deficiencies occurred in cases 2, 3, 23, 26, 27, and 34.

[32] Transfer-in deficiencies occurred in cases 11, 33, and 34. A significant deficiency occurred in case 34.

[33] Transfer-out deficiencies occurred in cases 11 and 35.

require more care and place a strain on the institution's resources. In addition, because these patients have complex medical issues, successful transfers of health information are necessary for good quality care. Any transfer lapse can result in serious consequences for these patients.

CCWF also had a mixed performance in the return process for hospitalizations and emergency room encounters. Compliance testing showed staff often completed follow-up appointments within required time frames for patients returning from hospitalizations and emergency room encounters (MIT 1.007, 88.9%). Additionally, in all samples, staff scanned hospital discharge documents into the patient's electronic health record within three calendar days of discharge (MIT 4.003, 100%). However, compliance testing also found providers only intermittently reviewed and endorsed documents in a timely manner (MIT 4.005, 61.1%).

Case review found opportunities for improvement in the return hospitalization process. Our clinicians reviewed 25 hospitalization events in 10 cases, 16 of which were hospitalization or emergency room encounter returns. We identified 12 deficiencies, six of which were significant.[34] Five of the six significant deficiencies related to hospital records and are further addressed in the **Health Information Management** indicator. The one additional significant deficiency related to nursing performance, as follows:

- In case 23, the nurse evaluated the patient upon return from a prescheduled surgical procedure and subsequent hospitalization. The patient had the left upper section of the lung removed, a previous central line and chest tube, and postsurgical incisions.[35] However, the nurse documented the patient's skin was intact and did not indicate any abnormalities, such as dressings, sutures, or staples. In addition, the nurse documented breath sounds were present and clear in all lobes, although the left upper lobe was no longer present. Furthermore, the patient complained of pain, but the nurse did not administer pain medication as needed.

Further compliance testing showed CCWF performed poorly in ensuring staff administered, made available, or delivered ordered medications to patients within required time frames (MIT, 7.003, 15.4%). In contrast, OIG clinicians found only one minor deficiency related to medication continuity upon return from a community hospitalization. This is addressed further in the **Medication Management** indicator.

Clinician On-Site Inspection

OIG clinicians inspected the R&R area and interviewed the RN, who stated the R&R was staffed with one RN on the afternoon and night shifts and two RNs on the morning shift. The RN also reported the R&R received a list of incoming and outgoing scheduled transfers for the following week on Wednesdays, with amendments sent daily. The RN further reported an estimated weekly range of 40 to 55 incoming patients and 20 to 25 outgoing patients.

[34] Deficiencies occurred in cases 2, 3, 23, 24, 26, 27 and 60. Significant deficiencies occurred in cases 2, 3, 23, 26, and 27.

[35] A central line or a central venous catheter is a flexible thin tube inserted into a large vein of the patient. Medical staff use the central line to administer medications, fluids, blood, or nutrition.

OIG clinicians inspected the TTA, where patients who needed a higher level of care and off-site specialty transfers and returns were processed. The TTA RN reported the area was responsible for these transfers and returns in addition to responding to emergency calls. Please see the **Emergency Services** indicator for more information related to higher-level-of-care transfers. During interviews, nursing leadership shared they had identified a lapse in medication continuity in patients receiving their scheduled medications transferring to or returning from off-site specialty appointments. Nursing leadership indicated they were updating their local operating procedure to include a new process to address this situation. Please see the **Medication Management** indicator for further information on medication continuity.

Compliance Testing Results

Compliance On-Site Inspection and Discussion

R&R nursing staff ensured all 10 sampled patients transferring out of the institution had the required medications, transfer documents, and assigned durable medical equipment (DME) (MIT 6.101, 100%).

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)	5	18	0	21.7%
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	1	1	95.5%
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)	13	5	5	72.2%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	10	0	0	100%
				Overall percentage (MIT 6): **72.4%**

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

Table 12. Other Tests Related to Transfers

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	15	3	5	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)	16	2	0	88.9%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	13	0	5	100%
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)	11	7	0	61.1%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003)	2	11	5	15.4%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	10	15	0	40.0%
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)	3	4	0	42.9%

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

Recommendations

- Nursing leadership should determine the root cause(s) of challenges that prevent nurses from thoroughly completing the initial health screening process, including documenting last menstrual period, answering all questions, and documenting an explanation for all "Yes" answers before the patient is transferred to the housing unit. Nursing leadership should implement remedial measures as appropriate.

Medication Management

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Inadequate	***Inadequate* (55.5%)**

Case review found CCWF continued to perform poorly in medication management in Cycle 7. Although we found improvement in new medications and hospital discharge medications compared with Cycle 6, CCWF continued to have challenges with chronic care medications that included lapses in medication continuity and missed doses of nurse-administered or directly observed medications. We identified a pattern of inaccurate and incomplete documentation as well as missed doses occurring during the medication renewal process. Furthermore, CCWF struggled with staff neglecting to offer medications prior to or upon return from off-site specialty appointments. Taking all factors into account, the OIG rated the case review component of this indicator ***inadequate***.

Compliance testing similarly showed CCWF needed improvement in this indicator. CCWF scored low in providing patients with chronic care medications, newly prescribed medications as ordered, community hospital discharge medications, and medications for patients arriving from county jail, transferring within the institution, and laying over at the institution. 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 184 events, in 40 cases, related to medications and found 54 deficiencies, 19 of which were significant.[36]

New Medication Prescriptions

Compliance testing showed CCWF needed improvement with timely administration and availability of new prescription medications (MIT 7.002, 68.0%). In contrast, OIG clinicians found only two significant deficiencies related to new prescriptions in the outpatient setting. Examples are as follows:

[36] Deficiencies occurred in cases 1–3, 6, 7, 10, 11, 14–16, 19–21, 23–26, 30, 33, 41, 59, and 60. Significant deficiencies occurred in cases 2, 6, 15, 16, 19, 21, 23–26, 30, and 60.

- In cases 6 and 21, the provider entered a KOP order for an oral steroid. However, for both patients, we identified a delay of two days in the patients receiving the prescriptions.

Chronic Medication Continuity

CCWF performed poorly in chronic medication continuity. Compliance testing showed patients rarely received their chronic care medications within required time frames (MIT 7.001, 16.7%). Similarly, OIG case reviewers found CCWF had many lapses in delivering and administering chronic care medications. The following are examples:

- In cases 1, 6, 16, 19, 20, 21, 24, 25, 26, and 30, patients either did not receive their KOP chronic care medications timely or at all.

- In cases 1, 7, 15, 23, 26, and 30, patients did not receive one or more doses of nurse-administered chronic care medications.

- In case 15, in the months of June, September, and October 2023, the patient was prescribed oral hormones to be taken during the first 10 days of the month. However, on multiple occasions, nurses administered the medication on incorrect dates or did not administer the medication at all.

Hospital Discharge Medications

In compliance testing, CCWF performed poorly in ensuring patients received their medications upon return from an off-site hospital or emergency room encounter (MIT 7.003, 15.4%). In contrast, OIG clinicians found only one minor deficiency in which the patient received a new order for a multivitamin one day late.[37]

Specialized Medical Housing Medications

OIG clinicians found CCWF had opportunities for improvement in ensuring patients received their needed medications during admission into the skilled nursing facility (SNF). We found 10 medication administration deficiencies, three of which were significant.[38] The following are examples:

- In case 2, in August 2023, while the patient was admitted to the SNF, staff did not administer multiple intravenous fluids, antibiotics, and supplements to the patient as ordered. In addition, the patient did not receive a blood thinning injection or multiple chronic care oral medications as ordered.

- In case 23, the patient did not receive an afternoon dose of antibiotics the day after returning from a community hospitalization.

- In case 60, the patient had an order for a hormonal vaginal cream that was ordered incorrectly on two occasions. On one occasion, the medication order was unscheduled, resulting in the inability to validate when the medication

[37] This hospital discharge medication deficiency occurred in case 2.

[38] Specialized medical housing medication deficiencies occurred in cases 2, 23, 25, 59 and 60. Significant deficiencies occurred in cases 2, 23, and 60.

was administered. On another occasion, the order for the medication contained conflicting application instructions: one to apply the medication twice a week and one to apply it daily.[39] In addition, on two additional separate occasions, the patient missed one dose of a thyroid medication and an antibiotic.

Transfer Medications

Compliance testing showed CCWF had opportunities for improvement in transfer medications. Nurses intermittently ensured patients who transferred into the institution received their medications timely (MIT 6.003, 72.2%). In addition, CCWF performed poorly in medication continuity for patients transferring from yard to yard (MIT 7.005, 40.0%). Furthermore, CCWF also performed poorly with patients who were on layover and temporarily housed at CCWF, as those patients only sporadically received their medications within required time frames (MIT 7.006, 30.0%). In contrast, OIG clinicians found only two minor medication deficiencies within the transfer process. The following are examples:

- In case 11, the patient was held for safety in the TTA for over nine hours pending transfer to a mental health crisis bed; however, TTA nurses did not administer the patient's afternoon medications prior to transferring the patient out of the institution. Instead, the medication line LVN documented the patient, "did not show up despite multiple prompts by custody."

- In case 33, the patient arrived with transfer medication, and nurses documented they would send the medications to the housing unit. However, nurses did not document whether the patient received the transferred KOP medications on her placement in the restricted housing unit.

OIG clinicians also found three minor medication deficiencies for new arrivals through the reception center. Examples are as follows:

- In cases 3 and 41, the patients did not receive the next interval dose of a scheduled medication upon arrival from the county jail to CCWF.

- In case 11, the pregnant patient was transferred with an order to start prenatal vitamins the same day as arrival. However, the patient did not receive the vitamins until the following day.

Medication Administration

Compliance testing showed nurses performed well in administering tuberculosis (TB) medications within required time frames (MIT 9.001, 88.0%). OIG clinicians did not have any case review samples with events related to TB medications.

OIG clinicians found nurses had opportunities for improvement in administering medications properly. We reviewed 54 events in 16 cases for patients returning from off-

[39] An *unscheduled order* is an order with an open-ended administration date intended for a single dose medication, such as a vaccine. In the case of a medication requiring multiple administrations, such as a topical cream, an unscheduled order prevents staff from documenting more than one administration.

site specialty consultations and found, on four occasions, nurses did not ensure the patient received her scheduled medications prior to transfer or upon return to the institution.[40] The following are examples:

- In case 2, the patient had a one-time order for a magnesium sulfate injection and a scheduled daily blood thinning injection. However, nurses did not administer the injections prior to or upon return from the specialty consultation. In addition, nurses did not request to reschedule or reorder the one-time injections.

- In case 26, the patient had a scheduled order for a daily injection to treat bone loss. However, nurses did not administer the injection upon the patient's return from an off-site specialty consultation.

OIG clinicians also found CCWF had challenges with administering insulin in the outpatient and inpatient units. We reviewed six cases in which insulin was administered and identified 11 deficiencies, five of which were significant.[41] The following are examples:

- In case 16, during the month of May 2023, records indicated a lapse in administering sliding scale insulin to the patient for three days. Then, in August 2023, the patient's insulin expired in the evening, but the medication was not renewed.

- In case 19, on multiple occasions in July, August, and September 2023, nurses did not administer insulin as ordered, although the blood-sugar test results warranted administration. In addition, on several occasions, LVNs did not administer the insulin when the patient reported nausea; moreover, the LVNs did not notify the RN or provider of the patient's complaint, as required. Furthermore, in one event, the nurse did not notify the provider of a low blood-sugar test result.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians met with the pharmacists to discuss medication-related questions. OIG clinicians also toured the medication lines and interviewed medication LVNs. Medication LVNs were also observed attending the daily clinic huddles, in which they communicated medication issues.

The medication LVNSs in Facility B medication area reported this medication area was staffed with two nurses on the morning and afternoon shifts. The LVNs were familiar with medication-related processes, such as KOP medications, medication returns, patient no-shows, and requests for refills. The LVNs also shared they were responsible for responding to health care emergencies with a wheelchair, an emergency bag, and an AED.

[40] Off-site specialty consultation medication continuity deficiencies occurred in cases 2, 23, and 26.

[41] Nursing staff administered insulin medications in cases 14, 16, 17, 19, 59, and 60. Deficiencies occurred in cases 14, 16, 19, and 59. Significant deficiencies occurred in cases 16 and 19.

Medication Practices and Storage Controls

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

CCWF appropriately stored and secured nonnarcotic medications in four of 13 clinic and medication line locations (MIT 7.102, 30.8%). In nine locations, we observed one or more of the following deficiencies: nurses did not maintain unissued medication in its original labeled packaging; the treatment cart log was missing daily security check entries; and the medication area lacked a clearly labeled designated area for medications to be returned to the pharmacy

Staff kept medications protected from physical, chemical, and temperature contamination in only three of the 13 clinic and medication line locations (MIT 7.103, 23.1%). In 10 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 members' personal food items were stored with medication; and the medication refrigerator was unsanitary.

Staff successfully stored valid and unexpired medications in nine of the 13 applicable medication line locations (MIT 7.104, 69.2%). In three locations, medication nurses did not label multiple-use medication as required by CCHCS policy. At the remaining location, medication nurses stored unopened and previously opened medications beyond their expiration dates.

Nurses did not exercise proper hand hygiene and contamination control protocols in any of the seven applicable locations (MIT 7.105, zero). In all seven locations, we found one or more of the following deficiencies: nurses neglected to wash or sanitize their hands before preparing medications, before donning gloves, or before each subsequent regloving; nurses did not change gloves when necessary; and nurses did not have access to hand hygeine supplies during medication administration.

Staff in all seven applicable medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 100%).

Staff in four of the seven applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 57.1%). In three locations, we observed one or more of the following deficiencies: medication nurses did not always verify a patient's identification using a secondary identifier; medication nurses did not reliably observe patients while they swallowed direct observation therapy medications; and medication nurses did not follow the CCHCS care guide when administering Suboxone medication.[42]

[42] Suboxone is a medication containing buprenorphine and naloxone. Suboxone is used to treat opioid dependence and addiction.

Pharmacy Protocols

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

The institution did not properly store refrigerated or frozen medications in the pharmacy. We found an unsanitary medication refrigerator (MIT 7.110, zero).

The PIC correctly accounted for narcotic medications stored in the CCWF pharmacy (MIT 7.111, 100%).

We examined 24 medication error reports. The PIC timely and correctly processed 22 of these 24 reports (MIT 7.112, 91.7%). For one medication error, the PIC did not complete the pharmacy error follow-up review within the required time frame. For the other medication error, the form had no documentation of the PIC's determination or findings regarding the error.

Nonscored Tests

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

The OIG clinicians interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Eight of 10 applicable patients interviewed indicated they had access to their rescue medications. Two patients reported they did not have their prescribed rescue inhalers. Both patients had submitted refill requests since using up their medications the day prior. We promptly notified the CEO of this concern, and health care management immediately reissued replacement rescue inhalers to the patients (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)	3	15	7	16.7%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	17	8	0	68.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003)	2	11	5	15.4%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004)	8	6	6	57.1%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	10	15	0	40.0%
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)	9	0	4	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	4	9	0	30.8%
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)	3	10	0	23.1%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	9	4	0	69.2%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	0	7	6	0
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	7	0	6	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	4	3	6	57.1%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	1	0	0	100%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	22	2	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): **55.5%**

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

Table 14. Other Tests Related to Medication Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	13	5	5	72.2%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	10	0	0	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	22	4	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)	9	16	0	36.0%
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)	0	10	0	0

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

Recommendations

- Nursing leadership should determine the challenges that prevent staff from providing medication continuity for patients prescribed chronic care medications, hospital discharge patients, en route patients, and patients returning from off-site specialty consultations and should implement remedial measures as appropriate.

- Nursing leadership should identify the root cause(s) of nurses not administering insulin medications as ordered and should implement remedial measures as appropriate.

- The institution should consider developing and implementing measures to ensure staff timely make available and administer medications to patients, and staff document the administration of medications in the electronic health record system (EHRS), as described in CCHCS policy and procedures.

- Nursing leadership should assess the root cause(s) for nursing staff failing to document patient refusals in the medication administration record (MAR), as described in CCHCS policy and procedures, and should implement remedial measures as needed.

Prenatal and Postpartum Care

This indicator evaluates the institution's capacity to provide timely and appropriate prenatal, delivery, and postnatal services to pregnant patients. This includes ordering and monitoring indicated screening tests, follow-up appointments, referrals to higher levels of care (e.g., high-risk obstetrics clinic) when necessary, and postnatal follow-up.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Proficient	***Proficient*** **(90.0%)**

As with Cycle 6, case review found CCWF continued to perform excellently in prenatal and postpartum care. We found timely and appropriate care in all cases with only three minor deficiencies, two of which we discuss in other indicators as noted below. Taking all factors into account, the OIG rated the case review component of this indicator ***proficient***.

Compliance testing similarly showed CCWF's performance was excellent in this indicator. Patients received timely obstetric appointments as well as timely housing, vitamins, and meals. Staff usually documented patient blood pressure, weight, and fundal height at each obstetric appointment and completed prenatal screening tests timely.[43] 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 144 events in four cases sampled for perinatal services. Of these 144 events, 13 related to prenatal or postpartum care. We identified two minor deficiencies.[44]

Prenatal Care

Staff delivered excellent performance in prenatal care. Compliance testing showed obstetric appointments always occurred timely (MIT 8.004, 100%), while initial provider appointments for newly identified pregnant patients generally occurred timely (MIT 8.001, 80.0%). Additionally, all patients timely received appropriate housing as well as vitamins, meals, and nutrition supplementation (MITs 8.002 and 8.003, 100%). Staff usually obtained patient weight, blood pressure, and fundal height at each obstetric appointment (MIT 8.006, 80.0%).

OIG clinicians reviewed four perinatal care cases. On-site providers generally performed prenatal care. Overall, pregnant patients received appropriate care prior to delivery, including high-risk pregnancy patients. One patient had a spontaneous missed abortion; she had refused OB visits multiple times despite repeated attempts by the provider.

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[43] Fundal height is a measurement taken during pregnancy to monitor the growth and development of the fetus.

[44] Minor deficiencies occurred in cases 10 and 11.

Overall, pregnant patients received appropriate care prior to delivery. OIG clinicians identified two minor deficiencies for a prenatal case: the first related to missing a single dose of a prenatal vitamin, which we further discuss in the **Medication Management** indicator, and we discuss the second in the **Provider Performance** indicator.

Postpartum Care

Compliance did not have any postpartum care samples for review (MIT 8.007, N/A). OIG clinicians reviewed only one postpartum case. We identified one minor deficiency related to the transfer-in process, which did not affect the patient's care.

Clinician On-Site Inspection

CCWF had one obstetrician-gynecologist (OBGYN) on staff. At the time of the on-site inspection, the OBGYN was not present. However, OIG clinicians met with the on-site specialty RN who reported having responsibility for conducting an antepartum evaluation with pregnant patients.[45] The nurse shared R&R nurses send a message to the onsite specialty nurse to notify of any newly arrived pregnant patients. The onsite specialty nurse scheduled these patients the following morning for the antepartum appointment. The nurse reported the antepartum appointment is utilized to obtain a patient and family history and a release of information for previous care at outside medical facilities, order required laboratory studies and referral appointments, provide a snack card and pregnancy vest, and ensure the patient is assigned a low bunk and prenatal vitamins are ordered. The nurse also shared a copy of the education packet provided to patients.

[45] *Antepartum*, also known as *prenatal*, is a term that means *before birth*.

Compliance Score Results

Table 15. Prenatal and Postpartum Care

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For patients identified as pregnant, did the institution timely offer initial provider visits? (8.001)	4	1	0	80.0%
Was the pregnant patient timely issued a comprehensive accommodation chrono for a lower bunk and lower-tier housing and did the patient receive the correct housing placement? (8.002)	5	0	0	100%
Did medical staff promptly order recommended vitamins, extra daily nutritional supplements and food for the patient? (8.003)	5	0	0	100%
Did timely patient encounters occur with an OB physician or OB nurse practitioner in accordance with the pregnancy encounter guidelines? (8.004)	5	0	0	100%
Were the results of the patient's initial prenatal screening tests timely completed and reviewed? (8.005)	4	1	0	80. 0%
Was the patient's weight, fundal height, and blood pressure documented at each clinic OB visit? (8.006)	4	1	0	80. 0%
Did the patient receive her six-week postpartum obstetric visit? (8.007)	N/A	N/A	5	N/A
				Overall percentage (MIT 8): **90.0%**

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

Recommendations

The OIG offers no recommendations for this indicator.

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. Case review does not rate this indicator.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Adequate* (83.8%)**

Overall, CCWF delivered good performance in preventive services. Staff performed well to excellently in administering TB medications, screening patients annually for TB, offering patients an influenza vaccine for the most recent influenza season, screening patients for breast and cervical cancer, and offering colorectal cancer screening for patients from ages 45 through 75. However, CCWF performed poorly in monitoring patients taking prescribed TB medications or offering required immunizations to chronic care patients. These findings are set forth in the table on the next page. Based on the overall compliance score result, the OIG rated this indicator ***adequate***.

Compliance Score Results

Table 16. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	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)	9	16	0	36.0%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	24	1	0	96.0%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	25	0	0	100%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	25	0	0	100%
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	25	0	0	100%
Are required immunizations being offered for chronic care patients? (9.008)	8	8	9	50.0%
Are patients at the highest risk of coccidioidomycosis (Valley Fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
			Overall percentage (MIT 9): **83.8%**	

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

Recommendations

- Nursing leadership should develop and implement measures to ensure nursing staff monitor patients who are on TB medications per policy.
- Medical leadership should determine the root cause(s) of challenges to the timely provision of vaccinations for chronic care patients and should implement appropriate remedial measures.

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

Ratings and Results Overview

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

CCWF's overall nursing care was satisfactory. Although we found differences in the volume of the review, the overall performance was similar to that of Cycle 6. Specifically, in Cycle 7, OIG clinicians reviewed more cases, but the cases contained significantly fewer nursing encounters. In these fewer encounters, we found fewer overall and fewer significant deficiencies than in Cycle 6. However, we still identified opportunities for nurses to improve in nursing assessments and interventions. Taking all factors into account, the OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 281 nursing encounters in 50 cases. Of the nursing encounters we reviewed, 146 occurred in the outpatient setting, which included 78 nursing sick call encounters and 36 transitional care unit (TCU) events.[46] We identified 111 overall nursing performance deficiencies, 23 of which were significant.[47]

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)

[46] Similar to those of the specialized medical housing unit, transitional care unit encounters were bundled with up to two weeks of patient care into a single event due to the frequency of nursing encounters.

[47] Deficiencies occurred in cases 1–9, 11, 18–28, 34, 35, 40, 42–47, 49–53, 55, and 57–60. Significant deficiencies occurred in cases 2, 3, 5, 6, 8, 20, 21, 23, 25, 26–28, 44, 50, 52, and 60.

elements. A comprehensive assessment allows nurses to gather essential information about their patients and develop appropriate interventions.

Nurses had opportunities for improvement in several areas of providing patient care. OIG clinicians identified 52 outpatient nursing deficiencies, nine of which were significant.[48] We identified patterns of nurses not scheduling patients with urgent symptoms to be seen the same day for evaluation as well as inappropriate use of the nursing protocol for acute low back pain complaints. Furthermore, we identified a trend in nurses not co-consulting with a provider when a patient's conditions warranted it. Examples are listed below:

- In cases 3, 44, and 51, nurses triaged urgent symptomatic health care requests but did not schedule the patients to be seen the same day for evaluation. Symptoms included complaints of "bleeding wounds," knee pain with increased swelling, difficulty standing and walking, and a "bad rash" on a patient's chest and back.

- In cases 18, 47, and 58, nurses assessed patients with complaints of new onset or acute lower back pain and either issued KOP pain medications or did not co-consult with or refer the patient to a provider. The nursing protocol for low back pain only allows for pain medication to be offered for a documented chronic low back pain diagnosis. Referral to the provider is required for new onset or acute episodes of back pain.

- In cases 21, 23, 25, and 50, nurses assessed the patients and identified conditions or complaints that warranted a co-consultation with the provider; however, nurses did not conduct one. Conditions or complaints included: unresolved asthma symptoms; eye itching, redness, tearing, and mild vision changes; a patient reporting missing a scheduled off-site appointment for infusions to treat low blood platelet counts and specialist orders not being honored; and a patient reporting many falls and intermittent dizziness.

- In case 52, the sick call nurse assessed the patient in the TTA for recurring symptoms of a vaginal infection with recent noncompliance with previously prescribed antibiotics. However, the nurse messaged the on-call provider rather than conducting a telephone consultation, delaying the patient receiving a new order for antibiotics.

Outpatient Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. Nurses generally documented their assessment findings and interventions sufficiently. However, the following are examples of outpatient documentation deficiencies:

[48] Outpatient nursing deficiencies occurred in cases 1–3, 6–8, 18–23, 25, 26, 42–47, 49–53, 55, 57, and 58. Significant outpatient nursing deficiencies occurred in cases 3, 20, 21, 23, 44, 50, and 52.

- In case 3, the patient complained of skin bruising, abrasions, and tears. However, the nurse did not describe the appearance of the skin.

- In case 6, the nurse did not document the systolic blood pressure.

- In case 22, the nurse ordered ibuprofen for the patient who complained of foot pain; however, the nurse did not document on the medication administration record issuing the medication to the patient.

- In case 55, the nurse evaluated the patient for a request to remove an intrauterine device (IUD) due to frequent bleeding and possible dislodgment.[49] The nurse documented vaginal discharge but did not describe the color, consistency, or presence of odor.

Case Management

OIG clinicians reviewed only one care coordinator event during this review period, although referrals to these nurses were present. Each clinic at CCWF had RN care managers who were responsible for screenings, tracking dashboard measures, patient education, vaccination, preparing documentation for review by the providers prior to chronic care appointments, offering medications, and reporting information in the nursing huddles.

Wound Care

OIG clinicians reviewed three cases involving wound care, dressing changes, line care, or drain care.[50] We identified five minor deficiencies in the three cases in which nurses did not perform care as ordered or did not thoroughly document care provided. The following are examples:

- In case 2, the patient had wound care orders in July and August 2023. Nurses did not perform the wound care on one occasion. In addition, on several days, nurses did not document cleansing or applying a dressing to the wounds or describing the appearance of the site.

- In case 3, nurses either documented inconsistent wound measurements or did not measure the wounds. In addition, nurses inconsistently labeled the wound location and type, and they did not perform wound care for two days during the order period.

- In case 23, although nurses performed daily wound care as ordered, nurses did not always document a description of the drainage present at the wound site.

Emergency Services

OIG clinicians reviewed 42 urgent or emergent events. CCWF nurses generally responded promptly to medical alarms; however, we identified opportunities for

[49] An IUD is an intrauterine birth control device that is inserted into the uterus to prevent pregnancy.

[50] Wound care occurred in cases 2, 3, and 23.

improvement in nursing assessments, interventions, and documentation. OIG clinicians identified 18 nursing deficiencies, six of which were considered significant and are detailed further in the **Emergency Services** indicator.[51]

Hospital Returns

OIG clinicians reviewed 14 nursing events in which patients returned from a community hospital or emergency room. Nurses generally performed good nursing assessments, but OIG clinicians identified five nursing deficiencies, one of which was significant.[52] We discuss these assessments in further detail in the **Transfers** indicator.

Prenatal and Postpartum Care

OIG clinicians reviewed three cases involving prenatal and postpartum care. Nurses initiated referrals for nurse and provider evaluations within appropriate time frames. OIG clinicians did not identify any nursing care deficiencies related to prenatal or postpartum care, although we found one minor nursing documentation deficiency on the reception center arrival of a postpartum patient. This deficiency did not affect patient care and is detailed in the **Reception Center** indicator.

Transfers and Reception Center

OIG clinicians reviewed 16 cases involving transfer-in and transfer-out processes, as well as new reception center arrivals. Nurses frequently evaluated patients appropriately and initiated provider appointments within appropriate time frames. OIG clinicians identified five nursing deficiencies, none of which were significant. These deficiencies are detailed further in the **Transfers** and **Reception Center** indicators.[53]

Specialized Medical Housing

OIG clinicians reviewed seven cases with a total of 108 events, 38 of which were nursing encounters. In the SNF, OIG clinicians found nurses generally provided good care. OIG clinicians identified 21 nursing deficiencies, five of which were significant. Please refer to the **Specialized Medical Housing** indicator for further details.[54]

Specialty Services

OIG clinicians reviewed 23 cases with a total of 216 events, 54 of which included nurse evaluations prior to a procedure or upon a patient's return from an off-site specialist appointment. OIG clinicians identified nine nursing deficiencies related to specialty

[51] Emergency services nursing deficiencies occurred in cases 1, 3–5, 7–9, 21, and 24–28. Significant nursing deficiencies occurred in cases 3, 5, and 26–28.

[52] Hospital nursing deficiencies occurred in cases 2, 3, 23, 26, and 60. A significant nursing deficiency occurred in case 23.

[53] Transfer-in nursing deficiencies occurred in cases 11 and 34. Transfer-out nursing deficiencies occurred in case 35. Reception center nursing deficiencies occurred in cases 9 and 40.

[54] Specialized medical housing nursing deficiencies occurred in cases 2, 8, 59, and 60. Significant nursing deficiencies occurred in cases 2, 8, and 60.

services, only one of which was significant.[55] Please refer to the **Specialty Services** indicator for additional details.

Medication Management

OIG clinicians reviewed 184 events involving medication management and administration. We identified 54 deficiencies, 19 of which were significant. Nurses had opportunities for improvement in administering medications timely and as ordered. Further details are provided in the **Medication Management** indicator.

Clinician On-Site Inspection

OIG clinicians toured and interviewed nursing staff in the outpatient clinics, medication areas, specialty clinics, TTA, SNF, TCU, and R&R. The clinicians observed several well-organized huddles and population management meetings. Nursing staff were knowledgeable and familiar with their patient population.

The TCU was located on the B Yard housing unit, which had been converted into a medical outpatient unit. TCU staff reported having one RN on the morning shift and one LVN and two CNAs on the afternoon shift seven days a week. They reported having no staff on the night shift. Staff also shared patients in this unit had medical risk factors and required monitoring, making them inappropriate candidates for general housing; however, the patients were mostly independent. RNs performed admission physicals and conducted rounds if they identified a change in a patient's condition. Staff reported CNAs obtained vital signs at least twice daily and reported abnormal vital signs to an RN. The RN reported being responsible for triaging health care requests and evaluating the patients as well as also being considered the care manager for these patients rather than the main clinic RN. Patients were assigned according to their surnames, alphabetically, to clinic primary care providers.

While touring the medical clinics, nurses reported the institution had the highest volume of health care requests in the State prison system. They reported challenges with seeing patients timely due to the volume of requests. In addition, they reported implementing solutions such as holding weekend clinics to ensure patients were seen within required time frames. Nurses reported the biggest challenge with nurse sick call lines was health care requests submitted on the weekends. Due to a system default setting, any appointment ordered after 2:00 p.m. on Friday would not generate a ducat for the patient. This resulted in patients who requested care on the weekend not receiving a ducat and being unaware of, or unwilling, to come to the clinic on Monday without a ducat.[56] Nurses reported a previous solution to this was discontinued due to it having caused overtime charges. Nurses also reported difficulties with bringing patients to the clinic on Mondays without a ducat due to custody being short-staffed and unable to locate or escort patients who were involved in programming, school, or jobs. This sometimes resulted in a similar challenge: if patients were rescheduled for appointments after 2:00 p.m. on Monday, they would not receive a ducat to report to the clinic on Tuesday. These challenges then put the institution out of compliance with nurse sick call time frame requirements. Although nurses in both clinics we toured shared facing this same

[55] Specialty nursing deficiencies occurred in cases 1, 2, 25, 26, and 60. A significant nursing deficiency occurred in case 25.

[56] A ducat refers to a paper pass allowing the patient permission to report to assigned or scheduled locations.

challenge, all nurses also shared a prevailing team-effort sentiment, feeling a sense of good morale, and receiving support from their leadership.

During the on-site inspection, the CNE position was vacant. OIG clinicians met with the SRN III and the regional NCPR to discuss OIG case findings. The regional NCPR informed us they previously self-identified some of the areas the OIG clinicians brought for discussion. The NCPR shared being in the process of updating LOPs and implementing nurse training to address identified gaps.[57] In addition, the NCPR shared being in the midst of completing the Emergency Medical Response Program Training, rolling out the Narcan program, and monitoring the performance improvement plan related to transport team delays for higher-level-of-care transfers. The NCPR and the SRNIII also shared challenges with staffing shortages, explaining that outside agency feedback likely attributed to noncompetitive wages. At the time of the OIG inspection, CCWF leadership reported a backlog of 74 RN appointments, although 38 had already been scheduled to occur.

[57] LOP is the Local Operating Procedure.

Recommendations

- Nursing leadership should determine the challenges preventing nurses from performing complete assessments and interventions and should implement remedial measures as appropriate.

Provider Performance

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

Ratings and Results Overview

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

CCWF providers delivered acceptable care. Providers made appropriate assessments and clinical decisions, reviewed records satisfactorily, triaged emergencies well, and reasonably managed chronic care conditions. Provider specialized medical housing care was excellent, while gynecology and perinatal care were good. However, we found providers needed improvement in following specialist recommendations. Considering all aspects, the OIG rated this indicator ***adequate***.

Case Review Results

OIG clinicians reviewed 214 medical provider encounters and identified 36 deficiencies, 19 of which were significant.[58] In addition, we examined the quality of care in 28 comprehensive case reviews. Of these 28 cases, we found 24 ***adequate*** and four ***inadequate***.

Outpatient Assessment and Decision-Making

Generally, providers made appropriate assessments and sound medical decisions for their patients. They formulated diagnoses, ordered reasonable tests, and referred patients when necessary. However, we found 19 assessment and decision-making deficiencies. Of the 19 deficiencies, six related to inadequate physical examinations based on the patients' complaints, three related to not addressing abnormal laboratory results timely or at all, and three related to not ordering the correct tests. The following are examples:

- In case 16, the patient requested surgery for possible carpal tunnel syndrome. However, the provider did not perform a pertinent physical examination nor consider other causes to determine whether further evaluation was

[58] Provider deficiencies in cases 1, 3, 6, 11, 15, 16, 20, 22, 23, 25–28, and 30. Significant deficiencies occurred in cases 1, 15, 16, 20, 25–28, and 30.

necessary. Instead, the provider documented "vague tenderness of hands and wrists."

- In case 20, the patient had a thyroid ultrasound performed. In the ultrasound report, the radiologist documented a possible right parathyroid adenoma.[59] The provider notified the patient that the ultrasound but normal and did not document this finding on subsequent encounters. The provider followed up on this after the OIG notified the institution about the adenoma on the ultrasound.

- In case 28, the provider evaluated the patient for shortness of breath and intended to prescribe an inhaler for the patient. However, the provider did not order the inhaler or consider other causes for the patient's shortness of breath.

Prenatal and Postpartum care

The CCWF obstetrician-gynecologist (OBGYN) and primary care providers appropriately managed prenatal and postpartum care patients. We only identified one deficiency as follows:

- In case 11, the provider evaluated the patient at an appointment for an obstetrics evaluation. Although the patient's blood pressure was elevated, the provider did not address this or enact a plan for further monitoring.

Outpatient Review of Records

Providers generally reviewed medical records appropriately. We identified six deficiencies related to review of records. The following are examples:

- In case 1, the patient, who was on antiseizure medication, had a seizure and refused an urgent evaluation in the TTA. When the provider evaluated the patient during the chronic care encounter, the provider was unaware of this seizure and the low level of antiseizure medication on the laboratory test. This was important as it may have indicated the patient's noncompliance with antiseizure therapy and increased risk of further seizures.

- In case 16, the provider evaluated the diabetic patient, who had a history of anemia, for renewal of supplies for hemorrhoids. The provider did not review the patient's medical records thoroughly to recognize the patient's iron pills—the treatment for anemia—had expired. In addition, the patient's blood sugar levels were elevated. Again, the provider did not review the patient's medical records thoroughly to recognize the patient's insulin was not renewed after it expired.

- In case 27, two different providers evaluated the patient to follow up for hand pain and a chronic care appointment, respectively. Both providers were unaware the patient had a displaced fracture of the right fifth finger.

[59] An adenoma is a tumor or growth in an organ or gland.

- In case 30, the provider was not aware the patient had already received her upper gastrointestinal scope and kidney imaging and still documented these were upcoming studies that needed to be completed.

Emergency Care

For the most part, providers appropriately managed patients in the TTA with urgent and emergent conditions. They usually triaged patients appropriately and transferred them to a higher level of care when needed. We identified four deficiencies, one of which is described below:

- In case 15, the TTA provider evaluated the patient for a tissue infection around her eyes and planned on having the patient follow-up in three days. However, the provider did not follow through and order this appointment. As a result, the patient was not seen for this issue.

Chronic Care

Providers appropriately managed patients' chronic health conditions of hypertension, diabetes, asthma, and cardiovascular disease. We identified three deficiencies: one related to hypertension, and two related to diabetes care. The following is an example:

- In case 16, the diabetic patient had elevated blood sugar levels. The provider planned to increase the patient's diabetes medication and ordered this change. However, the provider then canceled and reordered several doses of the medication with the end result of not actually increasing the medication at all. Later in the case, the provider was not aware the insulin prescription had expired.

Specialized Medical Housing

Providers appropriately completed admission history and physical examinations thoroughly and timely. Providers rounded at clinically appropriate intervals and delivered acceptable care.

Specialty Services

CCWF providers referred patients to specialists appropriately and reviewed specialty reports timely. However, they did not always follow specialist's recommendations. The following are examples:

- In case 16, the patient had uncontrolled blood sugar levels and was followed by a kidney specialist. When the primary care provider evaluated the patient after a nephrology appointment, the provider did not order the requested laboratory tests or appointments. Also in this case, we identified a pattern of multiple primary care providers not following specialist recommendations. This occurred three times with three different specialists: nephrology, ophthalmology, and gastroenterology.

- In case 25, the patient saw a hematologist, who recommended starting acyclovir, an antiviral for prevention against viral infection.[60] The provider did not follow this recommendation. When we were on site, the provider stated he did not see the recommendation in the body of the report.

- In case 28, the provider planned to have the patient see the cardiologist but mis-ordered this referral, which resulted in an appointment delay in seeing the specialist.

Outpatient Documentation Quality

Providers' documentation quality was very good. OIG clinicians did not find any significant deficiencies.

Patient Notification Letters

Providers performed poorly in relaying diagnostic test results letters to their patients. Providers often sent incomplete patient test result notification letters or did not send them at all. We discuss these deficiencies in the **Diagnostic Services** indicator.

Provider Continuity

Generally, the institution offered good provider continuity with the exception of one case, as described below:

- In case 16, the patient did not receive good continuity of care. She received care from four different providers, and the providers who reviewed specialty reports were not the same providers who evaluated the patient after the specialty appointments. As a result, specialist recommendations were dropped, and the patient never received further appointments with the kidney specialist or the gastroenterology specialist. In addition, several of the patient's medications expired, with providers seemingly unaware of these expirations.

Clinician On-Site Inspection

We met with the Chief Medical Executive (CME), the Chief Physician and Surgeon (CP&S), and providers. Providers included physicians and advanced practitioners, who delivered primary medical care for patients. We attended several morning huddles and observed a population management meeting.

Providers generally expressed good morale but commented leadership should involve them in discussing institutional problems. They voiced having good relationships with custody staff and nurses. They did not report any issues with obtaining specialty services or diagnostic services performed timely.

[60] A hematologist is a medical specialists who evaluates and treats disorders of the blood.

Recommendations

- The OIG offers no recommendations for this indicator.

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	Compliance Rating and Score
Adequate	***Inadequate* (67.9%)**

Case review found CCWF delivered satisfactory care for patients arriving at the reception center. Similar to Cycle 6, the receiving and release (R&R) nurses appropriately assessed newly arrived patients timely, reviewed health records from county jails, and referred to providers. However, CCWF showed minor lapses in medication continuity for newly arrived patients. Taking all factors into account, the OIG rated the case review component of this indicator ***adequate.***

Compliance testing showed a mixed performance in this indicator. Nurses timely completed assessments, providers performed history and physical examinations within required time frames, and staff ordered and completed screening laboratory tests. However, providers needed improvement in communicating the laboratory results timely and ensuring patient letters included all key required elements. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate.***

Case Review and Compliance Testing Results

OIG clinicians reviewed 32 events in 10 cases, and identified six deficiencies, none of which were significant.[61] We identified three new arrival medication deficiencies, which were discussed further in the **Medication Management** indicator. We further discuss an additional deficiency related to the health record in the **Health Information Management** indicator.

Provider Access

Compliance testing showed patients almost always received a history and physical examination by a provider within seven days as required by policy (MIT 12.004, 94.7%).

[61] Deficiencies occurred in cases 3, 9, 11, and 39–41.

Staff generally offered or completed intake screening tests within required time frames (MIT 12.005, 75.0%). Case review did not find any deficiencies with provider access.

Nursing Performance

Compliance testing showed nurses only occasionally completed the initial health screening forms thoroughly (MIT 12.001, 45.0%). However, the R&R nurses always timely signed and completed the assessment and disposition portion of the health screening form (MIT 12.002, 100%). OIG clinicians reviewed four cases and found nurses generally assessed and appropriately referred patients to providers, except in the following two cases:

- In case 9, the R&R nurse assessed the patient returning from an extended out-to-court stay.[62] The patient's blood pressure was elevated; however, the nurse did not recheck the patient's blood pressure prior to discharging the patient to the housing unit.

- In case 40, the R&R nurse assessed the newly arrived patient to CCWF. However, the nurse did not obtain an intake height and weight, order required laboratory tests, or provide required education.

Clinician On-Site Inspection

OIG clinicians toured the intake area and interviewed the reception center RN. The RN reported the reception center assigned one nurse each to the afternoon and night shifts and two RNs on staggered morning shifts. Our clinicians inquired whether assistance was available during instances with a larger volume of newly arrived patients. The nurse reported assistance was available and leadership was supportive; but noted the R&R nurses were usually able to handle large patient volumes on their own. In addition, the nurse shared newly arrived reception center patients required different orders and education than transfer-in patients. The nurse provided a copy of CCWF's education packet for our review. The nurse also reported R&R nurses were trained to perform fetal heart tone monitoring for newly arrived patients who were pregnant. The nurse referred OIG clinicians to the on-site specialty nurse for more information on education provided to pregnant patients. Please see the **Prenatal and Postpartum Care** indicator for further information.

[62] Out-to-Court Returns refers to patients who are away from the institution for court proceedings seven or more calendar days per CCHCS HCDOM 3.1.9 Health Care Transfer.

Compliance Score Results

Table 17. 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)	9	11	0	45.0%
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)	18	1	1	94.7%
For patients received from a county jail: Were all screening tests offered or completed within specified time lines? (12.005)	15	5	0	75.0%
For patients received from a county jail: Did the primary care provider review and communicate the intake test results to the patient within specified time lines? (12.006)	5	15	0	25.0%
For patients received from a county jail: Was a coccidioidomycosis (Valley Fever) skin test offered, administered, read, or refused timely? (12.007)	0	0	20	N/A
				Overall percentage (MIT 12): **67.9%**

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

Table 18. Other Tests Related to Reception Center

	Scored Answer			
Compliance Questions	**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)	8	6	6	57.1%

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

Recommendations

- Nursing leadership should determine the root cause(s) of challenges preventing nursing staff from thoroughly completing the reception initial health screening questions. Leadership should implement remedial measures as appropriate.

Specialized Medical Housing

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (56.0%)**

Case review found CCWF performed satisfactorily in this indicator. In Cycle 7, OIG clinicians found similar performance to that of Cycle 6. SNF providers and nurses generally provided good care. However, we identified opportunities for improvement related to notifying providers when conditions warranted and incomplete nursing documentation. Considering all factors, OIG clinicians rated the case review component of this indicator ***adequate.***

Compliance testing showed a mixed performance in this indicator. Staff failed to complete admission assessments and history and physical examinations within the required time frame. CCWF performed poorly in ensuring medication continuity for newly admitted patients in specialized medical housing. In addition, nonoperational call light buttons were not clearly labeled or identified. 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 108 SNF events, including 37 provider encounters and 38 nursing encounters. Due to the frequency of nursing and provider contacts in the specialized medical housing unit, the OIG bundled up to two weeks of patient care into a single event. We identified 31 deficiencies, eight of which were significant.[63]

Provider Performance

Providers delivered good care. Although compliance testing showed providers only intermittently completed admission history and physical examinations without delay

[63] Deficiencies occurred in cases 2, 8, 23, 24, 59, and 60. Significant deficiencies occurred in cases 2, 8, 23, and 60.

(MIT 13.002, 60.0%), OIG clinicians did not identify any provider deficiencies in the care provided to patients housed in the SNF.

Nursing Performance

Compliance testing showed SNF nurses intermittently performed timely admission assessments (MIT 13.001, 70.0%). OIG clinicians reviewed 38 nursing events and found 21 nursing deficiencies, five of which were significant.[64] We found nurses frequently conducted regular rounds and generally provided good care. However, we also found opportunities for improvement in nursing assessments, interventions, and documentation, as follows:

- In case 2, on admission to the SNF, the RN evaluated the patient with a colostomy, an ileostomy, and an IV.[65] However, the nurse did not describe the location and appearance of the sites or identify the IV was a central catheter type, known as a PICC line.[66] In addition, the nurse did not document the contents of both ostomy bags or measure the baseline length of the PICC line. Furthermore, the nurse initiated an interdisciplinary plan of care for falls but did not initiate a plan for impaired skin integrity or risk for infection related to an abdominal wound and a decubitus ulcer.[67]

- In addition, in case 2, on multiple occasions, the PICC line was not functioning properly, and nurses did not timely notify the provider to obtain an order for heparin flushes to assist in clearing the PICC lines.[68] Furthermore, nurses did not always administer the heparin flush when noting the PICC line was not working properly or document when the heparin flushes were effective in clearing the line. Moreover, nurses did not routinely document PICC line cap and tubing changes.

- In case 60, the patient had a Jackson-Pratt (JP) drain installed at the left breast.[69] Nurses did not notify the provider of the foul drainage odor emanating from the JP site or document the drainage color. In addition, nurses did not always measure the drain output volume or document a description of the drainage and condition of the surrounding dressing.

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[64] Nursing SNF deficiencies occurred in cases 2, 8, 59, and 60. Significant deficiencies occurred in cases 2, 8, and 60.

[65] A colostomy is an opening in the abdominal wall made during surgery to reroute waste from the colon to the surgical opening. An ileostomy is an opening in the abdominal wall made during surgery to reroute waste from the small intestine to the surgical opening. IV is an intravenous access by which medication or fluids can be administered into the vein.

[66] A peripherally inserted central catheter (PICC) provides intravenous access to administer fluids and medication.

[67] Decubitus ulcer is also known as a bed sore or pressure sore, which is caused by a long period of constant pressure to a specific area of the body.

[68] A heparin flush for a PICC line means injecting a small amount of medicine called heparin into the line to prevent blood from clotting inside of the line, essentially keeping the catheter clean and working properly when not in use.

[69] A Jackson-Pratt (JP) drain is a medical device that collects bodily fluids from surgical sites after surgery. It is used to reduce swelling and the risk of infection and other complications.

Medication Administration

Compliance testing showed CCWF performed poorly in ensuring patients admitted to the SNF received their medications within required time frames (MIT 13.003, zero). OIG clinicians also identified 10 deficiencies related to medication management, three of which were significant.[70] These are addressed further in the **Medication Management** section.

Clinician On-Site Inspection

OIG clinicians toured the SNF and interviewed nursing staff. The SNF had 20 medical beds, including one negative pressure room for respiratory isolation. At the time of the inspection, the SNF housed 20 patients. The SNF RN reported the beds were generally always at capacity. The SNF RN shared the SNF staffed one RN on the night shift, three RNs on the morning shift, and two RNs on the afternoon shift. OIG clinicians inquired about challenges staff experienced in the SNF. Staff shared they did not have any CNAs to assist with the activities of daily living and bed changes, and the unit was often short-staffed. LVNs were used to assist with administering medication , and RNs provided skilled nursing and changed bed sheets on shower days. Shower days for half of the unit were on Monday, Wednesday, and Friday, and the other half of the unit had shower days on Tuesday, Thursday, and Saturday.

Compliance Testing Results

Compliance On-Site Inspection and Discussion

At the time of the compliance on-site inspection, the mental health crisis bed (MHCB) had a functional call light communication system. However, the SNF also had other call light buttons in disrepair (MIT 13.101, 50.0%). Despite having nonfunctional call light buttons, the SNF's nursing staff maintained patient safety check logs as specified in the institution's local operating procedure (MIT 13.102, 100%).

[70] Medication administration deficiencies occurred in cases 2, 23, 24, 59, and 60. Significant deficiencies occurred in cases 2, 23, and 60.

Compliance Score Results

Table 19. Specialized Medical Housing

	Scored Answer			
Compliance Questions	**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)	7	3	0	70.0%
Was a written history and physical examination completed within the required time frame? (13.002)	6	4	0	60.0%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	0	10	0	0
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101)	1	1	0	50.0%
For specialized health care housing (CTC, SNF, hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102)	1	0	1	100%
				Overall percentage (MIT 13): **56.0%**

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

Recommendations

- Nursing leadership should ascertain the root cause(s) preventing SNF nurses from timely completing admission assessments and should implement remedial measures as appropriate.
- Medical leadership should ascertain the root cause(s) preventing providers from completing history and physicals timely and should implement remedial measures as appropriate.
- Nursing leadership should determine the root cause(s) of challenges to patients receiving all ordered medications within the required time frame 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	Compliance Rating and Score
Adequate	***Adequate* (77.4%)**

Case review found CCWF provided satisfactory specialty services for their patients. Provider and nursing care were good. However, specialty access to care and health information management needed improvement. Considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed slight improvement for specialty services compared with Cycle 6. Access to specialists ranged from excellent to poor, depending on the priority specialty appointment. Continuity for preapproved specialty referrals for newly arrived patients sporadically occurred within ordered time frames. In addition, retrieval of specialty reports and prompt provider endorsements both needed improvement. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***adequate.***

Case Review and Compliance Testing Results

We reviewed 197 events related to specialty services, 135 of which were specialty consultations and procedures. We found 44 deficiencies in this category, 11 of which were significant.[71] For this indicator, we reviewed whether patients had access to specialists, whether staff retrieved specialty reports, and whether medical staff followed the specialty report recommendations.

Access to Specialty Services

In compliance testing, CCWF performed excellently with access to routine-priority specialty services (MIT 14.007, 100%) but needed improvement with access to high-priority (MIT 14.001, 73.3%) and medium-priority specialty services (MIT 14.004, 66.7%). Transfer continuity of approved specialty referrals from other institutions was poor (MIT 14.010, 42.9%).

[71] Specialty deficiencies occurred in cases 1, 2, 3, 8, 10, 14, 16, 22, 23, 25–29, and 60. Significant deficiencies in cases 2, 8, 14, 16, 23, 25, and 28.

Case review also found access to specialty services needed improvement. We found 10 deficiencies in which specialty appointments were delayed or did not occur. Examples are shown below:

- In case 23, the patient with lung cancer had a lobectomy surgery.[72] The follow-up appointment with the surgeon was delayed by 18 days.

- In case 25, the patient was scheduled to have weekly infusions of rituximab for four weeks.[73] However, the patient did not receive the third dose as ordered.

Further examples are detailed in the **Access to Care** indicator.

Provider Performance

CCWF providers timely requested specialty services with appropriate priorities. Compliance testing showed providers often evaluated patients promptly after specialty services (MIT 1.008, 86.7%). Case review found providers generally reviewed the specialty reports and followed recommendations. We identified four deficiencies with providers not following specialists' recommendations. We also discuss this in the **Provider Performance** indicator.

Nursing Performance

Case review found CCWF specialty nurses appropriately reviewed specialty service requests and scheduled patients for specialty appointments. TTA nurses generally performed thorough assessments of patients returning from specialty appointments, reviewed specialists' recommendations, and almost always communicated the recommendations to the providers. We reviewed 54 nursing encounters related to specialty services and identified nine nursing deficiencies, one of which was significant.[74] The following is an example:

- In case 25, the nurse assessed the patient upon return from an off-site hematology specialty consultation. The nurse documented having reviewed the medication and educated the patient. However, the nurse did not notify the provider of the specialist-recommended medication. Consequently, the patient did not start the new medication as recommended.

Health Information Management

Compliance testing showed poor provider review of routine-priority (MIT 14.008, 57.1%) and medium-priority (MIT 14.005, 60.0%) specialty reports, but very good review of high-priority (MIT 14.002, 92.9%) specialty reports. Additionally, CCWF generally scanned specialty reports timely into the EHRS (MIT 4.002, 83.3%).

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[72] Lobectomy is a surgical procedure to remove a lobe of the lung.

[73] Rituximab is a medication given intravenously to treat blood disorders and cancers.

[74] Nursing deficiencies occurred in cases 1, 2, 25, 26, and 60. A significant nursing deficiency occurred in case 25.

Case review identified 17 deficiencies related to health information in specialty services. The deficiencies related to late or no endorsements, delays in retrieval or scanning, and misfiled or mislabeled documents.

Clinician On-Site Inspection

We discussed specialty processes with CCWF specialty nurse supervisors, medical records supervisor, and providers. Specialty nurses reported reaching out to providers to address recommendations as needed. The medical records supervisor reported no staffing shortages during the review period but relayed challenges with obtaining transgender services and high-priority biopsies. The supervisor also mentioned distributing specialty tracking information to patient care teams for discussion during the morning daily huddles.

Compliance Score Results

Table 20. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	11	4	0	73.3%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	13	1	1	92.9%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	7	1	7	87.5%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004)	10	5	0	66.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	9	6	0	60.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	8	1	6	88.9%
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)	8	6	1	57.1%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	6	1	8	85.7%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	3	4	0	42.9%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	18	2	0	90.0%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	16	3	1	84.2%
			Overall percentage (MIT 14): **77.4%**	

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

Table 21. Other Tests Related to Specialty Services

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	26	4	15	86.7%
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

The OIG offers no recommendations for this indicator.

Administrative Operations

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

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Adequate* (77.9%)**

CCWF's performance was mixed in this indicator. While CCWF scored well in some applicable tests, it needed improvement in several areas. The Emergency Medical Response Review Committee (EMRRC) only occasionally completed the required checklists and reviewed the cases within required time frames. The institution conducted medical emergency response drills with incomplete documentation. Additionally, physician managers rarely completed annual performance appraisals or probationary reports in a timely manner. These findings are set forth in the table on the next page. Based on the overall compliance score result, the OIG rated this indicator ***adequate***.

Compliance Testing Results

Nonscored Results

At CCWF, 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. Five patient deaths occurred during our review period. We found no evidence in the submitted documentation the preliminary mortality reports had been completed. These reports were overdue at the time of OIG's inspection review period (MIT 15.998).

Compliance Score Results

Table 22. 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)	4	8	0	33.3%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	N/A	N/A	N/A	N/A
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the 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)	5	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	9	1	0	90.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	1	8	2	11.1%
Did the providers maintain valid state medical licenses? (15.106)	19	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)	1	0	0	100%
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): **77.9%**

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

Recommendations

The OIG offers no recommendations for this indicator.

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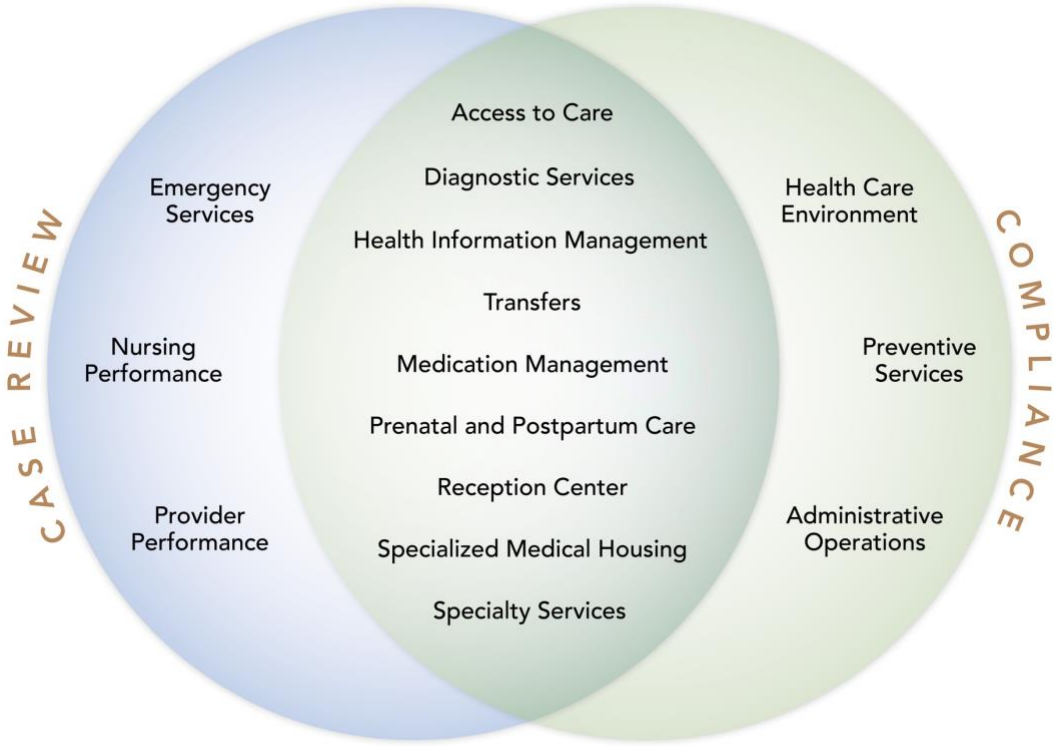
Appendix A: Methodology

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

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

Figure A–1. Inspection Indicator Review Distribution for CCWF



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

Case Reviews

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

Table A–1. Case Review Definitions

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

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

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

Case Review Sampling Methodology

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

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

Case Review Testing Methodology

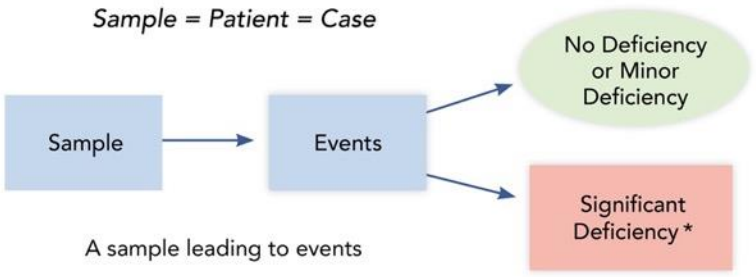
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

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

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

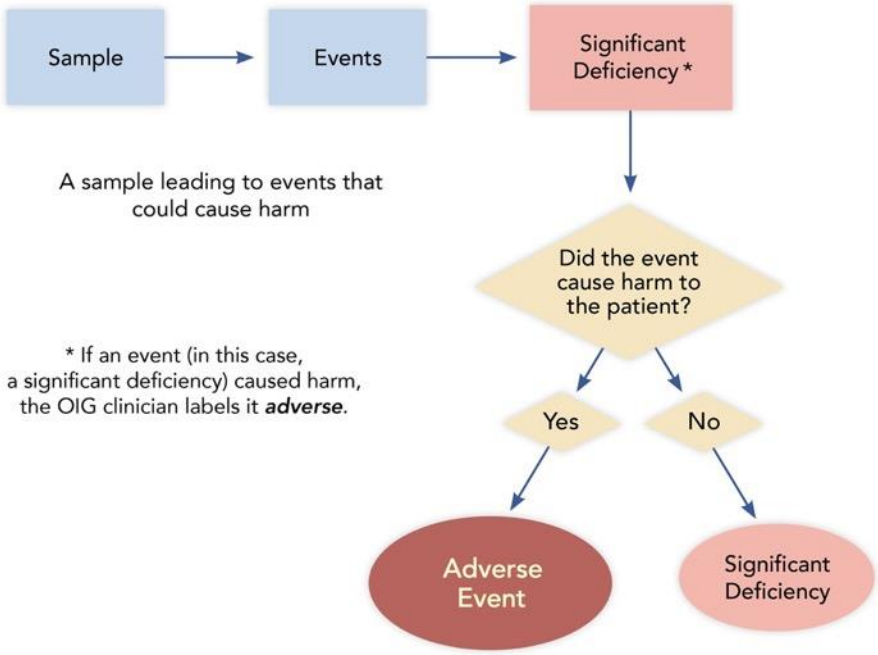
Figure A–2. Case Review Testing

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



Deficiencies

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



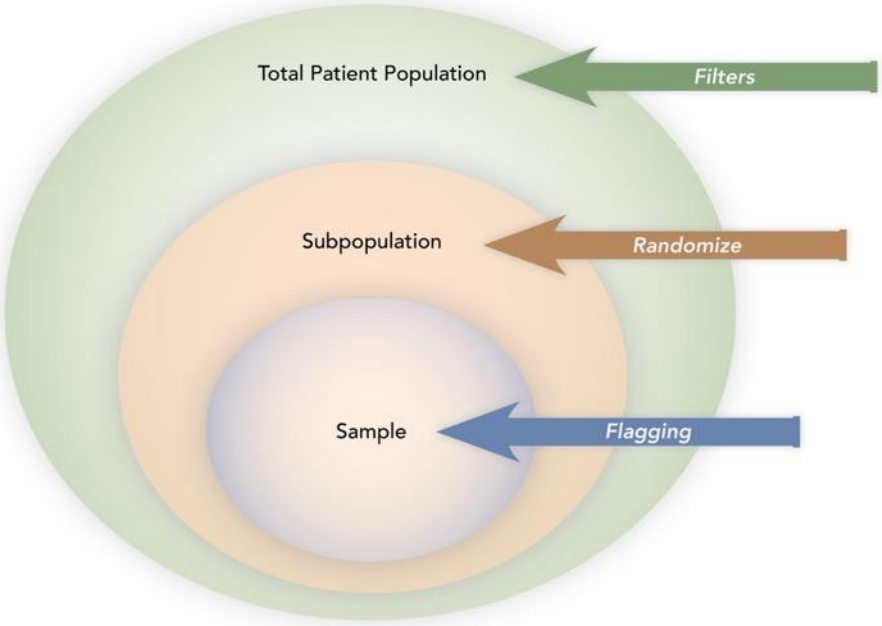
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

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

Figure A–3. Compliance Sampling Methodology



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

Compliance Testing Methodology

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

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

Scoring Methodology

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

Indicator Ratings and the Overall Medical Quality Rating

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

Appendix B: Case Review Data

Table B–1. CCWF Case Review Sample Sets

Sample Set	Total
Anticoagulation	1
CTC/OHU	2
Death Review/Sentinel Events	3
Diabetes	4
Emergency Services – CPR	2
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	17
Reception Center Transfers	4
Specialty Services	4
	59

Table B–2. CCWF Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	21
Anticoagulation	1
Arthritis/Degenerative Joint Disease	8
Asthma	17
Cancer	8
Cardiovascular Disease	7
Chronic Kidney Disease	9
Chronic Pain	17
Cirrhosis/ End Stage Liver Disease	1
COPD	5
COVID-19	3
Diabetes	11
DVT/PE	1
GERD	19
Hepatitis C	11
HIV	1
Hyperlipidemia	18
Hypertension	24
Mental Health	36
Migraine Headaches	11
Rheumatological Disease	1
Seizures	6
Sleep Apnea	6
Substance Abuse	28
Thyroid Disease	9
	279

Table B–3. CCWF Case Review Events by Program

Diagnosis	Total
Diagnostic Services	292
Emergency Care	66
Hospitalization	25
Intrasystem Transfers In	8
Intrasystem Transfers Out	14
Not Specified	511
Outpatient Care	13
Reception Center Care	32
Specialized Medical Housing	108
Specialty Services	216
	1,285

Table B–4. CCWF Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	28
MD Reviews Focused	0
RN Reviews Detailed	19
RN Reviews Focused	31
Total Reviews	78
Total Unique Cases	59
Overlapping Reviews (MD & RN)	19

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Appendix C: Compliance Sampling Methodology

Central California Women's Facility

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	23	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	18	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC, BMP, or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC, BMP, or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology-related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	18	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested incarcerated person	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	18	CADDIS off-site admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	13	OIG inspector on-site review	• Identify and inspect all on-site clinical areas
Transfers				
MITs 6.001–003	Intrasystem Transfers	23	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	10	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	• See Access to Care • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	18	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	20	OIG Q: 12.001	• See Reception Center
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	10	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	24	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	10	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	0	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	5	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	25	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (45 or older) • Randomize
MIT 9.006	Mammogram	25	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	25	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–007	RC	20	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–003	Specialized Health Care Housing Unit	10	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care /addiction medication, narcotic treatment program, and transgender services • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Specialty Services (continued)				
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize
MIT 14.010	Specialty Services Arrivals	7	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	20	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	0	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	N/A at this institution	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations (continued)				
MIT 15.103	Death Reports	5	Institution-list of deaths in prior 12 months	• Most recent 10 deaths Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	11	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	19	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff • Providers (ACLS) • Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	CCHCS Mortality Case Review	5	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services mortality reviews

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California Correctional Health Care Services' Response

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April 3, 2025

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

Dear Ms. Singh:

California Correctional Health Care Services has reviewed the draft Medical Inspection Report for CCWF conducted by the Office of the Inspector General from December 2023 to May 2024. Thank you for preparing the report.

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

Sincerely,

DocuSigned by:
DeAnna Gouldy
3D7168B9AC0A4D1...

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 II, CCHCS
Chief Executive Officer, CCWF
Heather Pool, Chief Assistant Inspector General, OIG
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Amanda Elhardt, Report Coordinator, OIG

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P.O. Box 588500
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Cycle 7

Medical Inspection Report

for

Central California Women's Facility

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
April 2025

OIG