Amarik K. Singh, *Inspector General*

Shaun Spillane, *Chief Deputy Inspector General*

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

January 2026

Cycle 7

Medical Inspection Report

Ironwood State Prison

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

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

For questions concerning the contents of this report,
please contact Shaun Spillane, Public Information Officer,
at 916-288-4212.

Connect with us on social media


Contents

Illustrations

Tables

Figures

Photographs

Introduction

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

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

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

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

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

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

[2] The OIG's medical inspections are not designed to resolve questions about the constitutionality of care, and the OIG explicitly makes no determination regarding the constitutionality of care 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 Ironwood State Prison (ISP), 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 June 2024 to November 2024.[4]

[4] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between January 2024 and June 2024.

Summary: Ratings and Scores

We completed the Cycle 7 inspection of ISP in May 2025. OIG inspectors monitored the institution's delivery of medical care that occurred between June 2024 and November 2024.

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

The OIG rated the compliance component of the overall health care quality at ISP ***adequate***.

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 47 cases, which contained 747 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, which may occur throughout the delivery of care. After examining the medical records, our clinicians completed a follow-up on-site inspection in May 2025 to verify their initial findings. The OIG physicians rated the quality of care for 20 comprehensive case reviews. Of these 20 cases, our physicians rated 18 ***adequate,*** and two ***inadequate***.

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 363 patient records and 1,080 data points and used the data to answer 89 policy questions. In addition, we observed ISP's processes during an on-site inspection in January 2025.

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

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

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

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

MIT Number	Health Care Indicators	Case Review Ratings: Cycle 7	Case Review Ratings: Change Since Cycle 6*	Compliance Scoring Ranges: Cycle 7	Compliance Scoring Ranges: Cycle 6	Compliance Scoring Ranges: 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	Proficient	=	91.6%	83.8%	↑
2	Diagnostic Services	Adequate	=	76.7%	73.3%	↑
3	Emergency Services	Adequate	=	N/A	N/A	N/A
4	Health Information Management	Adequate	=	88.9%	96.4%	=
5	Health Care Environment†	N/A	N/A	68.1%	42.9%	=
6	Transfers	Adequate	↓	85.8%	86.1%	=
7	Medication Management	Adequate	=	56.8%	38.9%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	91.9%	78.3%	↑
10	Nursing Performance	Adequate	=	N/A	N/A	N/A
11	Provider Performance	Adequate	=	N/A	N/A	N/A
12	Reception Center	N/A	N/A	N/A	N/A	N/A
13	Specialized Medical Housing	Adequate	↓	81.1%	55.6%	↑
14	Specialty Services	Proficient	↑	84.2%	72.3%	↑
15	Administrative Operations†	N/A	N/A	71.5%	65.7%	=

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

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

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

Medical Inspection Results

Deficiencies Identified During Case Review

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

The OIG found no adverse events at ISP during the Cycle 7 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to ISP. Of these 10 indicators, OIG clinicians rated two ***proficient*** and eight ***adequate***. The OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 18 were ***adequate*** and two were ***inadequate***. In the 747 events reviewed, we identified 95 deficiencies, 17 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at ISP:

- Staff performed excellently with access to care by timely offering and completing appointments for patients.
- Staff performed very well in completing specialty services. Staff also retrieved and scanned all specialty service reports timely.
- Nurses generally performed good assessments, interventions, and documentation.
- Nurses documented medication administration very well.

Our clinicians found the following weaknesses at ISP:

- Providers needed improvement in communicating diagnostic test results to patients with complete patient test result notification letters.
- Nurses needed improvement in performing complete assessments and in informing providers of significant abnormal findings.
- Staff did not always complete discharge summaries when patients were discharged from the outpatient housing unit.

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

Compliance Testing Results

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

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

- Nursing staff received and reviewed health care services request forms and performed face-to-face evaluations timely. In addition, ISP housing units contained sufficient supplies of health care request forms.
- Providers timely reviewed radiology, laboratory, and pathology results.
- The institution's medical staff usually timely scanned nondictated progress notes, initial health care screening forms, community hospital discharge reports, and requests for health care services into patients' electronic medical records.
- ISP nursing staff performed excellently with providing TB medications to patients. The institution performed well in offering immunizations and in providing preventive services for patients, such as influenza vaccinations, annual testing for tuberculosis (TB), and colorectal cancer screenings.

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

- Patients did not receive their prescribed chronic care medications, hospital discharge medications, and newly prescribed medications within the specified time frames.
- Clinical staff did not consistently follow universal hand hygiene precautions before or after patient encounters.
- Nurses did not regularly inspect emergency medical response bags.

Institution-Specific Metrics

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

As of August 22, 2025, the department reported on its public tracker 73 percent of ISP's incarcerated population was fully vaccinated for COVID-19 while 68 percent of ISP's staff was fully vaccinated for COVID-19.[7]

On February 27, 2024, the Health Care Services Master Registry showed ISP had a total population of 2,978. A breakdown of the medical risk level of the ISP population as determined by the department is set forth in Table 2 below.[8]

Table 2. ISP Master Registry Data as of December 2024

Medical Risk Level	Number of Patients	Percentage*
High 1	49	1.6%
High 2	171	5.7%
Medium	489	16.4%
Low	2,269	76.2%
Total	**2,978**	**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 2-27-24.

[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, ISP had one vacant executive leadership position, one vacant primary care provider position, 0.2 nursing supervisor vacancy, and 8.7 nursing staff vacancies.

Table 3. ISP Health Care Staffing Resources as of December 2024

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	4.0	7.0	11.7	75.7	98.4
Filled by Civil Service	3.0	2.0	11.5	67.0	83.5
Vacant	1.0	1.0	0.2	8.7	10.9
Percentage Filled by Civil Service	75.0%	28.6%	98.3%	88.5%	84.9%
Filled by Telemedicine	7.0	4.0	0	0	4.0
Percentage Filled by Telemedicine	0.0%	57.1%	0.0%	0.0%	4.1%
Filled by Registry	0	1.0	0	9.0	10.0
Percentage Filled by Registry	0.0%	14.3%	0.0%	11.9%	10.2%
Total Filled Positions	3.0	7.0	11.5	76.0	97.5
Total Percentage Filled	**75.0%**	**100.0%**	**98.3%**	**100.4%**	**99.1%**
Appointments in Last 12 Months	1.0	1.0	1.5	27.0	30.5
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	0	0	7.0	7.0
Adjusted Total: Filled Positions	**3.0**	**7.0**	**11.5**	**69.0**	**90.5**
Adjusted Total: Percentage Filled	**75.0%**	**100.0%**	**98.3%**	**91.1%**	**92.0%**

* 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 12-27-24, 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 ISP's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. Currently, only two HEDIS measures are available for comparison: **poor HbA1c control**, which measures the percentage of diabetic patients who have poor blood sugar control, and the **colorectal cancer screening rate** for patients ages 45 to 75. We list the applicable HEDIS measures in Table 4.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—ISP's percentage of patients with poor HbA1c control was significantly lower at six percent, 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. ISP had a 35 percent influenza immunization rate for adults 18 to 64 years old and a 66 percent influenza immunization rate for adults 65 years of age and older.[9] The pneumococcal vaccination rate was 81 percent.[10]

Cancer Screening

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—ISP's colorectal cancer screening rate of 69 percent was higher than California Medi-Cal, but

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

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

lower than Kaiser Northern California (Medi-Cal) and Kaiser Southern California (Medi-Cal) indicating a need for improvement on this measure.

Table 4. ISP Results Compared With State HEDIS Scores

HEDIS Measure	ISP Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (> 9.0%) ‡,§	**6%**	33%	26%	19%
HbA1c Control (< 8.0%) ‡	86%	–	–	–
Blood Pressure Control (< 140/90) ‡	98%	–	–	–
Eye Examinations	90%	–	–	–
Influenza – Adults (18–64)	35%	–	–	–
Influenza – Adults (65+)	66%	–	–	–
Pneumococcal – Adults (65+)	81%	–	–	–
Colorectal Cancer Screening	69%	40%	**71%**	**71%**

Notes and Sources

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

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2023–June 30, 2024 (published April 2025); **https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2023-24-Medi-Cal-Managed-Care-Physical-Health-External-Quality-Review-Technical-Report-Vol1-F1.pdf**.

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

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

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

Recommendations

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

Diagnostic Services

- The department should develop and implement strategies, such as an electronic solution, to ensure providers create patient notification letters at the time of endorsement, and the patient notification letter automatically populates accurately with all required elements per CCHCS policy.

Emergency Services

- Nursing leadership should analyze the challenges to nurses performing thorough assessments and reassessments of emergent and urgent conditions. Leadership should implement remedial measures as appropriate.

- Health care leadership should analyze the root cause(s) of the Emergency Medical Response Review Committee (EMRRC) not thoroughly reviewing emergency response events or accurately detailing findings and should implement remedial measures as appropriate.

Health Care Environment

- Health care leadership should determine the root cause(s) for staff not following all required universal hand hygiene precautions and should implement remedial measures as appropriate.

- Health care leadership should determine the root cause(s) for staff not following equipment and medical supply management protocols and should implement remedial measures as appropriate.

- Nursing leadership should determine the root cause(s) for staff not ensuring the emergency medical response bags (EMRBs) are regularly inventoried and sealed and should implement remedial measures as appropriate.

Transfers

- Health care leadership should identify the challenges to medication continuity for patients returning from hospitalizations or emergency rooms.

Medication Management

- Medical and nursing leadership should analyze the root cause(s) of the challenges to staff ensuring chronic care medications, newly prescribed medications, hospital discharge medications, and specialized medical housing patients are administered timely and without interruption. Leadership should implement remedial measures as appropriate.

Nursing Performance

- Nursing leadership should analyze the challenges to nurses performing thorough assessments, consulting with the provider regarding abnormal test findings in a timely manner, and assessing and documenting wound care thoroughly. Leadership should implement remedial measures as appropriate.

Specialized Medical Housing

- Nursing leadership should develop strategies to ensure specialized medical housing nursing staff perform thorough patient assessments and documentation and should implement remedial measures as appropriate.

Specialty Services

- Medical leadership should determine the root cause(s) of challenges to the timely provision of high- and medium-priority specialty appointments and should implement remedial measures as appropriate.

Access to Care

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Proficient	***Proficient*** **(91.6%)**

Case review found ISP performed outstandingly in this indicator. We found all nursing appointments occurred timely, and all provider appointments, including outpatient, after hospitalization, specialty, or TTA events, occurred timely. After reviewing all aspects of access to care, the OIG rated the case review component of this indicator ***proficient***.

Compliance testing similarly showed ISP performed excellently in this indicator. Nurses always reviewed patient sick call requests and almost always completed face-to-face triage within required time frames. Staff often timely evaluated patients returning from hospitalizations and specialty appointments as well as patients newly transferred into ISP. However, staff needed improvement in timely completing chronic care appointments for patients. Based on the overall **Access to Care** compliance score result, the OIG rated the compliance testing component of this indicator ***proficient***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 385 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events requiring the institution to generate appointments. We found no deficiencies related to access to care.

Access to Clinic Providers

Compliance testing showed staff timely completed all nurse-to-provider appointments (MIT 1.005, 100%). However, they only timely completed just more than half of chronic care follow-up appointments (MIT 1.001, 60.0%). In contrast, OIG clinicians reviewed 133 clinic provider appointments and did not identify any deficiencies.

Access to Specialized Medical Housing Providers

ISP performed excellently with access to specialized medical housing providers. The OIG clinicians reviewed 22 provider encounters and did not identify any deficiencies related to timely completing provider appointments.

Access to Clinic Nurses

Compliance testing showed nurses reviewed all nurse sick call requests on the same day they were received (MIT 1.003, 100%). The nurses also completed almost all face-to-face encounters within the required one business day (MIT 1.004, 96.7%). Similarly, OIG clinicians reviewed 89 nursing encounters and did not identify any deficiencies related to clinic nurse access.

Access to Specialty Services

Compliance testing revealed a variable performance in completing initial high-priority (MIT 14.001, 66.7%), medium-priority (MIT 14.004, 73.3%), and routine-priority (MIT 14.007, 100%) specialty appointments within required time frames. Compliance testing also showed most follow-up specialty appointments occurred timely, regardless of order priority (MIT 14.003, 75.0%, MIT 14.006, 81.8%, and MIT 14.009. 87.5%). In contrast, OIG clinicians reviewed 94 specialty events and did not identify any access deficiencies.

Follow-Up After Specialty Services

Compliance testing showed nearly all provider appointments after specialty services occurred within required time frames (MIT 1.008, 93.0%). OIG clinicians did not identify any missed or delayed provider appointments.

Follow-Up After Hospitalization

Compliance testing showed nearly all provider appointments after hospitalizations occurred within required time frames (MIT 1.007, 91.3%). OIG clinicians reviewed 20 hospital returns and did not identify any access deficiencies.

Follow-Up After Urgent or Emergent Care (TTA)

Providers always evaluated their patients following a TTA event as medically indicated. OIG clinicians reviewed 27 TTA events and did not identify any access deficiencies.

Follow-Up After Transferring Into ISP

Compliance testing showed most provider appointments for newly arrived patients occurred timely (MIT 1.002, 83.3%). OIG clinicians reviewed three transfer-in events and did not identify any missed or delayed provider appointments.

Clinician On-Site Inspection

ISP has five main clinics: A, B, C, D, and E. Each clinic was staffed with one provider and an office technician who attended the morning huddle. The office technicians reported scheduling and bundling provider appointments to optimize each appointment. Each provider evaluated about 12 patients per day. At the time of the on-site inspection, ISP staff reported five overdue nurse appointments but no provider appointment backlog.

Compliance Testing Results

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

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)	15	10	0	60.0%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	20	4	1	83.3%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	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)	29	1	0	96.7%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005)	8	0	22	100%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006)	2	0	28	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007)	21	2	0	91.3%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	40	3	2	93.0%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	6	0	0	100%
				Overall percentage (MIT 1): 91.6%

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

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

Table 6. Other Tests Related to Access to Care

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003)	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days (prior to 07/2022) or five working days (effective 07/2022)? (12.004)	N/A	N/A	N/A	N/A
Was a written history and physical examination completed within the required time frame? (13.002)	9	1	0	90.0%
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)	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	9	3	3	75.0%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004)	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	9	2	4	81.8%
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	100.0%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	7	1	7	87.5%

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

Recommendations

The OIG offers no recommendations for this indicator.

Diagnostic Services

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Adequate* (76.7%)**

Overall, case review found ISP performed well in diagnostic services. Staff completed all radiology tests and laboratory tests within requested time frames. The providers sometimes did not communicate test results to their patients with complete results notification letters; however, these deficiencies were minor. Taking all factors into consideration, the OIG rated the case review component of this indicator ***adequate***.

In Cycle 7, ISP's overall compliance testing score improved for this indicator. Staff performance ranged from good to excellent in timely completing radiology and laboratory services. Provider performance also ranged from very good to excellent in reviewing and endorsing diagnostic test results. However, staff needed improvement in retrieving pathology reports and generating complete patient test result notification letters with all required elements. Based on the overall **Diagnostics Services** compliance score result, the OIG rated the compliance component of this indicator ***adequate***.

Case Review and Compliance Testing Results

The OIG clinicians reviewed 103 diagnostic events and identified 19 deficiencies, three of which were significant. Of the 19 deficiencies, 18 related to health information management and one related to test completion.[11]

Test Completion

Compliance testing showed staff completed all radiology tests within requested time frames (MIT 2.001, 100%). OIG clinicians reviewed 17 radiology tests and did not identify any missed or delayed test completions.

Compliance testing showed staff completed most laboratory tests timely (MIT 2.004, 80.0%). Similarly, OIG clinicians reviewed 79 laboratory tests and did not identify any deficiencies related to test completion. OIG clinicians reviewed five electrocardiograms and found one test was not completed as requested:

[11] Diagnostic deficiencies occurred in cases 2, 5–7, 15, 16, 41, and 44–47. Significant deficiencies occurred in cases 2 and 15.

- In case 15, a provider requested an electrocardiogram to be completed within 10 days; however, the test was not done.

Compliance testing and OIG clinicians did not have any STAT laboratory tests to review in their samples (MIT 2.007, N/A).

Health Information Management

ISP performed variably in retrieving diagnostic reports. Compliance testing revealed ISP staff sometimes retrieved pathology reports within the required time frames (MIT 2.010, 70.0%). OIG clinicians reviewed two pathology events and found staff retrieved the reports timely. OIG clinicians found staff retrieved all radiology reports timely and retrieved most laboratory reports timely. However, we found staff did not retrieve two results as follows:

- In case 2, the patient returned from a hospitalization with the diagnosis of pneumonia. The results for blood cultures and sputum cultures were pending upon hospital discharge; however, ISP staff did not retrieve these laboratory test results.

- Also in case 2, the patient returned from another hospitalization with the diagnoses of pneumonia and sepsis. The results for blood cultures and fecal occult blood tests were pending upon hospital discharge; however, ISP staff did not retrieve these laboratory test results.

Compliance testing showed providers endorsed nearly all radiology and pathology reports, as well as all laboratory test results timely (MIT 2.002, 90.0%, MIT 2.011, 90.0%, and MIT 2.005, 100%). OIG clinicians similarly found providers endorsed all diagnostic reports timely.

Compliance testing revealed providers performed poorly in timely generating patient test result notification letters for radiology results, laboratory results, and pathology results (MIT 2.003, 60.0%, MIT 2.006, 60.0%, and MIT 2.012, 40.0%). OIG clinicians also identified 14 examples of patient letters missing at least one of the required elements. The following is an example:

- In case 5, a provider sent a patient test result notification letter but did not include whether the test result was within normal limits.

We also found the provider did not send notification letters informing patients of pathology results on two occasions. The following is an example:

- In case 7, a provider reviewed a colon polyp pathology report but did not send a patient test result notification letter.

Clinician On-Site Inspection

OIG clinicians met with diagnostic supervisors and staff. ISP reported having three full-time phlebotomists, who collected about 30 laboratory tests per day, and one full-time radiology technician, who performed general x-rays on-site. Supervisors reported having openings for a senior radiology technician and a part-time radiology technician; however, a senior radiology technician from a nearby institution provided assistance when

necessary. ISP also performed on-site monthly mobile mammogram, ultrasound, CT, and MRI services.[12]

OIG clinicians discussed the missed laboratory results during patients' hospitalizations. The medical record supervisor explained ISP staff had a difficult time retrieving laboratory results from one particular community hospital, as ISP staff did not have direct access to the hospital's electronic medical record system.

[12] A CT is a computed, or computerized, tomography scan while an MRI is a magnetic resonance imaging scan. Both create detailed images of the organs and tissues to detect diseases and abnormalities.

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)	6	4	0	60.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	10	0	0	100%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	6	4	0	60.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	N/A	N/A	N/A	N/A
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	N/A	N/A	N/A	N/A
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	7	3	0	70.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	9	1	0	90.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	4	6	0	40.0%
				Overall percentage (MIT 2): 76.7%

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

Recommendations

- The department should develop and implement strategies, such as an electronic solution, to ensure providers create patient notification letters at the time of endorsement, and the patient notification letter automatically populates accurately with all required elements per CCHCS policy.

Emergency Services

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

Ratings and Results Overview

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

In this cycle, case review found ISP performed satisfactorily in providing emergency care. Compared with Cycle 6, we reviewed almost twice the number of urgent and emergent events, and ISP continued to perform well. Health care first responders (HCFR) frequently performed good assessments, intervened as required, and documented well. TTA nurses performed efficiently during emergencies and completed thorough documentation; however, we identified a pattern of deficiencies with incomplete nursing assessments. Providers often made good decisions and timely documented urgent and emergent events. Nursing and medical leadership completed timely clinical reviews but did not always identify the same deficiencies OIG clinicians identified. Considering all factors, the OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 27 urgent or emergent events and found 10 emergency care deficiencies. Of these 10 deficiencies, three were significant.[13]

Emergency Medical Response

ISP staff responded promptly to emergencies throughout the institution. They activated emergency medical services (EMS) and notified TTA staff in a timely manner. The HCFRs frequently performed good assessments, intervened as required, and documented well.

Cardiopulmonary Resuscitation Quality

During this period, we reviewed only one case in which CPR was initiated.[14] Custody and medical staff worked cohesively, provided prompt care, transported the patient to the

[13] Deficiencies occurred in cases 2, 3, 12, 13, and 41. Significant deficiencies occurred in cases 3, 12, and 41.

[14] Staff performed CPR on the patient in case 3.

TTA for additional interventions, and immediately activated the 9-1-1 system from the scene. In this one CPR case, we identified the following deficiencies:

- In case 3, the LVN responded to a medical emergency for the unresponsive patient with multiple penetrating wounds and bleeding and noted a weak pulse. Shortly after, the RN arrived at the patient's side but did not assess the patient's respiratory rate or pulse. During transport to the TTA, the patient stopped breathing, and nurses initiated CPR. Nursing staff initially delayed administering oxygen then improperly placed the patient on a nonrebreather mask instead of providing positive pressure ventilation.[15] Furthermore, nursing staff inconsistently documented the method of administering oxygen.

Provider Performance

Providers were generally available when TTA nurses requested consultation. Providers also made appropriate triage decisions and timely documented emergent events. The OIG did not identify any deficiencies related to provider performance.

Nursing Performance

ISP nursing staff usually performed well during emergent events and generally provided appropriate nursing assessments and interventions. However, we identified a pattern of deficiencies with incomplete nursing assessments. The following cases are examples:

- In case 2, the TTA RN responded to a medical emergency call for a patient with an allergic reaction and rash. The nurse documented the patient was experiencing an allergic reaction after taking antibiotics. However, the TTA RN did not inquire about the onset time of the rash, when the last dose of antibiotic was taken, and whether the patient had a history of allergic reactions. Moreover, the nurse did not document the general appearance and size of the rash.

- In case 41, the outpatient housing unit (OHU) and TTA nursing staff responded to a medical emergency for a patient with altered level of consciousness. The HCFR documented the patient was unresponsive but did not document obtaining vital signs such as blood pressure, respiratory rate or oxygen saturation. The patient became alert shortly after and was transferred to the TTA. The TTA RN documented the patient had stroke-like symptoms but did not document what neurological signs or symptoms the patient presented with. In addition, the TTA RN did not obtain vital signs until over one hour after the patient arrived to the TTA.

[15] A nonrebreather mask is a device used to assist in the delivery of oxygen but requires the patient be able to breathe unassisted. Positive pressure ventilation during CPR is delivered via an Ambu-bag and is recommended for those patients who are unresponsive with no breathing or abnormal breathing. It ensures oxygen is delivered to vital organs until spontaneous breathing and heartbeat can be restored.

Nursing Documentation

Nurses in the TTA usually performed thorough documentation for emergent events. We identified no pattern of deficiencies and noted nursing staff always documented medication administration times on the medication administration record (MAR).

Emergency Medical Response Review Committee

The EMRRC met twice per month and discussed emergency responses and unscheduled transports to the community hospital. However, compliance testing revealed deficient incident packages due to the EMRRC event checklists being incomplete in almost half the events reviewed (MIT 15.003, 58.3%). In contrast, OIG clinicians found nursing and medical leadership performed most clinical reviews; however, in three emergency responses or unscheduled transports to the community hospital, the nursing and medical leadership and the EMRRC did not identify the same opportunities for improvement OIG clinicians identified.[16] The following are examples:

- In case 2, a clinical review was completed for the patient who was transferred to higher level of care with shortness of breath. However, during the review process, the following deficiencies was not identified: the TTA RN did not assess the onset time of SOB and did not re-assess shortness of breath. Additionally, the patient was prescribed inhalers however, the TTA RN did not assess rescue inhaler use.

- In case 3, nursing staff responded an unconscious patient. The patient was treated for multiple penetrating wounds and bleeding in the TTA. The patient did not respond to resuscitative measures and was pronounced deceased by EMS. During the review process, a delay in oxygen administration and improper oxygen application by nursing staff was not identified.

Clinician On-Site Inspection

OIG clinicians went to the TTA and spoke to staff during our on-site inspection, The institution had three medical bays. Two bays were used for urgent or emergent care, and one was used for observation. One designated provider was available during regular business hours; otherwise, providers were assigned on an on-call basis and were available by telephone or via telemedicine. The nurses reported the TTA was staffed with two RNs during each shift and often three RNs on the weekends to assist with the weekend sick call process or assist with patient care in the OHU.

The TTA RNs reported they were notified of emergencies via a phone call or by the officers who were located in close proximity to the TTA. The TTA RNs reported they had no access to radios in the TTA but reported having good communication with custody staff.

During the on-site inspection, the OIG clinicians observed the daily central health huddle. The TTA RNs conducted the central health huddle via Microsoft teams. The TTA nurses discussed all TTA encounters from the previous day as well as patients returning from the community hospital and offsite specialty service appointments, including

[16] ISP's nursing and medical leadership did not identify opportunities for improvement in cases 2, 3, and 41.

specialty services recommendations. The huddle was very well run with good participation and communication evident.

The TTA RNs we interviewed were pleasant and knowledgeable. The TTA RNs had many years of experience within the institution, and they reported they felt supported by their leadership.

Recommendations

- Nursing leadership should analyze the challenges to nurses performing thorough assessments and reassessments of emergent and urgent conditions. Leadership should implement remedial measures as appropriate.

- Health care leadership should analyze the root cause(s) of the Emergency Medical Response Review Committee (EMRRC) not thoroughly reviewing emergency response events or accurately detailing findings and should implement remedial measures as appropriate.

Health Information Management

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Proficient*** **(88.9%)**

OIG clinicians found ISP performed well in this indicator. Staff retrieved all specialty reports, all radiology reports, all pathology reports, most hospital records, and most laboratory results within the required time frames. We identified two late specialty report endorsements and 16 incomplete or missing patient test result notification letters. Taking all factors into consideration, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed staff performed very well in health information management. Staff always timely scanned patient sick call requests. They frequently scanned specialty reports as well as scanned and reviewed hospital discharge reports within required time frames. Staff also satisfactorily labeled and scanned medical records into the correct patient files. Based on the overall **Health Information Management** compliance score result, the OIG rated the compliance testing component of this indicator ***proficient***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 747 events and identified 23 deficiencies related to health information management. Of these deficiencies, two were significant.[17]

Hospital Discharge Reports

ISP staff performed well in hospital records management. Compliance testing showed staff retrieved most hospital records timely (MIT 4.003, 81.0%). ISP staff often retrieved the hospital discharge reports with key elements and providers endorsed most hospital records timely (MIT 4.005, 87.0%). OIG clinicians reviewed 20 off-site emergency department and hospital encounters and found staff retrieved only one hospital record late:

[17] Deficiencies occurred in cases 2, 4, 5–7, 15, 16, 41, and 44–47. Significant deficiencies occurred in case 2.

- In case 16, the patient was discharged from a community hospital with a diagnosis of cellulitis requiring antibiotic treatment; however, the ISP staff retrieved the hospital record three days late.[18]

Specialty Reports

Compliance testing showed ISP staff retrieved and scanned almost all specialty reports within required time frames (MIT 4.002, 93.3%). ISP staff received, and providers endorsed, all high-priority (MIT 14.002, 100%), most medium-priority (MIT 14.005, 86.7%), and most routine-priority (MIT 14.008, 80.0%) specialty reports timely. OIG clinicians reviewed 94 specialty appointments and found staff retrieved all specialty reports timely. For specialty reports, OIG clinicians identified only two deficiencies related to late endorsements.[19]

Diagnostic Reports

Compliance testing revealed ISP staff intermittently retrieved pathology reports on time (MIT 2.010, 70.0%). OIG clinicians reviewed two pathology events and found staff retrieved reports timely. OIG clinicians also found ISP staff retrieved all radiology reports and most laboratory results timely. Staff did not retrieve two laboratory results, and we discussed these deficiencies in the **Diagnostic Services** indicator.[20]

Compliance testing showed providers endorsed all laboratory (MIT 2.005, 100%) and most radiology (MIT 2.002, 90.0%) reports within required time frames. The providers also endorsed almost all pathology reports within required time frames (MIT 2.011, 90.0%). Similarly, OIG clinicians found providers endorsed all diagnostic and pathology reports timely.

OIG clinicians identified 16 deficiencies related to missed or incomplete letters for radiology, laboratory, and pathology results. Please refer to the **Diagnostic Services** indicator for additional information.

Urgent and Emergent Records

OIG clinicians reviewed 27 emergency care events and identified no deficiencies related to documentation. Both the providers and nurses recorded these events very well.

Scanning Performance

Compliance testing showed all patient health care request forms were scanned timely (MIT 4.001, 100%), and most medical documents were scanned, labeled, and filed appropriately (MIT 4.004, 83.3%). OIG clinicians identified only one document not scanned into the medical record as follows:

- In case 15, a provider documented the patient signed a refusal for a provider appointment; however, staff did not scan the refusal into the patient's medical record.

---

[18] Cellulitis is a skin and soft tissue infection caused by bacteria.

[19] Deficiencies occurred in cases 4 and 7.

[20] Deficiencies occurred in case 2.

Legibility

OIG clinicians found most hand-written nursing assessments of the sick call requests were legible, except one case in which we could not read the nurse's signature.[21]

Clinician On-Site Inspection

OIG clinicians discussed health information management processes with the ISP health information management supervisor. The supervisor described a tracking process for specialty consultations, hospital records, and pathology results to ensure these documents are retrieved timely. ISP health information management staff also have access to the electronic medical record systems for five contracted hospitals to facilitate retrieving medical records.

[21] A deficiency occurred in case 2.

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)	28	2	15	93.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	17	4	2	81.0%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	20	4	0	83.3%
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)	20	3	0	87.0%
				Overall percentage (MIT 4): 88.9%

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)	10	0	0	100%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	7	3	0	70.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	9	1	0	90.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	4	6	0	40.0%
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)	14	0	1	100%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	13	2	0	86.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	12	3	0	80.0%

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

Recommendations

The OIG offers no recommendations for this indicator.

Health Care Environment

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

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (68.1%)**

Overall, ISP's performance in health care environment needed improvement. Medical supply storage areas in the clinics contained unidentified or unorganized labeled medical supplies. Several applicable clinics tested did not meet the requirements for essential core medical equipment and supplies. In addition, staff did not regularly sanitize or wash their hands during patient encounters. Lastly, emergency medical response bags (EMRBs) were missing staff verification, had not been properly inventoried when seal tags changed, or contained compromised sterile medical supply packaging. Based on the overall **Health Care Environment** compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Waiting Areas

We inspected only indoor waiting areas as ISP had no outdoor waiting areas. Health care and custody staff reported the existing waiting areas contained sufficient seating capacity (see Photo 1, right, and Photo 2, next page). During our inspection, we did not observe overcrowding in any of the clinics' indoor waiting areas.

Photo 1. Patient waiting area (photographed on 1-13-25).

Photo 2. Patient waiting area (photographed on 1-13-25).

Clinic Environment

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

All clinics we observed contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 100%).

Clinic Supplies

Only five of the 10 clinics followed proper medical supply storage and management protocols (MIT 5.107, 50.0%). We found one or more of the following deficiencies in five clinics: compromised sterile medical supply packaging (see Photo 3); expired medical supplies (see Photos 4 and 5, next page); unidentified or unorganized labeled medical supplies; cleaning materials stored with medical supplies; and medical supplies directly stored on the floor.

Four of the 10 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 40.0%). We found one or more of the following deficiencies in six clinics: missing nebulization unit or examination table disposable paper; staff did not properly document defibrillator performance test within the last 30 days; and several clinic daily glucometer quality control logs were inaccurate.

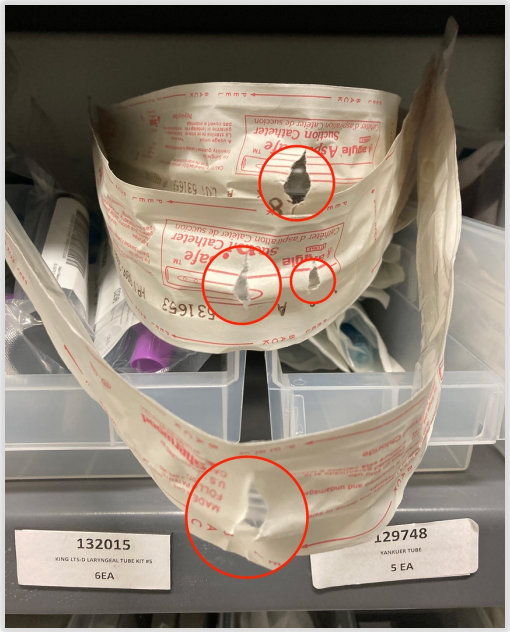


Photo 3. Compromised sterile medical supply packaging (photographed on 1-13-25).

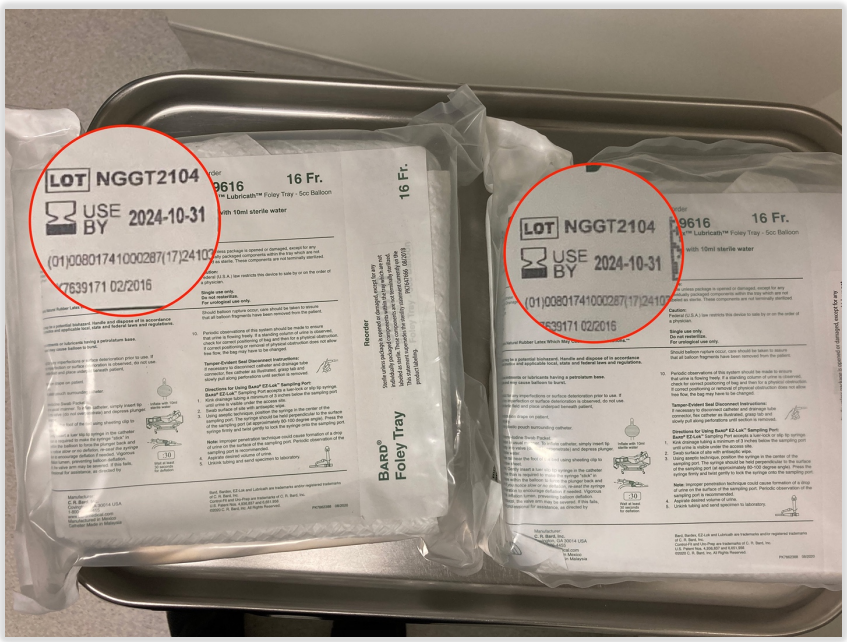


Photo 4. Expired medical supply dated October 31, 2024 (photographed on 1-13-25).

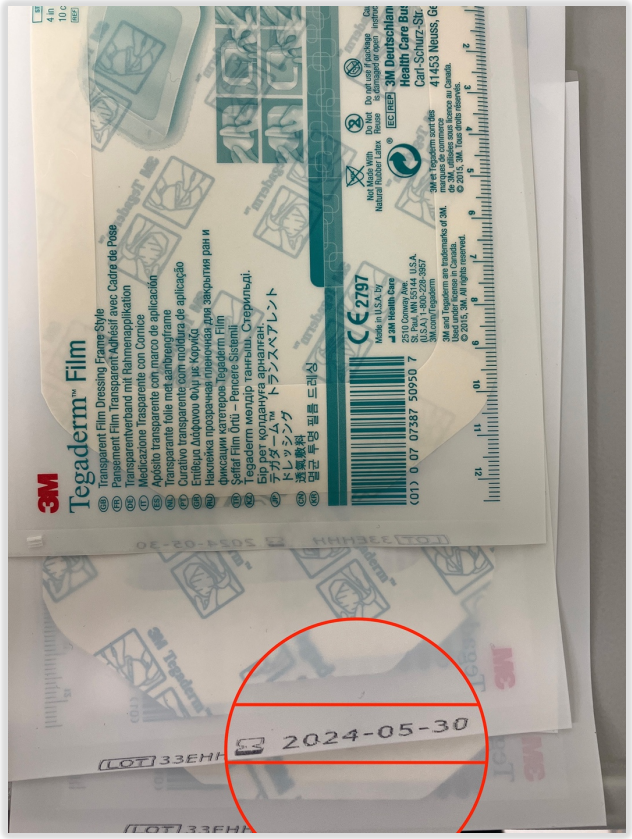


Photo 5. Expired medical supply dated May 30, 2024 (photographed on 1-15-25).

We examined EMRBs to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only one of the eight applicable EMRBs passed our test (MIT 5.111, 12.5%). We found one or more of the following deficiencies with seven EMRBs: staff did not ensure the EMRBs' compartments were sealed and intact; staff had not inventoried the EMRBs when seal tags were replaced; EMRBs contained compromised sterile medical supply packaging; and staff inaccurately logged the EMRBs' glucometer control solution range when performing the daily glucometer quality control.

Medical Supply Management

ISP staff always appropriately stored clinic medical supplies in the medical supply storage areas outside the clinics (e.g., warehouse, Conex containers, etc.) (MIT 5.106, 100%).

According to the Chief Executive Officer (CEO), health care leadership did not have any issues with the medical supply process. Health care and warehouse managers expressed no concerns about the medical supply chain or their communication process with the existing system in place.

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected seven of nine applicable clinics (MIT 5.101, 77.8%). In two clinics, we found one or both of the following deficiencies: the clinic's cabinet drawer or cabinet under the sink were unsanitary.

Staff in seven of 10 clinics (MIT 5.102, 70.0%) properly sterilized or disinfected medical equipment. In two clinics, staff did not mention disinfecting the examination table as part of their daily start-up protocol. In one clinic, we observed the clinician utilize the examination table without a disposable paper during a patient encounter.

We found operational sinks and hand hygiene supplies in the examination rooms in seven of 10 clinics (MIT 5.103, 70.0%). In three clinics, the patient restrooms lacked antiseptic soap or disposable hand towels.

We observed patient encounters in seven applicable clinics. In five of those seven clinics, clinicians did not wash their hands before or after examining their patients, or during subsequent regloving (MIT 5.104, 28.6%).

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

Physical Infrastructure

At the time of our medical inspection, the institution's administrative team reported no ongoing health care facility improvement program construction projects. The institution's health care management and plant operations manager reported all clinical area infrastructures were in good working order (MIT 5.999).

Compliance Score Results

Table 10. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	7	2	1	77.8%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	7	3	0	70.0%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	7	3	0	70.0%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	2	5	3	28.6%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	10	0	0	100%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	1	0	0	100%
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	5	5	0	50.0%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	4	6	0	40.0%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	10	0	0	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	10	0	0	100%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	1	7	2	12.5%
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 5): 68.1%

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

Recommendations

- Health care leadership should determine the root cause(s) for staff not following all required universal hand hygiene precautions and should implement remedial measures as appropriate.

- Health care leadership should determine the root cause(s) for staff not following equipment and medical supply management protocols and should implement remedial measures as appropriate.

- Nursing leadership should determine the root cause(s) for staff not ensuring the emergency medical response bags (EMRBs) are regularly inventoried and sealed and should implement remedial measures as appropriate.

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 staff performance in communicating vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals. Inspectors further 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	***Proficient*** **(85.8%)**

OIG clinicians found ISP performed sufficiently in the transfer process. Nurses screened patients appropriately and patients received good assessments and care when they returned from the hospital or emergency rooms. In addition, patients received timely follow-up appointments. However, we found opportunities for improvement in documentation and medication continuity. Considering all factors, the OIG rated the case review component of this indicator ***adequate.***

Compliance testing showed ISP performed well in this indicator. The institution performed excellently in completing the assessment and disposition sections of the screening process and ensured transfer packets for departing patients included all required documents and medications. In contrast, the institution scored low in completing initial health screening forms. The institution also needed improvement in medication continuity for newly transferred patients. Based on the overall **Transfers** compliance score result, the OIG rated the compliance testing component of this indicator ***proficient***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 32 events in 17 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 13 deficiencies, four of which were significant.[22]

Transfers In

ISP's transfer-in process had a mixed performance. Compliance testing showed nurses needed improvement with completing the initial health screening thoroughly and within required time frames (MIT 6.001, 68.0%). Nursing staff did not always follow up with additional questions when patients responded "Yes" to some of the screening questions, and we found instances in which nursing staff completed the initial health screening after the patient moved to the housing unit. However, when required, nurses always completed the assessment and disposition section on the initial health screening form on the same day as the health screening (MIT 6.002, 100%). OIG clinicians reviewed six events and identified two minor deficiencies.[23] Our clinicians found nurses performed very well in completing assessments.

Compliance testing showed ISP performed satisfactorily with ensuring providers evaluated newly arrived patients within required time frames (MIT 1.002, 83.3%). OIG clinicians found all patients were seen timely.

Case review and compliance testing showed mixed results in medication continuity for transfer-in patients. Compliance data showed staff occasionally did not deliver prescribed medications by the administration date and time ordered by providers (MIT 6.003, 75.0%). In contrast, OIG clinicians did not identify any concerns with medication continuity.

Compliance testing revealed ISP performed well in scheduling preapproved specialty appointments for patients who transferred into the institution (MIT 14.010, 85.0%). OIG clinicians did not identify any concerns with specialty appointments.

Transfers Out

ISP's transfer-out process was satisfactory. Compliance testing showed ISP performed excellently with ensuring patients transferred out with their medications and required documents (MIT 6.101, 100%). OIG clinicians reviewed six events and identified four deficiencies, one of which was significant.[24] We found nurses generally screened patients appropriately, completed the interfacility transfer information, and ensured all patients had their medical equipment. However, we identified one significant deficiency as follows:

- In case 20, the nurse completed the preboarding transfer screening nine days prior to the date of the patient's departure. Subsequently on the day of transfer, the nurse did not take vital signs, complete a Covid-19 screening, document a pending transplant surgery referral, or ensure the patient had

[22] Deficiencies occurred in cases 2, 11, 13, 16, 18, 19, and 20–22. Significant deficiencies occurred in cases 2, 11, and 20.

[23] Deficiencies occurred in cases 18 and 19.

[24] Deficiencies occurred in cases 20–22. A significant deficiency occurred in case 20.

their prescribed durable medical equipment (DME) and keep-on-person medications.[25]

Hospitalizations

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

OIG clinicians reviewed 20 hospitalization events and identified four deficiencies, one of which was significant.[26] One deficiency was due to hospital records being scanned late and is discussed in the **Health Information Management** indicator. The significant deficiency related to hospital discharge medications and is addressed in the **Medication Management** indicator. Overall, nurses performed good assessments, reviewed hospital recommendations, and notified providers appropriately.

Compliance testing showed staff frequently scanned hospital discharge documents within required time frames (MIT 4.003, 81.0%), and providers reviewed most documents timely (MIT, 4.005, 87.0%). OIG clinicians found ISP staff scanned most documents within required time frames, and providers reviewed most documents timely.

Compliance testing showed ISP performed poorly in medication continuity for patients returning from hospitalizations (MIT 7.003, 27.8%). In contrast, OIG clinicians found patients who returned from hospitals and emergency rooms generally received their medications timely.

Compliance testing showed patients almost always received timely follow-up appointments after returning from hospitals and emergency rooms (MIT 1.007, 91.3%). OIG clinicians found all follow-up appointments for these patients occurred timely.

Clinician On-Site Inspection

At the receiving and release (R&R) area, OIG clinicians interviewed the on-duty RN, who reported being the regular night shift nurse. The nurse was knowledgeable about the transfer process. The R&R area had two screening rooms and was staffed with one nurse on each shift. We were informed 15 to 20 patients transferred out of ISP weekly, and 25 to 30 patients transferred in weekly. The nurse reported generally obtaining from the TTA any medications or supplies patients needed on departure or arrival during nonbusiness hours. The R&R nurse also reported nursing morale was good, and rapport with nursing leadership and custody staff was positive.

[25] Durable medical equipment (DME) is medical equipment used for long periods of time and prescribed by a provider for example wheelchairs, walkers, and CPAP machines. KOP means "keep-on-person" and refers to medications a patient can keep and self-administer according to the directions provided.

[26] Deficiencies occurred in cases 2, 11, 13 and 16. A significant deficiency occurred in case 11.

Compliance On-Site Inspection and Discussion

R&R nursing staff ensured all nine applicable patients who transferred out of the institution had the required medications, transfer documents, and assigned durable medical equipment (MIT 6.101, 100%).

Compliance Score Results

Table 11. Transfers

	Scored Answer			
Compliance Questions	**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)	17	8	0	68.0%
For endorsed patients received from another CDCR institution: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	24	0	1	100%
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	3	1	21	75.0%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	9	0	1	100%
				Overall percentage (MIT 6): 85.8%

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)	20	4	1	83.3%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007)	21	2	0	91.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	17	4	2	81.0%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	20	3	0	87.0%
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)	5	13	5	27.8%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	23	2	0	92.0%
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)	4	1	0	80.0%
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)	17	3	0	85.0%

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

Recommendations

The OIG offers no recommendations for this indicator.

Medication Management

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (56.8%)**

In this cycle, case review found ISP provided good medication management. The results were similar to those in Cycle 6. ISP performed satisfactorily in ensuring medication continuity for patients receiving new and chronic care medications, specialty and hospital-recommended medications, and specialized medical housing medication as well as medications for patients transferring into and out of the institution. Considering all factors, the OIG rated the case review component of this indicator ***adequate.***

Compliance testing showed ISP needed improvement in providing medication management services. ISP performed sufficiently in ensuring medication continuity for patients laying over at ISP. However, the institution performed poorly in providing patients with chronic care medications, newly ordered medications, and community hospital discharge medications. Based on the overall **Medication Management** compliance score result, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 110 events in 27 cases related to medications and found eight medication deficiencies, two of which were significant.[27]

New Medication Prescriptions

Compliance testing revealed ISP needed improvement with timely administration and availability of new prescription medications (MIT 7.002, 72.0%). In contrast, OIG clinicians found most patients received their newly prescribed medications timely. However, we identified one significant deficiency as follows:

- In case 10, the patient was seen for coughing and wheezing and was prescribed steroid medication to treat a chronic lung disease flare-up; however, the patient did not receive his newly ordered medication.

[27] Deficiencies occurred in cases 1, 7, 9–11, 21, 41, and 43. Significant deficiencies occurred in cases 10 and 11.

Chronic Medication Continuity

ISP had mixed performance in chronic medication continuity. Compliance testing showed patients rarely received their chronic care medications within required time frames (MIT 7.001, 33.3%), mostly due to the pharmacy not timely filling and dispensing medications. In contrast, OIG clinicians found most patients received their chronic care medications timely, but we found room for improvement. The following is an example:

- In case 9, the patient received his blood pressure medication seven days late.

Hospital Discharge Medications

Compliance testing showed patients who returned from off-site hospitals or emergency rooms sporadically received their medications within required time frames (MIT 7.003, 27.8%). In contrast, OIG clinicians identified only one deficiency related to hospital discharge medication:

- In case 11, the patient, with a recently diagnosed heart condition, did not receive his newly prescribed medication to treat inflammation of the heart as ordered and missed three doses of the medication.

Specialized Medical Housing Medications

Compliance testing showed ISP needed improvement with administering medications timely when patients were admitted to the outpatient housing unit (MIT 13.003, 44.4%). OIG clinicians found two significant deficiencies as listed below:

- In case 41, the patient, with a history of acid reflux, was prescribed acid reflux medication. Nursing staff documented the medication was not given due to a task duplication; however, we found no documentation the patient actually received the medication.

- In case 43, the patient with a history of eye surgery received multiple vials of the same prescribed steroid eye drops within four days.

Transfer Medications

Compliance testing showed ISP staff generally performed well ensuring continuity of transfer medications. For the most part, patients who transferred into the institution received their medications within required time frames (MIT 6.003, 75.0%). Patients transferring from one housing unit to another almost always received their medications timely (MIT 7.005, 92.0%). ISP performed satisfactorily in administering medication for patients who were on layover and temporarily housed at ISP (MIT 7.006, 80.0%). ISP nurses always ensured all patients who transferred out of the institution received a five-day supply of medications (MIT 6.101, 100%). OIG clinicians also found most patients transferring into and out of ISP received their medications timely.

Medication Administration

Compliance testing showed nurses always correctly administered TB medications as prescribed (MIT 9.001, 100%). Nurses also often monitored these patients correctly (MIT

9.002, 81.8%). OIG clinicians did not have any case samples for patients on TB medications.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians interviewed the pharmacist-in-charge (PIC) and nurses. The PIC provided OIG clinicians with detailed responses to medication related questions identified during the case review process. In addition, we inspected the medication administration areas and spoke with medication-line LVNs. The medication administration areas were clean and well organized. The medication nurses were all very knowledgeable about the medication administration process.

The OIG team attended several huddles during the on-site inspection and observed good communication among members of each team regarding medication management. The medication nurses attended clinic huddles daily. Issues discussed included medication compliance, abnormal blood sugar levels, and medications expiring within three days. Nurses were expected to address any medication concerns with the provider during the huddle, or through the electronic health record system message pool. Nurses also reported calling the provider directly if orders were needed after hours for patients with abnormal blood sugar levels or elevated blood pressure. Nurses reported having a good rapport with leadership, pharmacy staff, and custody staff.

Medication Practices and Storage Controls

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

ISP appropriately stored and secured nonnarcotic medications in only four of eight applicable clinic and medication-line locations (MIT 7.102, 50.0%). In each of the four locations, we observed one of the following deficiencies: unsanitary medication storage area; unissued medication not maintained in its original labeled packaging; the medication area lacking a clearly labeled designated area for medications to be returned to the pharmacy; and a treatment cart log missing daily security check entries.

Staff kept medications protected from physical, chemical, and temperature contamination in five of the eight applicable clinic and medication-line locations (MIT 7.103, 62.5%). In three locations, the medication refrigerators were unsanitary. Additionally, in one of the three locations, staff did not store internal and external medications separately.

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

Nurses exercised proper hand hygiene and contamination control protocols in only two of six applicable locations (MIT 7.105, 33.3%). In four locations, some nurses neglected to wash or sanitize their hands before donning gloves or before each subsequent regloving.

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

Staff in five of six applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 83.3%). In one clinic, medication nurses did not reliably observe patients while they swallowed directly observed therapy (DOT) medications.[28]

Pharmacy Protocols

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

In its pharmacy, staff did not properly store nonrefrigerated medication (MIT 7.109, zero). We found medication with compromised packaging.

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

The PIC did not appropriately complete monthly inventories of controlled substances in the institution's clinic and medication storage areas (MIT 7.111, zero). Specifically, in one location, the pharmacist assigned to that location did not properly complete a monthly nonpharmacy licensed medication storage area inspection checklist (CDCR 7477-B) for the month of January 2025. In another location, the pharmacist assigned to that location did not complete a medication storage inspection checklist (CDCR 7477) for the month of July 2024.

We examined 25 pharmacy related medication error reports. The PIC timely or correctly processed only eight of these 25 reports (MIT 7.112, 32.0%). In six reports, we found one or more of the following deficiencies: the form's date was inaccurate; the form was not initiated timely; the form had no documentation of the PIC's recommended changes to correct the medication error; or the form had no documentation of the PIC's determination or findings regarding the error. For the remaining 11 reports, the PIC had not completed a Pharmacy-Related Medication Error Follow-Up form at the time of our inspection.

Nonscored Tests

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

Our compliance team interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. All seven patients indicated they had access to their rescue medications (MIT 7.999).

[28] DOT means "directly observed therapy" and refers to dose-by-dose administration of medications by appropriately licensed health care staff using the highest level of observation during patient ingestion of their administered medication.

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)	7	14	4	33.3%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	18	7	0	72.0%
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)	5	13	5	27.8%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004)	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	23	2	0	92.0%
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)	4	1	0	80.0%
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)	8	0	2	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	4	4	2	50.0%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	5	3	2	62.5%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	8	0	2	100%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	2	4	4	33.3%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	6	0	4	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	5	1	4	83.3%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	8	17	0	32.0%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 7): 56.8%

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)	3	1	21	75.0%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	9	0	1	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	12	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	9	2	1	81.8%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	4	5	1	44.4%

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

Recommendations

- Medical and nursing leadership should analyze the root cause(s) of the challenges to staff ensuring chronic care medications, newly prescribed medications, hospital discharge medications, and specialized medical housing patients are administered timely and without interruption. Leadership should implement remedial measures as appropriate.

Preventive Services

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Proficient*** **(91.9%)**

ISP performed very well in this indicator. Staff performed outstandingly in administering TB medications to patients as prescribed, screening patients annually for TB, and offering patients an influenza vaccine for the most recent influenza season. They performed very well in offering colorectal cancer screening for patients from ages 45 through 75, and satisfactorily in monitoring patients taking TB medications and offering immunizations to chronic care patients. These findings are set forth in the table on the next page. Based on the overall **Preventive Services** compliance score result, the OIG rated this indicator ***proficient***.

Compliance Score Results

Table 15. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	12	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	9	2	1	81.8%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	25	0	0	100%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	23	2	0	92.0%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	7	2	16	77.8%
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): 91.9%

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

Recommendations

The OIG offers no recommendations for this indicator.

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***

Case review found ISP's overall nursing performance was sufficient. Nurses generally performed appropriate assessments, interventions, and documentation in outpatient services, emergency services, transfers, hospital returns, specialized medical housing, specialty services, and medication management. However, OIG clinicians identified opportunities for improvement in the outpatient setting with nurses performing thorough assessments, consulting with the provider for abnormal findings in a timely manner, and with wound care assessment and documentation. Factoring all the information, the OIG rated this indicator ***adequate.***

Case Review Results

We reviewed 167 nursing encounters in 45 cases. Of the nursing encounters we reviewed, 89 occurred in the outpatient setting, and 12 were sick call requests. We identified 43 overall nursing performance deficiencies, seven of which were significant.[29]

Outpatient Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interviews) and objective (observation and examination) elements.

[29] Deficiencies occurred in cases 2, 3, 7, 8, 10, 12–14, 18–20, 22, 23, 26, 29, 31, 34, 39, and 40–43. Significant deficiencies occurred in cases 3, 12, 13, 20, and 23.

Nurses generally performed appropriate assessments and interventions. We identified 19 nursing outpatient deficiencies, three of which were significant.[30]

Nurses triaged sick call requests timely and initiated face-to-face appointments within policy guidelines and as clinically indicated. We identified a pattern of deficiencies related to incomplete assessments and nurses not informing the provider of significant abnormal findings. Although both deficiencies presented opportunities for improvement, neither significantly impacted the patients' care. Examples are as follows:

- In case 13, the patient complained of swelling and pain to his lower lip for two days that started when he began taking antibiotics. However, the sick call nurse did not recognize a possible allergic reaction and did not report the abnormal findings to the provider.

- In case 23, the patient complained he could not eat because his blood sugar levels were too high. He requested changes to his insulin because sometimes he felt weak. During the nursing encounter, the sick call nurse documented the patient's morning blood sugar levels were abnormally high for three days in a row. However, the nurse did not notify the provider of the abnormal blood sugar levels and instead ordered a provider follow-up in 14 days.

- In case 31, the patient reported receiving treatment for a penis infection three weeks prior but felt the medication was not helping. The sick call nurse documented a small amount of thin white discharge and mild redness on the head of the penis. However, the nurse ordered a provider follow up in 14 days instead of notifying the provider of the abnormal finding.

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 care appropriately.

Wound Care

We reviewed three cases in which nurses documented the patient had a wound. We identified three deficiencies, none of which were significant.[31] All the deficiencies occurred when nurses either did not assess the wound or did not provide thorough documentation. An example is listed below:

- In case 14, the patient was ordered to receive daily wound care for a right thigh incision; however, nursing staff often did not document the details of the wound care completed, including description of the wound, care performed to the wound, or dressing change.

[30] Deficiencies occurred in cases 2, 3, 8, 10, 12–14, 23, 26, 29, 31, 34, 39, and 40. Significant deficiencies occurred in cases 13, 23, and 31.

[31] Wound care deficiencies occurred in cases 13, 14, and 42.

Emergency Services

We reviewed 27 urgent or emergent events. Nurses responded promptly to emergent events. However, their assessments showed room for improvement, which we detail further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 20 events involving returns from off-site hospitals or emergency rooms. The nurses performed good nursing assessments, which we detailed further in the **Transfers** indicator.

Transfers

We reviewed three cases involving the transfer-in process. The nurses performed good assessments, interventions, and documentation. We also reviewed three cases involving the transfer-out processes. The nurses performed sufficient screenings and documentation. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

We reviewed 19 nursing events. The nurses generally performed sufficient assessments and interventions. For more specific details, please refer to the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed six cases with a total of 12 events in which patients returned from an off-site specialty service appointment for specialty procedures or consultations. We identified two deficiencies, neither of which was significant.[32] In both cases, nurses did not perform an assessment and did not document vital signs. Please refer to the **Specialty Services** indicator for additional details.

Medication Management

OIG clinicians reviewed 110 events involving medication management and found most nurses administered patients' medications as prescribed. Please refer to the **Medication Management** indicator for additional details.

Clinician On-Site Inspection

OIG clinicians interviewed nurse instructors and nurses in the TTA, OHU, R&R, outpatient clinics, and medication administration areas. We attended organized huddles. Patient care teams were familiar with their patient populations, and nurses were knowledgeable about processes in their respective areas. The nurse instructors provided information regarding updated RN protocol training. They reported all RNs were provided the RN protocol training.

[32] Deficiencies occurred in cases 7 and 13.

While on site, we met with the Chief Nurse Executive (CNE) and the Director of Nursing (DON) to discuss our case review findings. They agreed with most findings and were very organized and prepared for our discussion. Nursing staff generally reported nursing morale was good. In addition, they described having good rapport with nursing leadership and custody staff. At the time of our inspection, ISP staff voiced concerns regarding the recent news of an upcoming prison closure and the possibility of the local hospital closing.

Recommendations

- Nursing leadership should analyze the challenges to nurses performing thorough assessments, consulting with the provider regarding abnormal test findings in a timely manner, and assessing and documenting wound care thoroughly. Leadership 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***

Case review found ISP providers generally delivered good care. They made appropriate assessments and decisions, managed chronic medical conditions effectively, and reviewed medical records thoroughly. However, providers sometimes either did not generate or sent incomplete patient test result notification letters. After considering all aspects of care, the OIG rated this indicator ***adequate***.

Case Review Results

OIG clinicians reviewed 170 medical provider encounters and identified 16 deficiencies, five of which were significant.[33] OIG physicians also rated the overall adequacy of care for each of the 20 comprehensive case reviews. Of these 20 cases, we rated 18 ***adequate*** and two ***inadequate***.

Outpatient Assessment and Decision-Making

Providers generally made appropriate assessments and sound medical plans for their patients. OIG clinicians identified one deficiency related to poor assessment:

- In case 15, a provider evaluated the patient, who had prior chest pain and a recent positive cardiac stress test; however, the provider did not inquire whether the patient had any cardiac symptoms.

We found two deficiencies related to lack of pertinent physical examinations.[34] An example follows:

[33] Deficiencies occurred in cases 2, 7, 15, 41, 42, 43, and 44. Significant deficiencies occurred in cases 15, 42, 43, and 44.

[34] Deficiencies occurred in cases 7 and 44.

- In case 7, a provider evaluated the patient for groin rash and prescribed an antifungal cream; however, the provider did not perform a skin or groin exam.

Providers generally diagnosed medical conditions correctly, ordered appropriate tests, and coordinated effective treatment plans for their patients. OIG clinicians identified one deficiency related to lack of a medical plan:

- In case 7, a provider evaluated the patient for a recent colonoscopy showing large internal, and moderate-sized external, hemorrhoids; however, the provider did not formulate a plan for the management of the hemorrhoids.

Outpatient Review of Records

Providers performed satisfactorily in reviewing hospital records and addressing the hospitalists' recommendations. ISP providers also reviewed diagnostic tests on time and addressed abnormal results appropriately. However, OIG clinicians identified two deficiencies related to insufficiently addressed abnormal laboratory results:

- In case 7, a provider endorsed a positive fecal immunochemical test that was suggestive for possible blood in the stool, which can be an early sign of gastrointestinal bleed or cancer. However, the provider did not have the patient follow up urgently to assess for signs and symptoms of possible gastrointestinal bleed.

- In case 44, a provider assessed the patient for elevated bilirubin level but did not formulate a diagnosis or differential diagnoses for the cause of elevated bilirubin and did not document plan to recheck the bilirubin level.[35]

Providers generally performed well in reviewing medical records for patients transferring into the institution and ordered diagnostic tests and specialty appointments as medically indicated.

Providers also performed well in reviewing the medication administration record (MAR) and renewing patients' medications timely. However, we identified one deficiency related to delayed renewal of a chronic care medication:

- In case 15, the patient had Barrett's esophagitis and required a daily proton pump inhibitor, which decreases stomach acid, helps prevent further damage to the esophagus, and potentially lowers the risk of developing esophageal cancer.[36] The provider allowed the medication to expire, and the medication was not renewed until two and a half months later.

[35] Bilirubin is a yellow colored substance produced when red blood cells are broken down and processed by the liver.

[36] Barrett's esophagitis is a medical condition where the lining of the lower esophagitis has cellular changes due to acid reflux from the stomach. Without treatment, Barrett's esophagitis may progress to esophageal cancer.

Emergency Care

Providers generally made appropriate triage decisions and treatment plans for patients needing emergency care in the triage and treatment area (TTA). Providers also usually documented required progress notes for TTA events.

Chronic Care

Providers performed well in managing chronic medical conditions such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease. For patients with diabetes, the providers regularly monitored the patients' blood glucose levels and adjusted diabetic medications as indicated.

For patients with cardiovascular disease, the providers prescribed aspirin and cholesterol lowering medications to reduce the risk of heart attack or stroke.

Specialty Services

ISP providers appropriately referred patients to specialists and reviewed specialty reports in a timely manner. Providers also addressed most specialists' recommendations timely. OIG clinicians identified one deficiency related to not addressing a specialist's recommendation. We discuss this further in the **Specialty Services** indicator.

Outpatient Documentation Quality

Providers generally recorded outpatient encounters on the same day of the encounter and documented reasonings for prescribing medications or ordering diagnostic tests. OIG clinicians identified one deficiency related to not documenting a progress note.

- In case 41, the patient's record contained an order for x-rays of cervical spine and left scapula; however, we found no provider documentation of the medical rationale for the x-rays.

Patient Notification Letter

Providers generally sent patient letters to thoroughly communicate diagnostic test results with their patients. However, OIG clinicians identified 16 deficiencies related to missing or incomplete patient test results notification letters. We discussed these deficiencies further in the **Diagnostic Services** and **Health Information Management** indicators.

Clinician On-Site Inspection

At the time of the OIG inspection, ISP had three on-site providers and two telemedicine providers. Leadership reported plans to add one and a half provider positions in three months and noted ISP would then be fully staffed for providers. Providers expressed enthusiasm about their work and general satisfaction with nursing, diagnostic, and specialty services.

The OIG clinician attended the daily morning provider meeting where providers discussed patients who returned from specialty appointments or hospital and significant TTA events. Medical leadership reported conducting weekly provider meetings, which

occurs every Thursday. In these meetings, the Chief Physician and Surgeon discussed new policies and trainings.

OIG clinicians attended two organized clinic morning huddles which were well attended by the patient care teams. The clinic teams discussed specialty appointments with recommendations, patients' glucose logs, hospital returns, and medication refusals. The nurses informed the providers of the scheduled clinic appointments, expiring medications, and new arrivals from other institutions.

Recommendations

The OIG offers no recommendations for this indicator.

Specialized Medical Housing

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Adequate* (81.1%)**

OIG clinicians found ISP performed satisfactorily in this indicator. The providers performed timely admission history and physical examinations. Providers and nurses generally provided good care. However, we identified a pattern of deficiencies in incomplete nursing assessments and documentation. Considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed mixed results in this indicator. Nursing staff performed very well in completing initial assessments. Providers performed well in completing history and physical examinations within required time frames. However, nursing staff needed significant improvement in ensuring medication continuity for patients newly admitted to the specialized medical housing unit. Based on the overall **Specialized Medical Housing** compliance score result, the OIG rated the compliance testing component of this indicator ***adequate***.

Case Review and Compliance Testing Results

We reviewed six OHU cases that included 22 provider events and 19 nursing events. Due to the frequency of nursing and provider contacts in the specialized medical housing, we bundle up to two weeks of patient care into a single event. We identified 15 deficiencies, two of which were significant.[37]

Provider Performance

Compliance testing showed providers generally performed admission history and physical (H&P) examinations timely (MIT 13.002, 90.0%). OIG clinicians found providers completed all admission H&P examinations timely. However, OIG clinicians identified one missed discharge summary as follows:

[37] Deficiencies occurred in cases 41, 42 and 43. Significant deficiencies occurred in cases 42 and 43.

- In case 42, the OHU provider discharged a patient from the OHU but did not complete a discharge summary.

The providers mostly rounded on their patients at clinically appropriate intervals and documented their progress notes thoroughly. OIG clinicians identified one missed documentation:

- In case 41, the OHU provider did not document the reasoning for x-rays of cervical spine and left scapula.

The providers reviewed off-site specialty service reports timely and generally made appropriate diagnoses and medical decisions. Our clinicians identified one deficiency, and we discussed in the **Specialty Services** indicator.

Nursing Performance

Compliance testing showed OHU nurses performed timely admission assessments most of the time (MIT 13.001, 90.0%). The OIG clinicians reviewed 19 nursing events and identified nine deficiencies, none of which were significant.[38] We found OHU nurses conducted rounds appropriately and generally provided good care. However, we identified a pattern of deficiencies for incomplete nursing assessments and documentation. The following cases are examples:

- In case 42, a patient was admitted to the OHU for wound care after having a painful cyst removed from the buttock. During his stay, OHU nurses frequently documented wound care was performed, but often did not document the details of the wound care completed, including a description of the wound, care performed, or dressing change details.

- In case 43, the patient was admitted to the OHU due to a macular hole repair in his left eye. However, nursing staff did not always assess the patient's left eye. In addition, when the patient was discharged from the OHU, nurses did not complete the nursing discharge summary and did not educate the patient.

Medication Administration

Compliance testing showed patients admitted to the OHU only sporadically received their medications timely (MIT 13.003, 44.4%). In contrast, OIG clinicians identified only two deficiencies, which are detailed further in the **Medication Management** indicator.

Clinician On-Site Inspection

The OHU had 14 medical beds, five of which were negative-pressure rooms for respiratory isolation. At the time of our inspection, four beds were occupied.

At ISP's OHU, OIG clinicians interviewed the OHU nurse. The nurse reported the OHU had 24-hour nursing staff with one RN assigned during business hours and an LVN assigned during the afternoon and night shift. The nurse reported the OHU nurses are

[38] Deficiencies occurred in cases 41, 42, and 43.

expected to complete a daily assessment and round every two hours. In addition, the nurse reported TTA RNs were assigned to complete admissions and discharges, as well as help the LVNs as needed. The OHU had a designated OHU provider, who completed rounds with nursing staff.

The clinicians attended the morning huddle in the OHU. The huddle participants joined via Microsoft Teams online video meeting and included all yard office technicians, off-site and on-site specialty staff, the utilization management RN, TTA RNs, OHU nursing staff and supervisors, the OHU provider, the pharmacist, the dental supervisor, and the Chief Physician and Surgeon. The OHU RN discussed all the currently admitted patients and followed the huddle script. The huddle was well organized, and staff participation was good.

We met with nursing leadership to discuss some of our case review findings, which showed a pattern of incomplete or missing documentation for patients who had discharged from the OHU. The Chief Nurse Executive informed us changes had been made to the OHU local operating procedure to include the patient departing process workflow and stated instructions had been emailed to staff.

Compliance On-site Inspection and Discussion

At the time of on-site inspection, the OHU had a functional call light communication system (MIT 13.101, 100%).

Compliance Score Results

Table 16. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission? (13.001)	9	1	0	90.0%
Was a written history and physical examination completed within the required time frame? (13.002)	9	1	0	90.0%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	4	5	1	44.4%
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101)	1	0	0	100.0%
For specialized health care housing (CTC, SNF, hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102)	0	0	1	N/A
				Overall percentage (MIT 13): 81.1%

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

Recommendations

- Nursing leadership should develop strategies to ensure specialized medical housing nursing staff perform thorough patient assessments and documentation 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
Proficient	***Adequate* (84.2%)**

OIG clinicians found ISP performed very well in this indicator. All specialty appointments were completed as requested, and staff timely retrieved and scanned all specialty reports; however, we identified rare late endorsements. Overall, the OIG rated the case review component of this indicator ***proficient***.

Compliance testing showed mixed results in this indicator. Depending on the priority of the specialty service, access ranged from needing improvement to excellent. Preapproved specialty services for newly arrived patients generally occurred within required time frames. Performance in retrieving specialty reports and prompt provider endorsements ranged from satisfactory to excellent. Based on the overall **Specialty Services** compliance score result, the OIG rated the compliance testing component of this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 106 events related to specialty services and identified four deficiencies in this category; none of which were significant.[39]

Access to Specialty Services

Compliance testing revealed variable timely completion of initial high-priority (MIT 14.001, 66.7%), initial medium-priority (MIT 14.004, 73.3%), and initial routine-priority (MIT 14.007, 100%) specialty appointments. Staff completed most follow-up specialty appointments timely (MIT 14.003, 75.0%, MIT 14.006, 81.8%, and MIT 14.009, 87.5%). For patients who transferred to ISP with preapproved specialty requests, compliance testing showed most specialty appointments occurred timely (MIT 14.010, 85.0%). In contrast, OIG clinicians found all specialty appointments including preapproved specialty requests occurred within required time frames.

Provider Performance

OIG clinicians also found ISP providers delivered exceptional on-site specialty care, primarily in the area of medication assisted treatment (MAT) for substance use disorders.

[39] Deficiencies occurred in cases 4, 7, and 13.

Providers referred patients to specialists appropriately and addressed specialists' recommendations timely. OIG clinicians identified only one deficiency wherein the provider did not properly address the specialist's recommendations, as described below:

- In case 43, the OHU provider reviewed a rheumatology consultation but did not address the rheumatologist's recommendations to continue an anti-rheumatic drug and to order physical therapy for the left elbow. The provider did not document a medical rationale for not following the specialist's recommendations.

Nursing Performance

Overall, ISP nurses provided good care related to specialty services. TTA nurses assessed patients appropriately after return from off-site specialty appointments. TTA and telemedicine nurses generally documented accurately and ordered provider follow-up appointments within required time frames. OIG clinicians identified two deficiencies related to incomplete nursing assessments.[40] An example follows:

- In case 7, a nurse assessed a patient who returned from an off-site cardiology appointment but did not obtain vital signs or perform a cardiovascular examination.

Health Information Management

Compliance testing showed ISP staff retrieved and scanned almost all specialty documents within required time frames (MIT 4.002, 93.3%). In addition, ISP's receipt of, and the providers' performance with timely endorsing, high-priority (MIT 14.002, 100%), medium-priority (MIT 14.005, 86.7%), and routine-priority (MIT 14.008, 80.0%) specialty reports ranged from excellent to satisfactory. OIG clinicians found ISP staff retrieved and scanned all specialty reports within required time frames. However, we identified two deficiencies related to late endorsements.[41] One example follows:

- In case 4, staff scanned an ophthalmology specialty report into EHRS; however, the provider endorsed the consultation report five days late.[42]

Clinician On-Site Inspection

On-site specialty, off-site specialty, telemedicine specialty, and utilization management staff coordinated and scheduled specialty appointments at ISP. At the time of our on-site inspection, leadership reported no ISP staff shortage related to specialty services.

ISP has on-site specialty services for orthotics, optometry, general surgery, audiology, and sleep study. ISP staff coordinated all on-site specialty appointments, whereas CCHCS headquarters staff coordinated all telemedicine specialty appointments. ISP relied on multiple medical centers for off-site specialty appointments. Some medical centers were

[40] Deficiencies occurred in cases 7 and 13.

[41] Deficiencies occurred in cases 4 and 7.

[42] EHRS is the Electronic Health Records System. The department's electronic health record system is used for storing the patient's medical history. The health care staff use the system to communicate. This record stays with the patient throughout the patient's time in department's correctional system.

located in San Diego, about 200 miles away. At the time of the on-site inspection, ISP reported having a backlog of five specialty appointments.

The specialty services supervisor reported specialty nurses utilized a tracking tool for completing specialty appointments and retrieving specialists' reports. She discussed experiencing challenges in retrieving specialists' reports from medical centers and hospitals in which ISP staff lacked access to the electronic medical records. ISP staff had to fax requests for specialty reports. To ensure timely provider endorsements, after scanning the specialty reports into the EHRS, specialty staff would message providers to review and sign the reports.

Compliance Score Results

Table 17. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	10	5	0	66.7%
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)	14	0	1	100%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	9	3	3	75.0%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004)	11	4	0	73.3%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	9	2	4	81.8%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	15	0	0	100%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	7	1	7	87.5%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	17	3	0	85.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	4	0	0	100%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	3	1	0	75.0%
				Overall percentage (MIT 14): 84.2%

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

Table 18. Other Tests Related to Specialty Services

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	40	3	2	93.0%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	28	2	15	93.3%

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

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

Recommendations

- Medical leadership should determine the root cause(s) of challenges to the timely provision of high- and medium-priority specialty appointments and should implement remedial measures as appropriate.

Administrative Operations

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

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

Ratings and Results Overview

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

ISP's performance was mixed in this indicator. While ISP scored exceptionally in several applicable tests, it needed improvement in some areas. The EMRRC only intermittently completed the required checklists. In addition, physician managers did not complete all annual performance appraisals in a timely manner, and the nurse educator did not ensure all newly hired nurses received required onboarding training. Lastly, ISP's pharmacy Drug Enforcement Agency (DEA) registration certificate had a six-day renewal lapse during our testing period. These findings are set forth in the table on the next page. Based on the overall **Administrative Operations** compliance score, the OIG rated the compliance testing component of this indicator ***inadequate***.

Compliance Testing Results

Nonscored Results

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

We obtained CCHCS Mortality Case Review reporting data. In our inspection, for two patients, we found no evidence in the submitted documentation indicating the preliminary mortality reports had been completed. These reports were overdue at the time of OIG's inspection (MIT 15.998).

Scored Results

In addition to the above findings, OIG compliance inspectors found the following during our on-site inspection:

- ISP's pharmacy did not maintain a valid Drug Enforcement Agency (DEA) registration certificate during our testing period. As a result, ISP scored zero (MIT 15.109, zero). The renewal had a six-day lapse between November 30, 2023, and December 6, 2023. Upon inquiry, CCHCS reported the following: The delay was due to an improper hand off during a staffing change of the PIC. The outgoing PIC separated on October 9, 2023, and a new pharmacist assumed the PIC positions for both ISP and its neighboring institution, Chuckawalla Valley State Prison (CVSP), on October 10, 2023. The new PIC was instructed to renew the DEA license after filing the required Board of Pharmacy Notification Change of PIC on October 11, 2023. However, the new PIC did not renew the license by the deadline. CCHCS was only notified on December 4, 2023, and they issued emergency guidance. With the assistance of the Pharmacy HQ and Regional office, documentation showed the ISP Pharmacy DEA license renewal was issued on December 6, 2023. At the time of our inspection, the PIC reported medication distribution and administration continued, and the PIC was in constant communication with the Board of Pharmacy. CCHCS reported taking immediate mitigation efforts described above when made aware of the lapse. However, when OIG compliance inspectors asked about documentation of communication, the PIC could not provide any evidence.

Compliance Score Results

Table 19. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	This is a nonscored test. Please refer to the discussion in this indicator.			
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	7	5	0	58.3%
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)	3	0	0	100%
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)	2	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	0	2	1	0
Did the providers maintain valid state medical licenses? (15.106)	11	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)	0	1	0	0
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? Effective 05/2022: Did the Headquarters Mortality Case Review process mortality review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 3 for CCHCS-provided staffing information.			
				Overall percentage (MIT 15): 71.5%

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

Recommendations

The OIG offers no recommendations for this indicator.

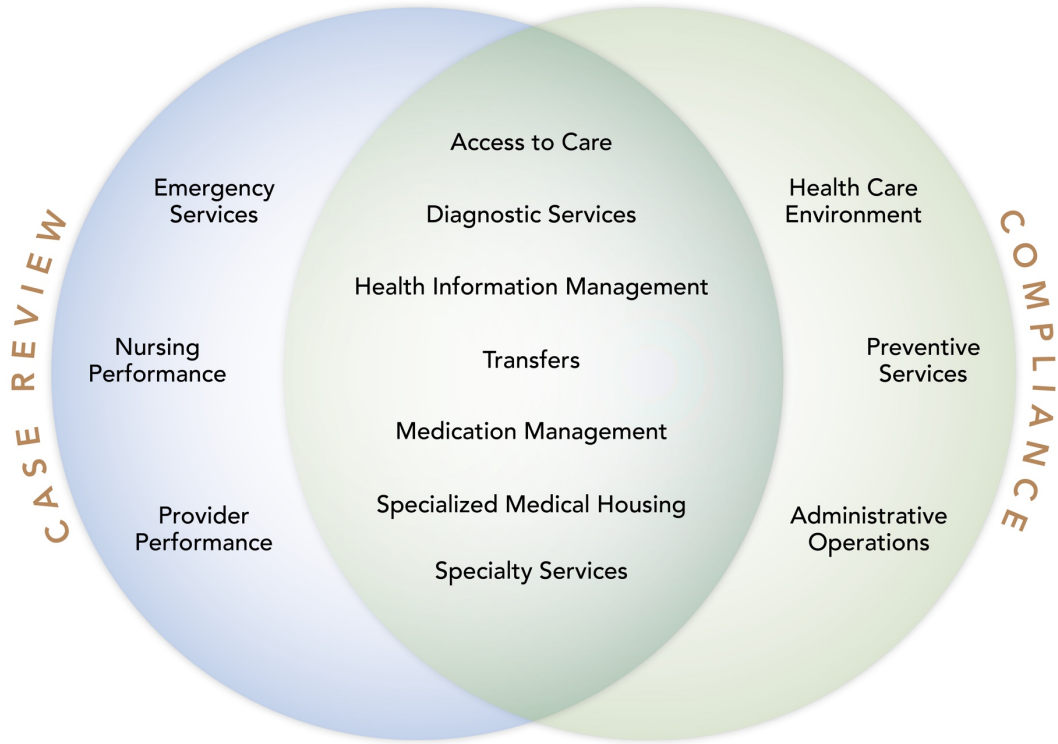
(This page left blank for reproduction purposes.)

Appendix A: Methodology

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

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

Figure A–1. Inspection Indicator Review Distribution for ISP



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

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 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

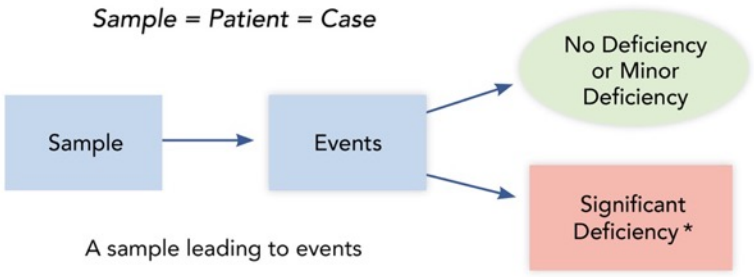
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

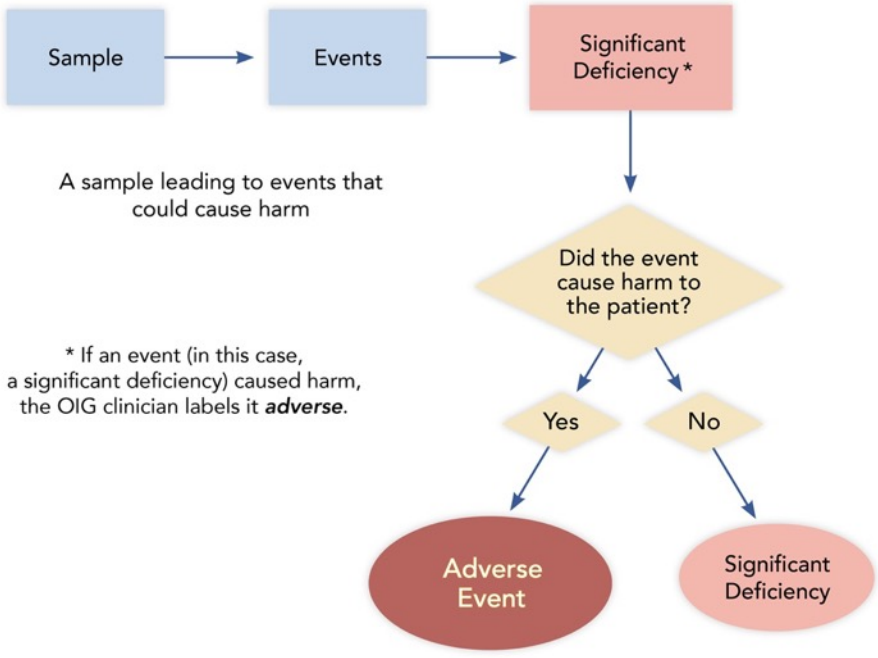
Figure A–2. Case Review Testing

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***.



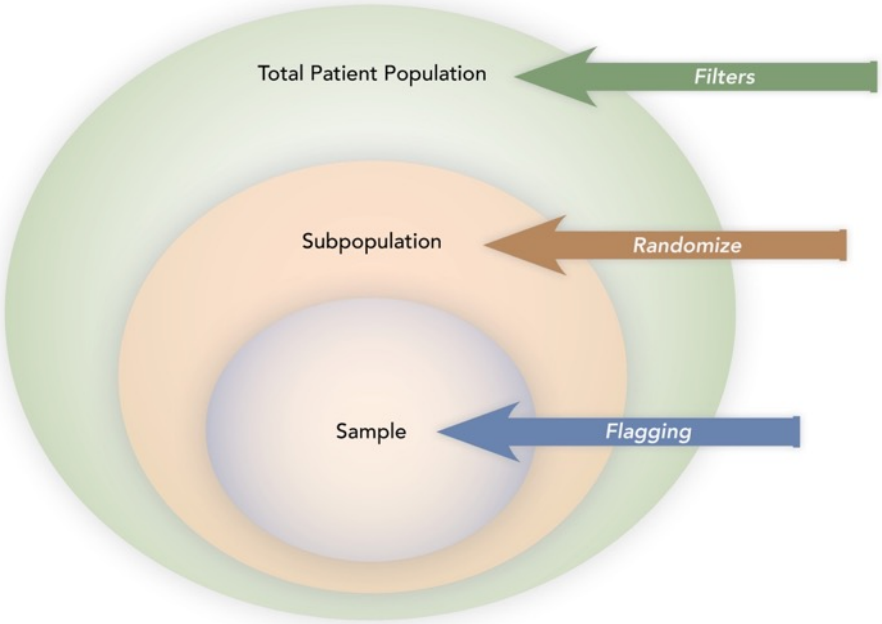
Source: The Office of the Inspector General medical inspection analysis.

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. ISP Case Review Sample Sets

Sample Set	Total
CTC/OHU	3
Death Review/Sentinel Events	1
Diabetes	5
Emergency Services – Non-CPR	2
High Risk	4
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	18
Specialty Services	4
	47

Table B–2. ISP Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	3
Arthritis/Degenerative Joint Disease	7
Asthma	5
COPD	1
COVID-19	3
Cancer	1
Cardiovascular Disease	1
Chronic Kidney Disease	4
Chronic Pain	8
Cirrhosis/End Stage Liver Disease	2
DVT/PE	1
Diabetes	15
Gastroesophageal Reflux Disease	10
Hepatitis C	8
Hyperlipidemia	20
Hypertension	16
Mental Health	4
Rheumatological Disease	1
Seizure Disorder	1
Sleep Apnea	1
Substance Abuse	13
Thyroid Disease	1
	126

Table B–3. ISP Case Review Events by Program

Program	Total
Diagnostic Services	108
Emergency Care	42
Hospitalization	33
Intrasystem Transfers In	6
Intrasystem Transfers Out	6
Outpatient Care	375
Specialized Medical Housing	61
Specialty Services	116
	747

Table B–4. ISP Case Review Sample Summary

	Total
MD Reviews Detailed	20
MD Reviews Focused	3
RN Reviews Detailed	11
RN Reviews Focused	27
Total Reviews	61
Total Unique Cases	47
Overlapping Reviews (MD & RN)	14

(This page left blank for reproduction purposes.)

Appendix C: Compliance Sampling Methodology

Ironwood State Prison

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	23	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC, BMP, or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	0	Quest	• Appt. date (90 days–9 months) • Order name (CBC, BMP, or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	23	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	23	CADDIS off-site admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	10	OIG inspector on-site review	• Identify and inspect all on-site clinical areas
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	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	23	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See Reception Center
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	5	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	10	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	25	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	7	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–007	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–003	Specialized Health Care Housing Unit	10	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	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	20	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	4	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	2	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	3	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	11	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	2	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services mortality reviews

(This page left blank for reproduction purposes.)

California Correctional Health Care Services' Response

Docusign Envelope ID: B1ED6309-B702-4AB7-9956-F20B42E631A9

January 20, 2026

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 Ironwood State Prison conducted by the Office of the Inspector General from June 2024 to November 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
3B7F6B95AC0A4D1...

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
Sarah Hartmann, 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
Rainbow Brockenborough, Deputy Director, Institution Operations, CCHCS
Robin Hart, Associate Director, Risk Management Branch, CCHCS
Regional Executives, Region (XX), CCHCS
Chief Executive Officer, INST
Heather Pool, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
Amanda Elhardt, Report Coordinator, OIG

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

Cycle 7

Medical Inspection Report

for

Ironwood State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
January 2026

OIG