

March 18, 2015

Raymond Smith, Warden
Desert View Modified Community Correctional Facility
10450 Rancho Rd
Adelanto, CA, 92301

Warden Smith:

During the week of February 2 through 3, 2015, the Private Prison Compliance and Monitoring Unit (PPCMU) staff and Nursing Services staff conducted a compliance review audit at the Desert View Modified Community Correctional Facility (DVMCCF). Enclosed is the final report for your review. The purpose of this audit is to ensure that DVMCCF is consistent in meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006.

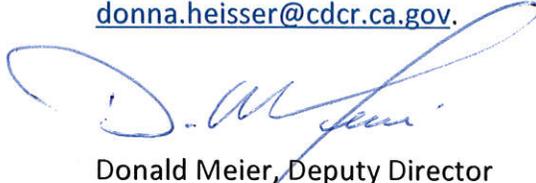
Attached you will find the audit report in which DVMCCF received an overall compliance rating of **84.4%**. The report contains an executive summary, an explanation of the methodology behind the audit, findings detailed by chapters of the *Contract Facility Health Care Monitoring Audit instrument* and a corrective action plan (CAP). Please submit a CAP, as detailed in the attached report, to Christopher Troughton, Health Program Specialist I (HPS I), PPCMU, Field Operations, Corrections Services, via email at Christopher.troughton@cdcr.c.gov within 30 days of the date of this letter.

The audit findings reveal that DVMCCF is struggling to provide adequate health care to CDCR inmate-patients that are housed at this facility, meeting Inmate Medical Services Policies and Procedures standard as it related to the deficient areas identified below.

- Access to Health Care
- Continuous Quality Improvement (repeat finding)
- Medical Emergency Services/Drills
- Medical Emergency Equipment
- Monitoring Logs
- Specialty/Hospital Services

PPCMU recommends that DVMCCF work diligently to improve the quality of medical services being provided to the CDCR inmate-patients. The deficient areas can be brought to compliance only by the facility's strict adherence to the established policy and procedures as outlined in the contract.

Thank you for your assistance and please extend my gratitude to your staff for their professionalism and cooperation during this audit. Should you have any questions or concerns, you may contact Donna Heisser, Health Program Manager II, PPCMU, Field Operations, Corrections Services, CCHCS, at (916) 691-4849 or via email at donna.heisser@cdcr.ca.gov.



Donald Meier, Deputy Director
Field Operations, Corrections Services
California Correctional Health Care Services

Enclosures

cc: Richard Kirkland, Chief Deputy Receiver, CCHCS
Diana Toche, Undersecretary, Health Care Services, California Department of Corrections and Rehabilitation (CDCR)
R. Steven Tharratt, M.D., M.P.V.M., F.A.C.P., Director, Health Care Operations, CCHCS
John Dovey, Director, Corrections Services, CCHCS
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Grace Song, M.D. Physician Advisor, Central Region, Utilization Management, CCHCS
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Catherine Murdoch, Correctional Administrator (A), Field Operations, Corrections Services, CCHCS
Patricia Matranga, R.N., Nursing Services, CCHCS
Donna Heisser, Health Program Manager II, PPCMU, Field Operations, Corrections Services, CCHCS
Christopher Troughton, Health Program Specialist I (HPS I), PPCMU, Field Operations, Corrections Services, CCHCS
Vera Lastosvkiy, HPS I, PPCMU, Field Operations, Corrections Services, CCHCS





CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Contract Facility
Health Care Monitoring Audit



Desert View
Modified Community Correctional Facility

February 2 – 3, 2015

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DATE OF REPORT

March 18, 2015

INTRODUCTION

As a result of an increasing inmate population and a limited capacity to house inmates, the California Department of Corrections and Rehabilitation (CDCR) entered into contractual agreements with private prison vendors to house California inmates. Although these inmates are housed in a contracted facility, either in or out-of-state, the California Correctional Health Care Services (CCHCS) is responsible to ensure health care standards equivalent to California's regulations, CCHCS's policy and procedure, and court ordered mandates are provided.

As one of several means to ensure the prescribed health care standards are provided, CCHCS staff developed a tool to evaluate and monitor the delivery of health care services provided at the contracted facility through a standardized audit process. This process consists of a review of various documents obtained from the facility; including medical records, monitoring reports, staffing rosters, Disability Placement Program (DPP) list, and other relevant health care documents, as well as an onsite assessment involving staff and inmate interviews and a tour of all health care services points within the facility.

This report provides the findings associated with the audit conducted on February 2 through 3, 2015, at Desert View Modified Community Correctional Facility (DVMCCF) which is located in Adelanto, California. At the time of the audit, CDCR's *Weekly Population Count*, dated January 30, 2015, indicated that DVMCCF had a design capacity of 700 beds, of which 647 were occupied with CDCR inmates.

EXECUTIVE SUMMARY

From February 2 through 3, 2015, the Private Prison Compliance and Monitoring Unit (PPCMU) audit team conducted a health care monitoring audit at DVMCCF. The audit team consisted of the following personnel:

Grace Song, Medical Doctor, Regional Physician Advisor
Patty Matranga, Registered Nurse
Christopher Troughton, Health Program Specialist I (HPS I)
Vera Lastovskiy, HPS I

The audit included two primary components: a *quantitative* analysis of established performance measures, and a *qualitative* analysis of operational processes. The end product of the quantitative portion of the audit is a compliance percentage, while the end product of the qualitative analysis is a narrative summary of findings.

Table 1 on the following page illustrates the overall compliance rating achieved during this audit, as well as how the ratings are calculated. The overall rating represents the percentage of the total points awarded out of the total points possible. Points are awarded in three categories; Administration, Delivery, and Operations, which are broken down further into the individual chapters of the audit.

Based on the quantitative portion of this audit, DVMCCF achieved an overall compliance rating of **84.4%** with a rating of 79.3% in Administration, 81.3% in Delivery, and 96.5% in Operations. Comparatively speaking, for the previous audit conducted on August 5 through 6, 2014, the overall quantitative score for DVMCCF was 88.8%, indicating a decline of 4.4 percentage points. Table 2 on the following page provides a comparative overview of facility's performance during the initial and follow-up audits, as well as a trend measurement to show improvement, decline, or sustainability.

The completed quantitative audit, summary of qualitative findings, and Corrective Action Plan (CAP) request are attached for your review.

Table 1.

Quantitative Compliance Ratings	Points Possible	Points Awarded	Score	CAP Required
Administration				
1. Administration	180.0	180.0	100.0%	No
2. Access to Health Care Information	80.0	47.5	59.4%	Yes
6. Continuous Quality Improvement (CQI)	60.0	50.0	83.3%	Yes
13. Licensure and Training	160.0	160.0	100.0%	No
15. Monitoring Logs	150.0	43.1	28.7%	Yes
20. Staffing	90.0	90.0	100.0%	No
Administration Sub Score:	720.0	570.6	79.3%	
Delivery				
5. Chronic Care	60.0	60.0	100.0%	No
7. Diagnostic Services	120.0	102.5	85.4%	No
8. Medical Emergency Services/Drills	270.0	217.5	80.6%	Yes
9. Medical Emergency Equipment	290.0	163.9	56.5%	Yes
14. Medication Management	150.0	142.5	95.0%	No
17. Patient Refusal of Medical Treatment	20.0	20.0	100.0%	No
18. Sick Call	260.0	247.1	95.0%	No
19. Specialty/Hospital Services	150.0	120.0	80.0%	Yes
Delivery Sub-Score:	1,320.0	1,073.5	81.3%	
Operations				
3. ADA Compliance	60.0	60.0	100.0%	No
4. Chemical Agent Exposure	20.0	20.0	100.0%	No
10. Grievance/Appeal Procedure	50.0	47.5	95.0%	No
11. Infection Control	160.0	160.0	100.0%	No
12. Initial Intake Screening/Health Appraisal	360.0	340.0	94.4%	No
16. Observation Unit	N/A	N/A	N/A	N/A
Operations Sub-Score:	650.0	627.5	96.5%	
21. Inmate Interviews (not rated)				
Final Score: 2,690.0 2,271.6 84.4%				

NOTE: For specific information regarding any non-compliance findings indicated in the chart above, please refer to the CAP request (located on page 8 of this report), or to the detailed quantitative findings (located on page 10).

Table 2.

Quantitative Performance Comparison	Audit I 8/2014	Audit II 2/2015	Variance Increase/(Decrease)
1. Administration	100.0%	100.0%	0.0%
2. Access to Health Care Information	100.0%	59.4%	-40.6%
3. ADA Compliance	100.0%	100.0%	0.0%
4. Chemical Agent Exposure	0.0%	100.0%	100.0%
5. Chronic Care	87.5%	100.0%	12.5%
6. Continuous Quality Imprvement (CQI)	0.0%	83.3%	83.3%
7. Diagnostic Services	83.9%	85.4%	1.5%
8. Medical Emergency Services/Drills	100.0%	80.6%	-19.4%
9. Medical Emergency Equipment	98.4%	56.5%	-41.9%
10. Grievance/Appeal Procedure	82.0%	95.0%	13.0%
11. Infection Control	100.0%	100.0%	0.0%
12. Initial Intake Screening/Health Appraisal	100.0%	94.4%	-5.6%
13. Licensure and Training	100.0%	100.0%	0.0%
14. Medication Management	85.0%	95.0%	10.0%
15. Monitoring Logs	20.0%	28.7%	8.7%
16. Observation Unit	N/A	N/A	N/A
17. Patient Refusal of Health Care Treatment/ No Show	93.4%	100.0%	6.6%
18. Sick Call	95.4%	95.0%	-0.4%
19. Specialty/Hospital Services	50.0%	80.0%	30.0%
	100.0%	100.0%	0.0%
Overall Score:	88.8%	84.4%	-4.4%

METHODOLOGY

The audit incorporates both *quantitative* and *qualitative* analyses.

The *quantitative* analysis uses a standardized audit instrument, which measures compliance against established standards at each facility. The audit instrument calculates an overall percentage score, as well as similar individual ratings for each chapter of the instrument. Additionally, a brief narrative is provided addressing each standard being measured which received less than a 100% compliance rating.

The *qualitative* portion of the audit evaluates areas of clinical access and the provision of clinically appropriate care which tends to defy numeric definition, but which nonetheless have a potentially significant impact on performance. Some examples of such areas are collaboration between entities, and efficiency of processes. This portion of the audit is primarily accomplished via interviews of key facility personnel, which also includes medical staff for the overall purpose of identifying staffing practices which may be adversely affecting clinical performance. The overall end product of the qualitative analysis is a summary of qualitative findings, which identifies any areas of concern, as well as any available data supporting the concern(s).

The audit utilizes the Inmate Medical Services Policies and Procedures (IMSP&P) as a means to identify a standard from which to measure health care delivery at contracted facilities. The audit consists of 20 chapters to gauge performance within the facility. Target performance benchmark for clinical access and the provision of clinically appropriate care are defined as follows:

- 85% for each chapter within the audit instrument.

Compliance and non-compliance are defined as follows:

- Compliance - the facility is fully meeting the requirement.
- Non-compliance - the facility is *not* fully meeting the requirement.

The methodology utilized by the audit team for determining compliance with each standard measure in the audit is described in detail in the *Instruction Guide for the Contracted Facilities Health Care Monitoring Audit*.

The scoring of each standard contained within the audit is weighted according to potential severity of impact should the facility be found out of compliance with the standard. The scoring standards are as follows:

Point Value	Weighting Criteria
50.0	Failing to meet the requirement poses <i>the greatest</i> medical risk to inmate-patients.
30.0	Failing to meet the requirement poses a <i>moderate</i> medical risk to inmate-patients.
10.0	Failing to meet the requirement poses <i>minimal</i> medical risk to inmate-patients.

At the conclusion of the audit, a compliance value is assigned to each question based on the data gathered during the audit. That value is expressed as a percentage. The total points possible for a given question is then multiplied by the percentage of compliance to yield the total points awarded. The final scores for each question and the compliance value percentages are rounded to the nearest tenth. For example, for a question valued at 50.0 total possible points, where the compliance rating is 96.0%, the resultant score for that question becomes $50.0 \times 0.96 = 48.0$ points.

The full point value is awarded only in cases of 100% compliance. Any questions for which the facility demonstrates compliance of less than 100% are assigned partial compliance scores by the method shown above.

Chapter scores are calculated by dividing the total points assessed in each chapter by the total points possible for that chapter, and multiplying by 100 to yield an overall percentage. For example, a chapter with 10 questions may have a total of 180.0 possible points. If during an audit a facility earns 140.0 of those points, the chapter score will be calculated as follows: $140.0 \div 180.0 = 0.777 \times 100 = 77.8\%$.

A CAP will be required for all deficiencies within any chapter with a final score below 85.0%, as well as for qualitative concerns which rise to a level at which they are tangibly affecting clinical performance.

The 20 ratable chapters of the *Contract Facility Health Care Monitoring Audit* have been categorized into three major operational areas: administration, delivery, and operations. These overall operational areas are sub-totaled, and sub-scored, on the Qualitative Analysis Findings section of the final report. This is provided for the informational benefit of the facility. As with individual chapter scores, the compliance percentage for each operational area is calculated by dividing the total points earned by the total points available in that area, and multiplying by 100 to yield a percentage. The final overall quantitative score is calculated by the same method.

Scoring for Non-Applicable Questions and Double-Failures:

For questions that are not applicable to the facility being audited, or where a single deviation from policy would result in multiple question failures, the weighted values of such questions are subtracted from the applicable points for the component.

CORRECTIVE ACTION PLAN REQUEST

The chart below reflects all quantitative analysis items where the facility was rated non-compliant, as well as any qualitative analysis items requiring a response from the facility. The audit results for DVMCCF require the facility to develop a CAP for the following specific items. The facility's response must be received no later than 30 days from the date of this report; specifically **April 17, 2015**.

Corrective Action Items – Desert View Modified Community Correctional Facility	
Chapter 2, Question 1	The Primary Care Provider (PCP) is not maintaining access to eUHR.
Chapter 2, Question 5	Inmate-patients' written requests for Release of Health Care Information (ROI) is not being consistently documented on the CDCR 7385, <i>Authorization for Release of Information</i> form or similar form.
Chapter 2, Question 7	ROI requests are not consistently being filed in the in the Medico-Legal section of the inmate-patients' shadow medical file.
Chapter 2, Question 8	Inmate-patients ROI requests are not consistently documented on a progress note.
Chapter 6, Question 6	Action and follow-up plans for opportunities for improvement that have been identified in the Continuous Quality Improvement (CQI) meeting minutes are not consistently documented.
Chapter 8, Question 4	The RN is not documenting the review of the inmate-patient's discharge plan upon the inmate-patient's return from a community hospital emergency department.
Chapter 8, Question 5	The RN is not consistently documenting the face-to-face evaluation upon the inmate-patient's return from a community hospital emergency department.
Chapter 9, Question 1	The RN is not consistently documenting the inspection of the Emergency Medical Response bag to ensure it is secured with a seal on each shift.
Chapter 9, Question 4	The RN is not consistently documenting the inspection of the Portable suction on each shift for operational readiness.
Chapter 9, Question 6	The RN is not consistently documenting the inspection of the oxygen tank on each shift for operational readiness.
Chapter 9, Question 8	The RN is not consistently documenting the inspection of the Automated External Defibrillator (AED) on each shift for operational readiness.
Chapter 9, Question 11	Spill kits are not located in all designated areas at the facility.
Chapter 15, Question 1	Inmate-patients are not being seen within the timeframes set forth in the sick call policy.
Chapter 15, Question 2	Inmate-patients are not being seen within the timeframes set forth in the specialty care policy.
Chapter 15, Question 3	Inmate-patients are not being seen within the timeframes set forth in the emergency/hospital services policy.
Chapter 15, Question 5	Inmate-patients are not consistently being seen within the timeframes set forth in the initial intake screening/health care appraisal policy.

Chapter 19, Question 6	The PCP does not review the consultant's report and have a follow-up appointment with the inmate-patients within the specified timeframe, upon their return from a specialty care appointment.
*Qualitative Action Item #1 (Chapter 7, Question 2)	The PCP does not consistently review, initial and date all inmate-patient diagnostic reports within the specified timeframe.
*Qualitative Action Item #2 (Chapter 7, Question 4)	Inmate-patients are not consistently receiving written notification of diagnostic test results within the specified timeframe.
*Qualitative Action Item #3 (Chapter 10, Question 2)	The facility does not have the CDCR Forms 602 HC, <i>Patient-Inmate Health Care Appeal forms available</i> in all housing units.
*Qualitative Action Item #4 (Chapter 12, Question 11)	The PCP is not consistently documenting the health appraisal/H&P on the intake H&P form, CDCR 196B.
*Qualitative Action Item #5 (Chapter 14, Question 1)	Medications are not consistently being administered to the inmate-patients within the specified timeframe.
*Qualitative Action Item #6 (Chapter 18, Question 7)	Inmate-patients are not consistently being seen within the specified timeframes when referred to the hub or MCCF PCP by the MCCF RN.

* Qualitative action items 1 through 6 are failed questions within passing (85% or higher) quantitative chapters.

QUANTITATIVE FINDINGS - DETAILED BY CHAPTER

<i>Chapter 1: Administration</i>	Point Value	Points Awarded
1. Does all health care staff have access to the contractor's health care policies and procedures?	10.0	10.0
2. Does all health care staff have access to health care operational procedures?	10.0	10.0
3. Do health care staff know where and how to access the contractor's health care policies and procedures and health care operational procedures?	10.0	10.0
4. Does the facility have a written policy and/or procedure related to the maintenance/management of the Unit Health Records (UHR)?	10.0	10.0
5. Does the facility have a written policy that addresses the requirements for the release of medical information?	10.0	10.0
6. Does the facility have a written policy and/or procedure related to the Chemical Agent/Use of Force process?	10.0	10.0
7. Does the Chemical Agent/Use of Force policy and/or procedure contain a decontamination process?	10.0	10.0
8. Does the facility have a written policy and/or procedure related to Chronic Care?	10.0	10.0
9. Does the facility have a written policy and/or procedure related to Health Screening?	10.0	10.0
10. Does the facility have a written policy and/or procedure related to the History and Physical (H&P) examination?	10.0	10.0
11. Does the facility have a written policy and/or procedure related to medication management?	10.0	10.0
12. Does the facility have a written policy and/or procedure related to the sick call process?	10.0	10.0
13. Does the facility have a written policy and/or procedure related to specialty services?	10.0	10.0
14. Does the facility have a written policy and/or procedure related to ADA?	10.0	10.0
15. Does the facility have an Infection Control Plan?	10.0	10.0
16. Does the facility have a written policy and/or procedure related to Bloodborne Pathogen Exposure?	10.0	10.0
17. Does the facility have a written policy and/or procedure related to licensure and training?	10.0	10.0
18. Does the facility have a written policy and/or procedure related to Emergency Services?	10.0	10.0
Point Totals:	180.0	180.0
Final Score:		100%

CHAPTER 1 COMMENTS

None.

<i>Chapter 2: Access to Health Care Information</i>	Point Value	Points Awarded
1. Does the treating physician have access to the inmate-patient's CCHCS Electronic Unit Health Record (eUHR)?	10.0	0.0
2. Are loose documents filed and scanned into the health record daily?	10.0	10.0
3. Does the facility have and maintain a Release of Information (ROI) log?	10.0	10.0
4. Does the ROI log contain all required information?	10.0	10.0

5. Are all inmate-patient's written requests for Release of Health Care Information documented on the CDCR 7385, <i>Authorization for Release of Information</i> , form or similar form?	10.0	2.5
6. Are all written requests from inmate-patients documented on a ROI log?	10.0	10.0
7. Are all inmate-patient's written requests for health care information filed in the MCCF's shadow file and in the Medico-Legal or miscellaneous section of the eUHR?	10.0	2.5
8. Are all inmate-patient's written requests for release of health care information noted in a progress note in the MCCF's shadow file in the eUHR?	10.0	2.5
9. Are all written requests for release of health care information from a third party accompanied by a valid CDCR 7385, <i>Authorization for Release of Information</i> , form or similar form?	10.0	N/A
10. Are all written requests from third parties documented on a ROI log?	10.0	N/A
11. Are all written requests for release of health care information from a third party filed in the MCCF's shadow file and in the Medico-Legal or Miscellaneous section of the eUHR?	10.0	N/A
Point Totals:	110.0	47.5 (80.0)
Final Score:		59.4%

CHAPTER 2 COMMENTS

1. Question 1 – The PCP was granted eUHR access, but did not maintain her access by logging into the eUHR at least once every thirty days, which is a system requirement to maintain the user's account active. This equates to 0.0% compliance. This is a significant decline from the previous audit score of 100% compliance.
2. Question 5 – Out of eight inmate-patient ROI requests received during the audit review period, two requests were documented on the CDCR 7385, *Authorization for Release of Information*. This equates to 25.0% compliance. This is a significant decline from the previous audit score of 100% compliance.
3. Question 7 – Out of eight inmate-patient ROI requests received during the audit review period, only two requests were noted in the Medico-Legal section of the shadow medical file. This equates to 25.0% compliance. This is a significant decline from the previous audit score of 100% compliance.
4. Question 8 – Out of eight inmate-patient ROI requests received during the audit review period, only two requests were noted on progress notes, which were observed in the shadow medical file. This equates to 25.0% compliance. This is a significant decline from the previous audit score of 100% compliance.
5. Questions 9 through 11 – There were no third party requests for release of information received by the facility during the audit review period.

<i>Chapter 3: ADA Compliance</i>	Point Value	Points Awarded
1. Is there a local operating procedure to track and monitor Disability Placement Program (DPP) inmate-patients and their accommodation(s) to ensure the needs of disabled inmate-patients are being addressed?	10.0	10.0
2. Is there a local operating procedure for tracking the provision of health care appliances for all DPP inmate-patients to ensure health care appliances are provided in a timely manner?	10.0	10.0
3. Is there a local operating procedure for tracking the repair of health care appliances for all DPP inmate-patients to ensure health care appliances are provided in a timely manner?	10.0	10.0
4. Is there a local operating procedure to provide an interim accommodation while an appliance is ordered, repaired, or in the process of being replaced?	10.0	10.0

5. Is there a local operating procedure explaining how the facility adds or removes an inmate-patient from the DPP list?	10.0	10.0
6. Is there a local operating procedure explaining how the facility ensures and documents the establishment of effective communication between health care staff and an inmate-patient during each clinical encounter?	10.0	10.0
Point Totals:	60.0	60.0
Final Score:		100%

CHAPTER 3 COMMENTS

None.

<i>Chapter 4: Chemical Agent Exposure</i>	Point Value	Points Awarded
1. In the event of Chemical Agent Exposure, if an inmate-patient refuses decontamination, did the facility staff document that he/she was given direction on how to self-decontaminate?	10.0	10.0
2. In the event of Chemical Agent Exposure, if an inmate-patient refuses decontamination, did the health care staff monitor the inmate-patient every 15 minutes for a minimum of 45 minutes?	10.0	10.0
Point Totals:	20.0	20.0
Final Score:		100%

CHAPTER 4 COMMENTS

None.

<i>Chapter 5: Chronic Care</i>	Point Value	Points Awarded
1. Was the inmate-patient's chronic care follow-up visit completed within the 90-day or less timeframe, or as ordered by the LIP?	30.0	30.0
2. Did the PCP provide health care education to inmate-patients regarding their chronic care condition during the last Chronic Care Clinic (CCC) follow-up visit?	30.0	30.0
3. If an inmate-patient refuses CCC services, is a Refusal of Treatment form completed?	30.0	N/A
4. If an inmate-patient refuses CCC services, is the inmate-patient referred to the PCP?	30.0	N/A
Point Totals:	120.0	60.0 (60.0)
Final Score:		100%

CHAPTER 5 COMMENTS

- Questions 3 and 4 – Not applicable. There were no documented instances of inmate-patients refusing a chronic care appointment during the audit review period. Therefore these questions were not evaluated.

<i>Chapter 6: Continuous Quality Improvement (CQI)</i>	Point Value	Points Awarded
1. Does the facility have an approved CQI Plan?	10.0	10.0

2. Does the facility CQI Committee ensure a quorum is established per the approved CQI Plan?	10.0	10.0
3. Is there documentation to support the CQI Committee meets at least quarterly?	10.0	10.0
4. Does the documentation of the CQI monitoring activity include the <i>Aspects of Care Monitoring</i> form, or similar form?	10.0	10.0
5. Does the facility complete an analysis for each identified "opportunity for improvement" as listed on the <i>Aspects of Care Monitoring</i> form, or similar form?	10.0	10.0
6. Is there a documented action and follow-up plan for each identified "opportunity for improvement"?	10.0	0.0
Point Totals:	60.0	50.0
Final Score:		83.3%

CHAPTER 6 COMMENTS

1. Question 6 – The CQI meeting minutes from the January 13, 2015 CQI meeting did not contain any documentation for the identified opportunities for improvement, which were identified at the October 8, 2014 CQI meeting. This equates to 0.0% compliance

<i>Chapter 7: Diagnostic Services</i>	Point Value	Points Awarded
1. Was the diagnostic test provided to the inmate-patient within the timeframe specified by the LIP?	30.0	30.0
2. Does the PCP review, initial, and date an inmate-patient's diagnostic reports within two days of receipt?	30.0	22.5
3. Was the inmate-patient seen by a PCP for a follow-up visit for a clinically significant diagnostic test result within 14 days, or as clinically indicated, from the date the test results were reviewed by the PCP?	30.0	30.0
4. Was the inmate-patient given written notification of the diagnostic test results within two days of receipt?	30.0	20.0
Point Totals:	120.0	102.5
Final Score:		85.4%

CHAPTER 7 COMMENTS

1. Question 2 – Of the four inmate-patients with diagnostic test orders, three inmate-patients' diagnostic reports were reviewed, initialed and dated by the PCP within two days of receipt. This equates to 75.0% compliance. This is a slight increase from the previous audit score of 50% compliance. However, this question remains a CAP item from the previous audit.
2. Question 4 –Of the three inmate-patients with diagnostic tests ordered, two inmate-patients received their diagnostic test results within the specified timeframe. This equates to 66.7% compliance. This is a decline from the previous audit score of 85.7% compliance.

<i>Chapter 8: Medical Emergency Services/Drills</i>	Point Value	Points Awarded
1. Does the facility have a current Medical Emergency Response procedure?	10.0	10.0
2. Does the facility's local operating procedure pertaining to medical emergencies/response contain instructions on how to communicate, respond, and transport inmate-patients during medical emergencies?	30.0	30.0

3. Does the facility's local operating procedure contain instructions on how to obtain Emergency Medical Services (EMS) transportation 24 hours a day, seven days a week?	30.0	30.0
4. When an inmate-patient returns from a community hospital emergency department, does an RN document their review of the inmate-patient's discharge plan?	30.0	0.0
5. When an inmate-patient returns from a community hospital emergency department, does an RN document the completion of a face-to-face evaluation of the inmate-patient?	30.0	7.5
6. When an inmate-patient returns from a community hospital emergency department, does the inmate-patient receive a follow-up appointment with a PCP within five calendar days of discharge, or sooner as clinically indicated, from the day of discharge?	30.0	30.0
7. Is there documentation that the Emergency Response Review Committee has met at least once a month?	10.0	10.0
8. In the documentation of the Emergency Response Review Committee meetings, does the committee discuss and/or implement a quality improvement action after reviewing the results of an emergency medical response and/or emergency medical response drill?	10.0	10.0
9. Does the facility conduct quarterly emergency medical response (man-down) drills on each shift?	30.0	30.0
10. During emergency medical response and/or drills, is a Basic Life Support (BLS) certified staff member on-site within four minutes of the emergency medical alarm?	30.0	30.0
11. During emergency medical response and/or drills, is an Advanced Cardiac Life Support (ACLS) certified health care staff member providing treatment within eight minutes of the emergency medical alarm?	30.0	30.0
Point Totals:	270.0	217.5
Final Score:	80.6%	

CHAPTER 8 COMMENTS

1. Question 4 – Of the four inmate-patients who returned from a community hospital emergency visit, none of the inmate-patients' discharge plans were reviewed by the facility RN upon their return to the facility. This equates to 0.0% compliance. This is a significant decline from the previous audit score of 100% compliance.
2. Question 5 –Of the four inmate-patients who returned from a community hospital emergency visit, only one inmate-patient received a face-to-face evaluation by the RN upon their return to the facility. This equates to 25.0% compliance. This is a significant decline from the previous audit score of 100% compliance.

<i>Chapter 9: Medical Emergency Equipment</i>	Point Value	Points Awarded
1. For each shift, do staff document that all Emergency Medical Response Bags in each clinic are secured with a seal?	30.0	0.0
2. Is there documentation, after each medical emergency, that all Emergency Medical Response Bags in each clinic are re-supplied and re-sealed?	30.0	N/A
3. Does the facility have functional Portable suction?	50.0	50.0
4. Is there documentation that the Portable suction in each clinic is checked every shift for operational readiness?	30.0	0.0
5. Does the facility have oxygen tanks?	50.0	50.0
6. Is there documentation that the oxygen tanks in each clinic is checked every shift for operational readiness (at least three-quarters full)?	30.0	0.0
7. Does the facility have a contract for routine oxygen tank maintenance service?	30.0	30.0
8. Is there documentation that the Automated External Defibrillator (AED) in each clinic is checked every shift for operational readiness?	30.0	0.0

9. Are first aid kits located in designated areas?	10.0	9.3
10. Do the first aid kits contain all required items?	10.0	9.3
11. Are spill kits located in the designated areas?	10.0	5.3
12. Do the spill kits contain all required items?	10.0	10.0
Point Totals:	320.0	163.9 (290.0)
Final Score:		56.5%

CHAPTER 9 COMMENTS

1. Question 1 - The facility did not have documentation showing that the Emergency Medical Response Bag was inspected on each shift. This equates to 0.0% compliance. This is a significant decline from the previous audit score of 100% compliance.
2. Question 2 – Not applicable. This facility has not had any medical emergencies since the previous audit; therefore this question was not evaluated.
3. Question 4 – The facility did not have documentation showing that the Portable suction was inspected on each shift. This equates to 0.0% compliance. This is a significant decline from the previous audit score of 100% compliance.
4. Question 6 – The facility did not have documentation showing that the oxygen tank was inspected for operational readiness on each shift. This equates to 0.0% compliance. This is a significant decline from the previous audit score of 100% compliance.
5. Question 8 – The facility did not have documentation showing that the AED was inspected for operational readiness on each shift. This equates to 0.0% compliance. This is a significant decline from the previous audit score of 100% compliance.
6. Question 9 – Of the 15 areas where first aid kits are required, 14 areas were observed to have first aid kits. This equates to 93.3% compliance. This is a slight decrease from the previous audit score of 100% compliance.
7. Question 10 – Of the 14 first aid kits inspected, 13 contained all the required items. The first aid kit in the reception control room did not have tape. This equates to 92.9% compliance. This is a slight decline from the previous audit score of 100% compliance.
8. Question 11 – Out of 15 designated areas where spill kits are required, spill kits were observed in eight of those areas.. This equates to 53.3% compliance. This is a slight increase from the previous audit score of 50.0% compliance. This question remains a CAP item from the previous audit.

<i>Chapter 10: Grievance/Appeal Procedure</i>	Point Value	Points Awarded
1. Does the inmate-patient handbook or similar document explain the grievance/appeal process?	10.0	10.0
2. Is CDCR Forms 602 HC, <i>Patient-Inmate Health Care Appeal</i> , readily available to inmate-patients while housed in all housing units?	10.0	7.5
3. Are inmate-patients able to submit the CDCR-602 HC forms on a daily basis in secured/locked boxes in all housing units?	10.0	10.0
4. Are the First Level Health Care Appeals being processed within specified timeframes?	10.0	10.0

5. Does the Appeals Coordinator log all screened/rejected appeals?	10.0	10.0
Point Totals:	50.0	47.5
Final Score:		95.0%

CHAPTER 10 COMMENTS

- Question 2 – Out of eight housing units checked, six housing units had a sufficient supply of the CDCR Form 602 HC, *Patient-Inmate Health Care Appeal* forms available. This equates to 75.0% compliance. This is a significant decline from the previous audit score of 100% compliance.

<i>Chapter 11: Infection Control</i>	Point Value	Points Awarded
1. Are disposable instruments discarded after one use?	10.0	10.0
2. Are inmate-patients who come to the clinic with a potential communicable disease isolated from the rest of the inmate-patients in the clinic area?	10.0	10.0
3. Does the staff practice hand hygiene?	30.0	30.0
4. Is personal protective equipment (PPE) (i.e. gloves, masks, face shields, gowns, etc.) available for staff use?	10.0	10.0
5. Does the facility have hand sanitizers which are maintained and available for staff use?	10.0	10.0
6. Is the inmate-patient clinic area cleaned after each inmate-patient use?	10.0	10.0
7. Is environmental cleaning of "high touch surfaces" completed within the medical clinic at least once a day?	10.0	10.0
8. Are biohazard materials placed in biohazard material labeled containers?	10.0	10.0
9. Are biohazard material containers picked up from the central storage location on a regularly scheduled basis?	10.0	10.0
10. Is the central storage area for biohazard materials labeled and locked?	10.0	10.0
11. Are sharps placed into a puncture resistant, leak-proof container that is closeable, locked, and labeled with the biohazard symbol?	10.0	10.0
12. Does the facility account for all sharps (needles, scalpels, etc.) by documenting the number at the end of each shift?	10.0	10.0
13. Does the facility have a process to reconcile the sharp count if needed?	10.0	10.0
14. Does the facility secure sharps?	10.0	10.0
Point Totals:	160.0	160.0
Final Score:		100%

CHAPTER 11 COMMENTS

None.

<i>Chapter 12: Initial Intake Screening/Health Appraisal</i>	Point Value	Points Awarded
1. Did the inmate-patient receive an Initial Intake Screening upon arrival at the facility by licensed health care staff?	30.0	30.0
2. Did the inmate-patient receive a complete H&P exam by a P&P14 calendar days of arrival at the facility?	30.0	30.0
3. If an inmate-patient was referred to a PCP by nursing staff during the Initial Intake Screening, was the inmate-patient seen in the specified timeframe? (Immediately, within 24 hours, or within 72 hours)	30.0	30.0

4. Was the inmate-patient who presented with an urgent medical, dental or mental health symptoms upon arrival given an immediate referral to appropriate health care professionals for emergency care, prescription management, or modality authorization?	30.0	N/A
5. If an inmate-patient presents with medical, dental, or mental health symptoms upon arrival does the nurse contact the Hub?	30.0	N/A
6. If an inmate-patient was referred for a follow-up medical, dental, or mental health appointment, was the appointment completed?	30.0	30.0
7. Does the MCCF RN compare the medication profile received from the sending facility/institution with the medications the inmate-patient arrived with?	30.0	30.0
8. Did the nurse identify current prescription medication orders and have the medication re-ordered within 8 hours of arrival or was the inmate-patient seen by a PCP within 24 hours of arrival?	30.0	30.0
9. Does the MCCF RN consult with the Hub RN and/or specialty services schedulers to ensure the inmate-patient does or does not have any pending medical appointment?	30.0	30.0
10. Did the MCCF RN sign and date the CDCR 7371, Health Care Transfer Information form?	30.0	30.0
11. Did the PCP document the health appraisal/H&P on the intake H&P form, CDCR 196B?	30.0	10.0
12. At the initial intake screening, did all inmate-patients receive orientation regarding the procedures for accessing health care?	30.0	30.0
13. Did the inmate-patient receive a complete screening for the signs and symptoms of Tuberculosis (TB) upon arrival?	30.0	30.0
14. Did the inmate-patient receive a Tuberculin Skin Test (TS) evaluation upon arrival?	30.0	N/A
15. Does the initial intake screening take place in a manner that ensures inmate-patient confidentiality both visually and orally?	30.0	30.0
Point Totals:	450.0	340.0 (360.0)
Final Score:		94.4%

CHAPTER 12 COMMENTS

1. Question 4 – Not applicable. During the audit review period there were no inmate-patients who presented with urgent medical, dental or mental health symptoms upon arrival at the facility; therefore this question was not evaluated.
2. Question 5 – Not applicable. During the audit review period there were no inmate-patients who presented with medical, dental or mental health symptoms upon arrival at the facility. Therefore; this question was not evaluated.
3. Question 11 – Of the three inmate-patient shadow medical files reviewed for health appraisal/H&P, only one shadow medical file included a CDCR 196B intake H&P form completed by the PCP. This equates to 33.3% compliance. This is a significant decline from the previous audit score of 100% compliance.
4. Question 8 – Not applicable. Due to a change in departmental policy, inmate-patients are not required to receive a Tuberculin (TB) skin test evaluation upon arrival. Inmate-patients receive a TB skin test upon arrival at the CDCR Reception Center and then conducted annually thereafter.

<i>Chapter 13: Licensure and Training</i>	Point Value	Points Awarded
1. Are copies of current licenses maintained for all health care staff?	30.0	30.0
2. Is there a centralized system for tracking expiration of license for all health care staff?	30.0	30.0
3. Are the ACLS certifications current for the Physician, Nurse Practitioner (NP), and/or Physician Assistant (PA)?	30.0	30.0
4. Are the BLS certifications current for the RN/Custody Staff?	30.0	30.0

5. Is there a method in place to address expired certifications/licenses?	10.0	10.0
6. Is there a centralized system in place to track training provided to health care staff?	10.0	10.0
7. Is there a system in place to ensure that health care staff receives training for new or revised policies that are based on Inmate Medical Services Policy and Procedures (IMSP&P) requirements?	10.0	10.0
8. Is annual training provided to medical staff?	10.0	10.0
Point Totals:	160.0	160.0
Final Score:		100%

CHAPTER 13 COMMENTS

None.

<i>Chapter 14: Medication Management</i>	Point Value	Points Awarded
1. Was the medication administered to the inmate-patient as ordered by the PCP?	30.0	22.5
2. Did the prescribing PCP document that they explained the medication to the inmate-patient?	30.0	30.0
3. Was a referral made to the PCP for a discussion for those inmate-patients who did not show for three consecutive days for medication administration or showed a pattern of missed doses?	30.0	N/A
4. Does the RN document the medication is administered on the Medication Administration Record (MAR) once the medication is given to the inmate-patient?	30.0	30.0
5. Are inmate-patient's no shows documented on the MAR?	10.0	N/A
6. Are inmate-patient's refusals for medication administration documented on the MAR?	10.0	N/A
7. Are medication errors documented on the Incident Report-Medication Error Form?	10.0	N/A
8. Does the RN directly observe an inmate-patient taking DOT medication?	30.0	N/A
9. Does the RN check every inmate-patient's mouth, hands and cup after administering DOT medications?	30.0	N/A
10. Does the inmate-patient take all keep on person (KOP) medications to the designated RN prior to transfer?	30.0	30.0
11. Does the RN verify the KOP medications against the current pharmacy medication profile prior to transfer?	30.0	30.0
Point Totals:	270.0	142.5 (150.0)
Final Score:		95.0%

CHAPTER 14 COMMENTS

1. Question 1 – Out of four inmate-patient shadow medical files reviewed for medication administration, three included documentation that the inmate-patients was administered his medication as ordered by the PCP. This equates to 75.0% compliance. This is a significant decline from the previous audit score of 100% compliance.
2. Question 3 – Not applicable. During the audit review period there were no inmate-patient “no-shows” for medication. Therefore; this question was not evaluated.
3. Questions 5 and 6 – Not applicable. During this audit review period there were no inmate-patient refusals or “no shows” for medication Therefore these questions were not evaluated.

4. Question 7 – Not applicable. During this audit review period there were documented no medication errors. Therefore this question could not be evaluated.
5. Question 8 through 9 – Not applicable. There were no inmate-patients requiring oral DOT medications during this audit review period. Therefore these questions could not be evaluated.

Chapter 15: Monitoring Log	Point Value	Points Awarded
1. Are inmate-patients seen within timeframes set forth in the sick call policy?	30.0	0.0
2. Are inmate-patients seen within the timeframes set forth in the specialty care policy?	30.0	0.0
3. Are inmate-patients seen within the timeframes set forth in the emergency/hospital services policy?	30.0	0.0
4. Are inmate-patients seen within timeframes as it relates to chronic care policy?	30.0	28.5
5. Are inmate-patients seen within timeframes set forth in the initial intake screening/health appraisal policy?	30.0	14.6
Point Totals:	150.0	43.1
Final Score:		28.7%

CHAPTER 15 COMMENTS

1. Question 1 – The sick call monitoring logs submitted for the previous quarter were incomplete. Therefore the auditors could not determine compliance. This equates to 0.0% compliance. *This is a significant decline from the previous audit score of 100% compliance.*
2. Question 2 – Although the Specialty Services monitoring log did not list any inmate-patients for specialty services, upon auditor’s review of the shadow medical files, one inmate-patient was identified who had been referred to the hub for specialty services. Since this inmate-patient was not listed on the monitoring log, the facility was determined to be non-compliant. This equates to 0.0% compliance. *This compliance rating remains unchanged from the previous audit. This question remains a CAP item from the previous audit.*
3. Question 3 – The Emergency/Hospital services monitoring logs submitted for the previous quarter were incomplete. This equates to 0.0% compliance. *This compliance rating remains unchanged from the previous audit. This question remains a CAP item from the previous audit.*
4. Question 4 – Of the 100 inmate-patients referred for a chronic care appointment, 95 were seen within the specified timeframe. This equates to 95.0% compliance. *This is a significant increase from the previous audit score of 0.0% compliance.*
5. Question 5 – Of the 37 inmate-patients who required an initial health appraisal, 18 were seen within the specified timeframe. This equates to 48.6% compliance. *This is a significant increase from the previous audit score of 0.0% compliance. This question remains a CAP item from the previous audit.*

Chapter 16: Observation Unit	Point Value	Points Awarded
1. Are inmate-patients checked by the nursing staff every eight hours or more as ordered by a PCP?	30.0	N/A
2. Did the PCP document daily face-to-face encounters with all inmate-patients housed in the Observation Unit?	30.0	N/A

3. Is there a functioning call system in all Observation Unit rooms?	30.0	N/A
Point Totals:	90.0	N/A
Final Score:		N/A

CHAPTER 16 COMMENTS

- Questions 1 through 3 – Not applicable. This facility does not have an observation unit. Therefore, these questions were not evaluated.

<i>Chapter 17: Patient Refusal of Health Care Treatment/No Show</i>	Point Value	Points Awarded
1. If an inmate-patient refuses a health care appointment/treatment, does an RN/PCP complete the CDCR Form 7225, <i>Refusal of Examination and/or Treatment Form</i> ?	10.0	10.0
2. If an inmate-patient refuses a health care appointment/treatment, does an RN/PCP document their discussion of risk and benefits of refusing the appointment/treatment in the inmate-patient's Progress Notes section of the Electronic Medical Record?	10.0	10.0
3. If an inmate-patient did not show for their medical appointment, did the RN/LIP contact the housing unit supervisor to have the inmate-patient escorted to medical to speak with health care staff?	10.0	N/A
4. If an inmate-patient was a no show for a medical appointment/treatment, did the RN contact the PCP to determine if/when the inmate-patient should be rescheduled?	10.0	N/A
5. If an inmate-patient did not show for their medical treatment appointment, did the RN document the reason why the inmate-patient did not show up for their medical treatment?	10.0	N/A
Point Totals:	50.0	20.0 (20.0)
Final Score:		100%

CHAPTER 17 COMMENTS

- Questions 3 through 5 – Not applicable. All inmate-patients presented to their medical appointments during the audit review period. Therefore, these questions were not evaluated.

<i>Chapter 18: Sick Call</i>	Point Value	Points Awarded
1. Does the inmate-patient handbook or similar document explain the sick call process?	10.0	10.0
2. Is an RN reviewing all sick call request forms within one day of receipt?	30.0	30.0
3. If the sick call request reflected inmate-patient symptoms, was it reviewed by an RN within one business day?	30.0	30.0
4. Are inmate-patients seen and evaluated face-to-face by an RN/PCP if the sick call request form indicates an emergent health care need?	30.0	30.0
5. Did the inmate-patient have a face-to-face (FTF) evaluation within the next business day if the health care request slip review indicates a non-emergent health care need?	30.0	30.0
6. Was the S.O.A.P.E. note on the CDCR Form 7362, <i>Request for Health Care Services</i> , and/or CDCR Form 7230, <i>Interdisciplinary Progress Note</i> , or a CCF similar form completed?	30.0	30.0
7. If an inmate-patient was referred to the Hub or MCCF PCP by the MCCF RN, was the inmate-patient seen within the specified timeframe?	30.0	17.1

8. If an inmate-patient presented to sick call three or more times in a one month period for the same complaint, was the inmate-patient referred to the PCP?	30.0	N/A
9. Does the RN maintain accurate and confidential medical records/shadow files?	10.0	10.0
10. Does the RN administrator ensure compliance with the inmate co-payment requirement?	10.0	10.0
11. If the MCCF RN/PCP determined the inmate-patient's request for medical services are beyond the level available at the facility, does the RN contact the medical Hub institution immediately?	30.0	N/A
12. If the MCCF RN/PCP determines the inmate-patient's request for medical services are beyond the level available at the facility, does the RN schedule a sick call appointment with the Hub for the inmate-patient and process the appropriate paperwork?	30.0	N/A
13. If the MCCF RN/PCP determines the inmate-patient's request for medical services are beyond the level available at the facility, does the RN obtain approval/authorization for the Hub CME or designee?	30.0	N/A
14. If the MCCF RN/PCP determines the inmate-patient's request for medical services are beyond the level available at the facility, does the RN notify the appropriate MCCF staff to coordinate transportation?	30.0	N/A
15. Do the sick call visit locations provide for inmate-patient confidentiality both visually and orally in all housing units?	30.0	30.0
16. Are the sick call request forms readily available to inmate-patients in all housing units?	10.0	10.0
17. Are inmate-patients able to submit sick call request forms on a daily basis in secured/locked boxes in all housing units?	10.0	10.0
Point Totals:	410.0	247.1 (260.0)
Final Score:		95.0%

CHAPTER 18 COMMENTS

1. Question 7 – Of the seven inmate-patient shadow medical files reviewed for RN referrals to the hub or PCP, four had documentation that the inmate-patient was seen within the specified timeframe. This equates to 57.1% compliance. This is a significant decline from the previous audit score of 100% compliance.
2. Question 8 – Not applicable. During the audit review period no inmate-patients presented to sick call three or more times in a one month period.. Therefore this question was not evaluated.
3. Question 11 through 14 – Not applicable. During the audit review period there were no inmate-patients who required medical services beyond the level available at the facility.. Therefore these questions were not evaluated.

<i>Chapter 19: Specialty/Hospital Services</i>	Point Value	Points Awarded
1. Does pertinent information from the eUHR accompany the inmate-patient to the consultation appointment?	30.0	30.0
2. Does the MCCF RN follow utilization review procedures by seeking advance approval from the CME or designee at the Hub institution for any non-emergent care outside the facility?	30.0	30.0
3. Was the inmate-patient seen by the specialist within the timeframe specified by the PCP?	30.0	30.0
4. Did the RN complete a FTF evaluation upon the inmate-patient's return from a specialty consultation appointment?	30.0	30.0
5. When inmate-patient returns from a specialty consult appointment, does an RN notify the PCP of any immediate medication orders or follow-up instructions provided by the specialty consultant?	30.0	N/A

6. Does a PCP review the consultant's report and see the inmate-patient for a follow-up appointment within the specified timeframe? (≤3 days for emergent/urgent and ≤ 14 days for routine)	30.0	0.0
Point Totals:	180.0	120.0 (150.0)
Final Score:		80.0%

CHAPTER 19 COMMENTS

1. Question 5 – Not applicable. Only one inmate-patient required specialty service during the audit review period. This inmate-patient was evaluated at the hub facility and did not have any immediate medication orders or follow-up instructions when he returned to the MCCF from the specialty consult appointment. Therefore this question was not evaluated.
2. Question 6 –Only one inmate-patient required specialty services during the audit review period. The PCP did not review the consultant's report nor have a follow-up appointment with this inmate-patient upon the inmate-patient's return to the facility after the specialty care appointment. This equates to 0.0% compliance. This question remains unresolved from the previous audit. This question remains a CAP item from the previous audit.

<i>Chapter 20: Staffing</i>	Point Value	Points Awarded
1. Does the facility have the required PCP staffing complement?	30.0	30.0
2. Does the facility have the required management staffing complement?	30.0	30.0
3. Does the facility have the required RN staffing complement?	30.0	30.0
Point Totals:	90.0	90.0
Final Score:		100%

CHAPTER 20 COMMENTS

None.

QUALITATIVE FINDINGS

As stated earlier in the report, the qualitative analysis portion of this audit attempts to specifically explore the efficacy of the facility's processes for delivering health care services. By their very nature, such processes often defy objective measurement, but are nonetheless worthy of attention and discussion. It bears repeating that although *this portion of the audit is not rated*, any concerning issues identified during the qualitative process may result in additional CAP items (see CAP request for further detail).

The audit team conducted the qualitative analysis primarily via interview of key facility personnel and through review of the electronic Unit Health Record (eUHR) and shadow medical files. At DVMCCF the personnel interviewed included the following:

Raymond Smith– Warden
Elias Valdivia – Facility Captain
Dina Villanueva – Medical Doctor
Michelle Stites – Health Services Administrator (HSA)
Jessica Hicks – Registered Nurse (RN)
Crystal Brooks – Medical Records Clerk

The following narrative represents a summary of the information gleaned through interviews of the above-listed personnel, as well as conclusions and inferences drawn from correlating observations and data collected during other portions of the audit. The findings are categorized into five areas: Prior CAP Resolution, Recent Operational Changes, Operations, Emergency Medical Response Drill, New CAP Issues, and Best Practices.

SUMMARY OF QUALITATIVE FINDINGS

Since conducting the previous audit in August 2014, the auditors have noted that the performance in administrative functions has significantly declined; most specifically in the areas of access to health care, maintenance of emergency medical equipment and insufficient documentation in the monitoring logs which has had an adverse effect on the overall compliance score dropping from the previous score of 88.8% to the current compliance score of 84.4%. The observations during the current audit showed that DVMCCF has made progress in addressing the deficient areas identified during the previous audit and there have been noticeable improvements in certain program critical areas such as chemical agent exposure, continuous quality improvement (CQI) and medication management.

PRIOR CAP RESOLUTION

During the August 2014 audit, DVMCCF received an overall rating of 88.8% compliance resulting in a total of 19 CAP items. The May 2014 audit CAP items are as follows:

1. *There is no documentation validating inmate-patients who had been exposed to Chemical Agents were given direction on how to self-decontaminate.* During the August 2014 audit, auditors found 0.0% compliance. The facility's CAP indicated that all inmate-patients exposed to OC spray would be given instructions on how to self-decontaminate if they refuse

decontamination and this will be documented on the CDCR 7219. Medical staff would also be trained on the GEO pepper spray protocol. The audit team found that the corrective action taken by DVMCCF to resolve this issue had the desired effect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.

2. *There is no documentation that health care staff monitored inmate-patients exposed to chemical agents every 15 minutes for a minimum of 45 minutes.* During the August 2014 audit, auditors found 0.0% compliance. During the current audit, the auditors reviewed shadow medical files onsite, resulting in 100% compliant. The corrective action is considered to be resolved.
3. *The facility does not have an approved Continuous Quality Improvement (CQI) Plan.* During the August 2014 audit, auditors found 0.0% compliance. The facility's CAP indicated that the facility was going to implement a CQI committee in the 4th quarter on October 3, 2014. The audit team found that the corrective action taken by DVMCCF to resolve this issue had the desired effect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.
4. *The PCP does not review, initial and date all inmate-patient diagnostic reports within the specified timeframe.* During the August 2014 audit, auditors found 50.0% compliance. The facility's CAP indicates that the hub facility PCP reviews, initials and dates all diagnostic reports. DVMCCF does not receive diagnostic reports for up to 2 to 3 weeks after the completion of the diagnostic tests. Upon receipt of the diagnostic reports, DVMCCF PCP will review, initial and date all diagnostic reports. The audit team found that the corrective action plan taken by DVMCCF to resolve this issue has not had the desired effect, nor is the CAP an acceptable resolution. Although the facility showed marginal improvement in this area receiving 25.0% compliance, this corrective item remains unresolved and will continue to be the subject of monitoring during subsequent audits.
5. *First Level Health Care appeals are not consistently processed within the specified timeframe.* During the August 2014 audit, auditors found 38.7% compliance. The facility's CAP indicated that all health care appeals since May 1, 2014 have been completed within the specified timeframe. The audit team found that the corrective action taken by DVMCCF to resolve this issue had the desired effect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.
6. *First Level Health Care appeals are not being logged on a consistent basis.* During the August 2014 audit, auditors found 38.7% compliance. The facility's CAP indicated that all health care appeals since May 1, 2014 have been completed within the specified timeframe. The audit team found that the corrective action taken by DVMCCF to resolve this issue had the desired effect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.
7. *The facility submits Specialty Care monitoring logs with incomplete data.* During the August 2014 audit, auditors found 0.0% compliance. The facility's CAP indicated that effective August 8, 2014 and monitoring logs are being submitted on the correct forms accurately. The audit team

found that the corrective action plan taken by DVMCCF to resolve this issue has not had the desired effect and the facility continues to remain at 0.0% compliance. The corrective action is unresolved and will continue to be the subject of monitoring during subsequent audits.

8. *The facility submits Emergency/Hospital Services monitoring logs with incomplete data.* During the August 2014 audit, auditors found 0.0% compliance. The facility's CAP indicated that effective August 8, 2014 and monitoring logs are being submitted on the correct forms accurately. The audit team found that the corrective action plan taken by DVMCCF to resolve this issue has not had the desired effect and the facility continues to remain at 0.0% compliance. The corrective action is unresolved and will continue to be the subject of monitoring during subsequent audits.
9. *The facility submits Chronic Care monitoring logs with incomplete data.* During the August 2014 audit, auditors found 0.0% compliance. The facility's CAP indicated that effective August 8, 2014 and monitoring logs are being submitted on the correct forms accurately. The audit team found that the corrective action plan taken by DVMCCF to resolve this issue has had the desired effect, and the facility has improved in this area and received 95.0% compliance. Since, DVMCCF failed this chapter; the corrective action is unresolved and will continue to be the subject of monitoring during subsequent audits.
10. *The facility submits Initial Intake Screening monitoring logs with incomplete data.* During the August 2014 audit, auditors found 0.0% compliance. The facility's CAP indicated that effective August 8, 2014 and all monitoring logs are being submitted on the correct forms accurately. The audit team found that the corrective action plan taken by DVMCCF to resolve this issue has not had the desired effect even though the facility showed marginal improvement in this area receiving 48.6% compliance. The corrective action is unresolved and will continue to be the subject of monitoring during subsequent audits.
11. *The facility RN does not complete face-to-face (FTF) evaluation upon inmate-patients' return from a specialty care appointment.* During the August 2014 audit, auditors found 0.0% compliance. The facility's CAP indicated that effective August 12, 2014 any inmate-patient returning from a specialty care appointment will receive a FTF evaluation and the RN will review the specialist's notes. The audit team found that the corrective action plan taken by DVMCF to resolve this issue had the desired effect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.
12. *The facility RN does not notify the PCP of any immediate medication orders or follow-up instructions from the specialty consultant, upon the inmate-patients' return from a specialty care appointment.* During the August 2014 audit, auditors found 0.0% compliance. The facility's CAP indicated that since DVMCCF does not have 24 hour PCP coverage, upon an inmate-patients' return from a specialty appointment, the inmate-patient will be scheduled for a follow-up appointment with the PCP the following day. The audit team could not evaluate this corrective action item for compliance since the one inmate-patient who returned from a specialty care appointment did not have any immediate medication order or follow-up instructions. Therefore, this issue is unresolved and will continue to be the subject to monitoring during subsequent audits.

13. *The PCP does not review the consultant's report and see inmate-patients within the specified timeframe, upon their return from a specialty care appointment.* During the August 2014 audit, auditors found 0.0% compliance. The facility's CAP indicated that the PCP will document that the consultant's reports were reviewed. The audit team found that the corrective action plan taken by DVMCCF to resolve this issue has not had the desired effect and facility remains to be at 0.0% compliance. The corrective action is unresolved and will continue to be the subject of monitoring during subsequent audits.
14. *Inmate-patients are not scheduled for follow-up chronic care appointments within the 90-day or less timeframe as ordered by the physician.* During the August 2014 audit, auditors found 75.0% compliance. The facility's CAP indicated that chronic care appointments are currently being scheduled to correct the missed follow-up and appointments that had not been completed. The audit team found that the corrective action plan taken by DVMCF to resolve this issue had the desired effect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.
15. *Spill kits are not placed in the designated areas in the facility.* During the August 2014 audit, auditors found 50.0% compliance. The facility's CAP indicated that the spill kits had been added to medical, R&R, A&B pods, kitchen, recreation yard, maintenance, visitation, central control and administration. The audit team found that the corrective action plan taken by DVMCCF to resolve this issue has not had the desired effect even though the facility showed marginal improvement in this area receiving 53.3% compliance. The corrective action is unresolved and will continue to be the subject of monitoring during subsequent audits.
16. *The PCP does not document that he explained newly prescribed medications to inmate-patients.* During the August 2014 audit, auditors found 25.0% compliance. The facility's CAP indicates that a meeting was scheduled for October 3, 2014 with the PCP to discuss the teaching and documentation of new medications and the new practice will be implemented the same day. The audit team found that the corrective action taken by DVMCCF to resolve this issue had the desired effect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.
17. *The RN/PCP is not documenting the risks and benefits when an inmate-patient refuses medical appointments/treatment.* During the August 2014 audit, auditors found 66.7% compliance. The facility's CAP indicates that all medical staff will be trained on the risks and benefits of refusing medical appointments/treatment. All medical staff will be trained to document refusals on a refusal form as well to document in the progress notes. The audit team found that the corrective action taken by DVMCCF to resolve this issue had the desired effect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.
18. *The facility RN does not review all sick call requests within the specified timeframes.* During the August 2014 audit, auditors found 71.4% compliance. The facility's CAP indicates that all facility RNs have been informed that, that they will review all sick call requests on the day they are received. The audit team found that the corrective action taken by DVMCCF to resolve this issue had the desired effect and the facility has improved in this area and received 100%

compliance. The corrective action is considered to have been effective and this issue is resolved.

19. *The facility RN and PCP are not having face-to face appointments with inmate-patients whose sick call request indicates an emergent health care need.* During the August 2014 audit, auditors found 83.3% compliance. The facility's CAP indicates that all medical staff has been informed that all inmate-patients submitting emergent sick call requests will be seen that same day. The audit team found that the corrective action taken by DVMCCF to resolve this issue had the desired effect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.

RECENT OPERATIONAL CHANGES

Effective September 1, 2014, the contract with CDCR was amended, requiring the facility to provide 24 hour nursing coverage seven days a week and to have physician coverage five days a week, four hours a day. DVMCCF is currently operating within contractual staffing obligations.

OPERATIONS

PERSONNEL:

Administration

With regards to the administrative aspect of the audit, the auditors discovered that DVMCCF is struggling to meet compliance in two areas; access to health care and monitoring logs. Prior to the onsite audit the auditors reviewed the monitoring logs for sick call, chronic care, emergency/hospital services, specialty care and initial intake/health appraisal, that were submitted by the facility during the previous quarter (Oct-Dec 2014). The audit team noticed that several of the monitoring logs were missing essential information, specifically dates when various services were rendered; therefore the auditors were unable to determine compliance for the logs. The audit team had a discussion with the HSA and the medical clerk and emphasized the importance of submitting the monitoring logs with accurate and complete data. The medical records clerk acknowledged that she was using the incorrect sick call monitoring log and had recently conversed with the PPCMU analyst, who sent the correct sick call monitoring log to the medical records clerk, which is being used currently.

While onsite the auditors reviewed the Release of Information (ROI) log and noticed a significant deficiency; only 2 of the 8 ROI requests were documented on the CDCR 7385, *Authorization for Release of Information* and filed in inmate-patients' shadow medical files. When the HSA and medical records clerk were questioned by the auditors, they stated that they had just started using the CDCR 7385, *Authorization for Release of Information* form in the past few weeks before the audit. The auditors confirmed this statement by checking the entries in the log and dates on the CDCR 7385 forms.

DVMCCF Health Care Staff – Nursing

The audit team observed nursing staff conducting their daily operations in the medical clinic. The CDCR 7362, *Request for Health Care Services* forms are collected on 1st watch and triaged by the nursing staff

daily. Inmate-patients are scheduled to be seen by nursing staff during 2nd and 3rd watches. If an inmate-patient's sick call request is outside the services provided at DVMCCF, then the HSA contacts the hub facility for further instructions.

The auditors noted that the portable oxygen tank, AED and portable suction were all operational and ready for use; however when the auditors reviewed the logs, the auditors noticed that the nursing staff inspected the equipment only on one shift and not on all three shifts. The auditors informed the nursing staff that it was a policy requirement to inspect the medical emergency equipment on each shifts. The HSA implemented this requirement immediately. This deficiency will be monitored for compliance during subsequent audits.

Since there were no inmate-patients transferring in or out of DVMCCF at the time of the onsite audit, the audit team interviewed the HSA on the process. The HSA stated that all nurses provide newly arriving inmate-patients are provided with an intake screening, tuberculosis screening and mental health screening. If an inmate-patient arrives with KOP medication the nurse checks the inmate-patients medication profiles and reorders any medications that are due for a refill. When a new inmate-patient arrives with medical, dental or mental health symptoms, she contacts the hub for further direction.

DVMCCF Health Care Staff – Primary Care Provider

The facility PCP has recently adjusted her schedule to comply with the contractual obligations; working four hours a day five days a week. The PCP sees approximately 15 inmate-patients in a four hour shift. This is a vast improvement from the prior PCP, who used to see only nine inmate-patients in a five hour period. The PCP has been instrumental in alleviating the prior backlog of 107 chronic care appointments and DVMCCF currently has no backlog. The auditors recommended to the Warden and the HSA that in future, they include the PCP for the training sessions at the hub and add her as a member in the newly formed CQI committee.

The physician-auditor observed the PCP conduct chronic care encounter for Hepatitis C follow-up. The PCP was observed to have established a good rapport with the inmate-patients and she explained the treatment plan to the inmate-patient adequately. In addition to observing the PCP conduct her examinations, the auditor also reviewed inmate-patient shadow medical files. During the review, the physician-auditor discovered a deficiency when reviewing a shadow medical file of a chronic care inmate-patient who suffered from high cholesterol. The physician-auditor did not find the cholesterol panel readings in the inmate-patient's chart. Upon further inquiry, it was revealed that the PCP does not have access to the eUHR. The PCP has since been granted access to the eUHR

The auditors inquired the HSA regarding the approximate time taken for receiving diagnostic test results from the hub and she stated that the results were available to the facility in approximately one to three weeks after the completion of diagnostic test. The hub physician reviews and signs all reports, which are then scanned into the eUHR. If lab results are abnormal, the hub physician notifies DVMCCF. The auditors informed the HSA and the PCP that they are being negligent and deficient in waiting one to three weeks for a hard copy of the test results since they have been provided access to the eUHR, the results are available for viewing in the eUHR within two days of diagnostic draws.

The physician-auditor also conducted a chart review while onsite. The physician-auditor reviewed 12 inmate-patient shadow medical files to determine the quality and timeliness of the medical services provided to the inmate-patients by the PCP. Of the 12 charts reviewed, there were no cases with extreme departures; there were six out of nine chronic care cases that had simple departures. Several of the chronic care departures were the result of ordering unnecessary labs. If the PCP had access to the eUHR she would have been able to determine if the labs were needed and should have been ordered. For two of the chronic care cases, the documentation by the PCP on the chronic care appointment was insufficient. The physician-auditor educated the PCP on documentation that is required to be included in chronic care progress notes. The additional chart reviews included two sick call and emergency services. All these charts had sufficient documentation to determine if the PCP provided adequate medical care to the inmate-patients.

In addition to the case reviews, the physician-auditor conducted a tracer audit on an inmate-patient that presented to medical for stomach pain. The inmate-patient was seen in medical on January 18, 2015. There was no physical exam conducted and inmate-patient was prescribed fiberlax and given directions to drink plenty of water and return in two days for follow-up. January 20, 2015 the inmate-patient returned to medical for his follow-up visit and was seen by another nurse; the inmate-patient told nurse that he had blood in his stool and had diarrhea. Again this nurse did not conduct a physical exam and plan of care was to monitor and have inmate-patient return to medical if he continued to see blood in his stool. January 21, 2015 inmate-patient was seen by the PCP, again no physical exam was completed and plan of action was to provide the inmate-patient with stool cards to test his stool. January 24 through 26, 2015, the inmate-patient was given stool cards to test his stool. This inmate-patient was a 32 year old male who was not at high risk of colon cancer and no familial colon cancer. A rectal exam should have been conducted to check for external hemorrhoids, fissures or wounds.

The physician-auditor made the recommendation that medical staff conduct a physical exam and to perform a rectal exam with a chaperone present, if the inmate-patient's primary complaint is blood in stool. The auditor reiterated that performing a rectal exam is critical and an essential step to determine the internal etiology such as a mass or hemorrhoids.

EMERGENCY RESPONSE DRILL

The audit team observed a mock medical emergency drill staged in a vocational classroom, involving an inmate-patient in cardiac arrest. The vocational instructor found the inmate-patient unresponsive, pulseless and not breathing and called a code blue (man-down) via institutional radio. Subsequent to calling the code blue the instructor returned to his desk and continued to work until the nurse and physician arrived two minutes later bringing with them the emergency medical response bag, portable oxygen and automated external defibrillator (AED). Upon the nurse's arrival, she assessed the inmate-patient and requested staff to call 9-1-1 and start Cardio Pulmonary Resuscitation (CPR). The nurse assembled the Ambu bag and AED machine, while custody continued CPR. Three and a half minutes after the instructor called the code blue the AED was placed on the inmate-patient's chest and a shock was delivered. The nurse reassessed the inmate-patient and requested that CPR to continue. Four and a half minutes after the 911 call, an announcement was made that the ambulance was on scene and the drill was discontinued.

The auditors conducted a debriefing at the conclusion of the emergency services drill discussing their key deficient observations, which are as follows:

1. The vocational instructor did not start CPR after calling the code blue.
2. Chest compressions were observed to be performed too quickly with frequent pauses between chest compressions, rendering it ineffective. This was an observation made regarding the drill that was conducted during the previous audit. The facility medical staff needs to review the American Heart Association guidelines on CPR. They should also minimize interruptions when performing chest compressions. Interruptions to CPR without defibrillation should not take place until two minutes of continuous compression have been performed.
3. The PCP was at the drill but did not participate in the drill.

NEW CAP ISSUES

As a result of the February 2015 audit, there are 20 quantitative CAP items as identified previously in the “Quantitative Findings” section and six qualitative CAP items resulting from failed questions but which are within the passing chapters

CONCLUSION

DVMCCF’s current audit revealed that it is struggling to adequately provide consistent medical care to the inmate-patients housed at this facility. The identified deficiencies has stemmed from a variety of reasons such as the PCP’s lack of use of the eUHR, poor documentation practices and medical staffs’ lack of training on various aspects of care as outlined in the IMSP&P. DVMCCF medical staff needs to be educated on IMSP&P, with special emphasis on access to care standards as outlined in Volume VI, Chapter 38. The facility is expected to work diligently to improve the deficient areas listed below:

- Access to Health Care Information
- Continuous Quality Improvement (CQI)
- Medical Emergency Services/Drills
- Medical Emergency Equipment
- Monitoring Logs
- Specialty/Hospital Services

DVMCCF is encouraged to address and resolve all identified CAP items and strive to attain the required 85% compliance in all components of the audit instrument.

During the exit conference, DVMCCF staff was receptive to constructive feedback presented by the PPCMU audit team. Staff acknowledged their need to adhere to contractual obligations as it relates to providing an adequate level of health care to the inmate-patients housed in DVMCCF. The Warden and DVMCCF medical staff expressed their intentions to meet CCHCS expectations by addressing all identified deficiencies promptly.

STAFFING UTILIZATION

Prior to the onsite audit at DVMCCF, the audit team conducted a review of all health care positions. The purpose of this review was not only to identify both budgeted (required) and filled positions on duty during this audit period, but also to provide talking points for subsequent qualitative interviews with staff during the onsite audit.

Effective September 1, 2014, the contract with CDCR was amended, requiring the facility to provide 24 hour nursing coverage seven days a week and to have physician coverage five days a week, for at least four hours a day.

It should be noted that during the discussion with the facility PCP, she mentioned that she contacts the physician at Registry of Physician Specialists who she is contracted through, for mentoring and clinical guidance. The auditors told her that she should contact the GEO Corporation for mentoring and clinical guidance, since they hold the contract with CDCR. Per contract, "Contractor is required to complete a written peer review after 30 days of employment, and then annually. The PCP has been employed at the facility since September 2014 and has not had a peer review. The audit team made the recommendation to the GEO Corporation that a peer review should be completed on the PCP immediately. On a subsequent conference call the GEO Regional Medical Director stated that she was currently working on the peer review and would submit to PPCMU upon completion.

INMATE INTERVIEWS

The intent of this portion of the audit is to elicit substantive responses from a designated number of the inmate-patients, by utilizing each question as a springboard for discussion, with appropriate follow up to identify any areas where barriers to health care access may potentially exist. In general population facilities, this is accomplished via interview of the Inmate Advisory Council (IAC) executive body. In segregated or reception facilities, this is accomplished via interview of a random sampling of inmate population housed in those buildings. The results of the interviews conducted at DVMCCF are summarized in the chart below.

Please note that while this chapter is not rated, audit team members made every attempt to determine with surety whether any claim of a negative nature could be supported by material data or observation. The results are briefly discussed in the “comments” section below.

Chapter 21: Inmate Interviews (not rated)

1. Are the inmate-patients aware of the sick call process?
2. Does the inmate-patient know where to get a Sick Call request form?
3. Does the inmate-patient know where to place the completed Sick Call request form?
4. Is there assistance available if you have difficulty in completing the Sick Call form?
5. Are inmate-patients aware of the grievance/appeal process?
6. Does the inmate-patient know where the CDCR-620 HC form can be found?
7. Does the inmate-patient know where and how to submit the CDCR-602 HC form?
8. Is assistance available if you have difficulty completing the CDCR 602-HC form?
9. Are you aware of your current disability/ADA status?
10. Are you receiving any type of accommodation based on your disability? (Housing Accommodation, Medical Appliance)
11. Are you aware of the process to request reasonable accommodation?
12. Do you know where to obtain a request for reasonable accommodation form?
13. Did you receive reasonable accommodation in a timely manner? If no, were interim accommodations provided?
14. Have you used the medical appliance repair program?
15. If yes, how long did the repair take?
16. If yes, were you provided an interim accommodation?
17. Are you aware of the grievance/appeal process for a disability related issue?
18. Can you explain where to find help if you need assistance obtaining or completing a form (i.e. CDCR 602-HC Inmate/Parolee Health Care Appeal Form, CDCR 1824 Reasonable Modification or Request for Reasonable Accommodation Form)
19. Have you submitted an ADA Grievance/Appeal?
20. If yes, how long did the process take?
21. Do you know the name of the ADA Coordinator at this facility?
22. Do you have access to license health care staff to address any issues regarding your disability?
23. During contact with medical staff do they explain things to you in a way you understand?

Comments:

1. Regarding questions 1 through 8 – No negative responses.
2. Regarding questions 9 through 23 –Not applicable. There are no inmate-patients with qualifying disabilities at DVMCCF during the review period for this audit.

The audit team met with five members of the IAC. All five of the IAC members arrived at DVMCCF within a few weeks of the facility's activation and were able to provide detailed information to the auditors with regards to medical care being provided at the facility. Below are some of the concerns that the IAC members informed the auditors:

1. CDCR Forms 602 HC, *Patient-Inmate Health Care Appeal*, are not consistently available in all housing units. The auditors disclosed to the inmate-patients, that their observation during their audit was the same as the IAC committee's and the HSA and Warden were made aware of this deficiency and the problem was rectified. The IAC members stated that inmate-patients housed at DVMCCF have not recently filed 602's because medical has improved greatly since the facility's activation. The IAC members stated the HSA, "Nurse Stites is on her game," and "the physician is really good."
2. The IAC member's main concern was that most inmate-patients do not utilize medical services for fear of going to California State Prison, Los Angeles County (LAC) and being kept there for arbitrary reasons. The IAC members stated that inmates like consistency and they like their programs. However there are medical services that are available at LAC that are not available at DVMCCF.
3. The IAC member's notified the auditors of an inmate-patient that claimed to have waited over 20 days for eye drops; possibly for cataracts. The auditors provided this inmate-patient's name to the HSA. The HSA assured the auditors that she would investigate this matter.
4. The IAC brought to the auditor's attention that inmate-patients who are transferred or paroled out of the facility are not given a 30 day supply of their medication. When the audit team addressed this issue with the Warden and HSA, the HSA stated that she verifies all inmate-patient medication orders against their current pharmacy profile. Inmate-patients being paroled are given a 30 day supply of their medications.
5. The IAC also informed the auditors that DVMCCF nurses allow inmate-patients to refuse laboratory services (blood draws) days and even weeks prior to their appointments at the hub. The audit team informed the inmate-patients that the GEO Corporation is in the process of obtaining a contract with Quest Diagnostics so that labs can be completed onsite.

Desert View Modified Community Correctional Facility
Health Care Monitoring Audit - Corrective Action Plan
Audit Dates: February 2-3, 2015
CAP Date: March 18, 2015



Reference Chap/Q	Specific Nature of Non-Compliance	Facility's Proposed Action Plan	Anticipated Completion Date	Assigned Personnel	Action Plan Status
2 1	The Primary Care Provider (PCP) is not maintaining access to eUHR.				Not Completed / In Progress / Completed [DATE]
2 5	Inmate-patients' written requests for Release of Health Care Information (ROI) are not consistently documented on the CDCR 7385, <i>Authorization for Release of Information</i> form or similar form.				Not Completed / In Progress / Completed [DATE]
2 7	ROI requests are not consistently being filed in the Medico-Legal section of the inmate-patients' shadow medical file.				Not Completed / In Progress / Completed [DATE]
2 8	Inmate-patients ROI requests are not consistently documented on a progress note.				Not Completed / In Progress / Completed [DATE]
6 6	Action and follow-up plans for opportunities for improvement, that have been identified in the Continuous Quality Improvement (CQI) meeting minutes are not documented.				Not Completed / In Progress / Completed [DATE]
8 4	The RN is not documenting the review of the inmate-patient's discharge plan upon the inmate-patient's return from a community hospital emergency department.				Not Completed / In Progress / Completed [DATE]
8 5	The RN is not consistently documenting the face-to-face evaluation upon the inmate-patient's return from a community hospital emergency department.				Not Completed / In Progress / Completed [DATE]

Reference Chap/Q		Specific Nature of Non-Compliance	Facility's Proposed Action Plan	Anticipated Completion Date	Assigned Personnel	Action Plan Status
9	1	The RN is not consistently documenting the inspection of the Emergency Medical Response bag to ensure it is secured with a seal on each shift.				Not Completed / In Progress / Completed [DATE]
9	4	The RN is not consistently documenting the inspection of the Portable suction on each shift for operational readiness.				Not Completed / In Progress / Completed [DATE]
9	6	The RN is not consistently documenting the inspection of the oxygen tank on each shift for operational readiness.				Not Completed / In Progress / Completed [DATE]
9	8	The RN is not consistently documenting the inspection of the Automated External Defibrillator (AED) on each shift for operational readiness.				Not Completed / In Progress / Completed [DATE]
9	11	Spill kits are not located in all designated areas at the facility.				Not Completed / In Progress / Completed [DATE]
15	1	Inmate-patients are not being seen within the timeframes set forth in the sick call policy.				Not Completed / In Progress / Completed [DATE]
15	2	Inmate-patients are not being seen within the timeframes set forth in the specialty care policy.				Not Completed / In Progress / Completed [DATE]
15	3	Inmate-patients are not being seen within the timeframes set forth in the emergency/hospital services policy.				Not Completed / In Progress / Completed [DATE]

Reference Chap/Q		Specific Nature of Non-Compliance	Facility's Proposed Action Plan	Anticipated Completion Date	Assigned Personnel	Action Plan Status
15	5	Inmate-patients are not consistently being seen within the timeframes set forth in the initial intake screening/health care appraisal policy.				Not Completed / In Progress / Completed [DATE]
19	6	The PCP does not review the consultant's report and have a follow-up appointment with the inmate-patients within the specified timeframe, upon their return from a specialty care appointment. This was a previous CAP item.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #1 (Chp.7, Q2)		The PCP does not consistently review, initial and date all inmate-patient diagnostic reports within the specified timeframe. This was a previous CAP item.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #2 (Chp.7, Q4)		Inmate-patients are not consistently receiving written notification of diagnostic test results within the specified timeframe.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #3 (Chp. 10, Q2)		The facility does not have the CDCR Forms 602 HC, <i>Patient-Inmate Health Care Appeal forms available</i> in all housing units.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #4 (Chp. 10, Q11)		The PCP is not consistently documenting the health appraisal/H&P on the intake H&P form, CDCR 196B.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #5 (Chp. 14, Q1)		Medications are not consistently being administered to the inmate-patients within the specified timeframe.				Not Completed / In Progress / Completed [DATE]

Reference Chap/Q	Specific Nature of Non-Compliance	Facility's Proposed Action Plan	Anticipated Completion Date	Assigned Personnel	Action Plan Status
Qualitative Action Item #6 (Chp.18, Q7)	Inmate-patients are not consistently being seen within the specified timeframes when referred to the hub or MCCF PCP by the MCCF RN.				Not Completed / In Progress / Completed [DATE]
Raymond Smith, Warden DVMCCF		Michelle Stites, Health Services Administrator DVMCCF			