

April 8, 2015

Edward Komin, Chief
Delano Modified Community Correctional Facility
2727 West Industry Way
Delano, CA, 93216

Dear Chief Komin,

The staff from Private Prison Compliance and Monitoring Unit (PPCMU), Field Operations, Corrections Services, California Correctional Health Care Services (CCHCS) completed an onsite health care monitoring audit at Delano Modified Community Correctional Facility (DMCCF) on March 3, 2015. The purpose of this audit is to ensure that DMCCF is 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 DMCCF received an overall compliance rating of 79.7%. 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) request. Please submit a CAP, as detailed in the attached report, to Susan Thomas, Health Program Specialist I (HPS I), PPCMU, Field Operations, Corrections Services, CCHCS, via e-mail at susan.thomas@cdcr.ca.gov within 30 days of the date of this letter.

The audit findings reveal that overall DMCCF has made slight improvements in the two quantifiable operational areas: administration and delivery of medical services. Although the current compliance rating of 79.7% is an improvement of 7.3 percentage points from the previous audit, the score is still below the minimum 85.0% compliance requirement. Numerous deficiencies were identified in the following program components and require facility's immediate attention and resolution:

- Administration - Policies and Procedures (repeat finding)
- Continuous Quality Improvement (repeat finding)
- Medical Emergency Services/Drills (repeat finding)
- Medical Emergency Equipment (repeat finding)
- Medication Management (repeat finding)
- Specialty/Hospital Services (repeat finding)
- Grievance/Appeal Procedure (repeat finding)

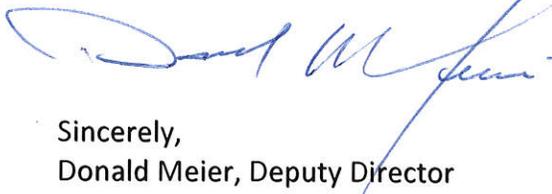
The Medical Emergency Services/Drills component received a score of 54.2%, which was a decrease of 28.4% percentage points from the previous audit. It is imperative

that the facility conduct frequent drills and also provide additional training to the health care staff in order to ensure they gain sufficient experience and expertise thereby empowering them to respond effectively during medical emergencies.

The continued failure to provide a quality level of care in the above listed categories is unacceptable. The facility's overall audit score has fallen below the 80.0% mark for the second straight audit cycle. It is the contractual responsibility of DMCCF to ensure an adequate level of medical care is provided to all inmate-patients in your custody.

It is the expectation of CCHCS that the administration at the DMCCF take the appropriate steps to address the listed areas of deficiency. All of the deficient program areas listed above can be brought into compliance by the facility's strict adherence to established contract requirements and policies and procedures as outlined in the *Inmate Medical Services Policies and Procedures*. DMCCF must work diligently to demonstrate their ability to improve the quality of medical services provided to the CDCR inmate population and to expediently resolve the concerns and deficiencies identified in the attached report.

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.



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

Enclosure

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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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
Susan Thomas, HPS I, PPCMU, Field Operations, Corrections Services, CCHCS





CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Contract Facility Health Care Monitoring Audit



Delano Modified Community Correctional Facility

March 3, 2015

TABLE OF CONTENTS

Introduction _____ *Page 3*

Corrective Action Plan Request _____ *Page 8*

Quantitative Findings – Detailed by Chapter _____ *Page 10*

Qualitative Findings _____ *Page 24*

Staffing Utilization _____ *Page 35*

Inmate Interviews _____ *Page 36*

DATE OF REPORT

April 8, 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 March 3, 2015, at Delano Modified Community Correctional Facility, (DMCCF) which is located in Delano, California. At the time of the audit, CDCR's *Weekly Population Count*, dated March 6, 2015 indicated that DMCCF had a design capacity of 578 beds, of which 513 were occupied with CDCR inmates.

EXECUTIVE SUMMARY

On March 3, 2015, Field Operations unit audit team conducted a health care monitoring audit at DMCCF. The audit team consisted of the following personnel:

- S. Thomas, Health Program Specialist I (HPS I)
- S. Moulis, Regional Physician Advisor
- P. Matranga, Registered Nurse

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, DMCCF achieved an overall compliance rating of **79.7%** with a rating of 90.6% in Administration, 71.6% in Delivery, and 87.4% in Operations. Comparatively

speaking, during the previous audit (conducted August 18 through 19, 2014) the overall quantitative score for DMCCF was 72.4%, indicating an improvement of 7.3 percentage points. Table 2 on the following page provides a comparative overview of facility's performance during the initial and follow-up audit, 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	150.0	83.3%	Yes
2. Access to Health Care Information	80.0	70.0	87.5%	No
6. Continuous Quality Improvement (CQI)	20.0	0.0	0.0%	Yes
13. Licensure and Training	160.0	160.0	100.0%	No
15. Monitoring Logs	150.0	146.2	97.5%	No
20. Staffing	90.0	90.0	100.0%	No
Administration Sub Score:	680.0	616.2	90.6%	
Delivery				
5. Chronic Care	60.0	60.0	100.0%	No
7. Diagnostic Services	120.0	112.5	93.8%	No
8. Medical Emergency Services/Drills	240.0	130.0	54.2%	Yes
9. Medical Emergency Equipment	290.0	106.3	36.7%	Yes
14. Medication Management	180.0	115.0	63.9%	Yes
17. Patient Refusal of Medical Treatment	20.0	20.0	100.0%	No
18. Sick Call	380.0	366.7	96.5%	No
19. Specialty/Hospital Services	150.0	120.0	80.0%	Yes
Delivery Sub-Score:	1,440.0	1,030.5	71.6%	
Operations				
3. ADA Compliance	60.0	60.0	100.0%	No
4. Chemical Agent Exposure	N/A	N/A	N/A	No
10. Grievance/Appeal Procedure	50.0	40.0	80.0%	Yes
11. Infection Control	160.0	140.0	87.5%	No
12. Initial Intake Screening/Health Appraisal	300.0	258.0	86.0%	No
16. Observation Unit	N/A	N/A	N/A	No
Operations Sub-Score:	570.0	498.0	87.4%	
21. Inmate Interviews (not rated)				
Final Score: 2,690.0 2,144.7 79.7%				

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 08/2014	Audit II 03/2015	Variance Increase/(Decrease)
1. Administration	77.8%	83.3%	5.5%
2. Access to Health Care Information	0.0%	87.5%	87.5%
3. ADA Compliance	0.0%	100.0%	100.0%
4. Chemical Agent Exposure	N/A	N/A	N/A
5. Chronic Care	80.0%	100.0%	20.0%
6. Continuous Quality Imprvment (CQI)	0.0%	0.0%	0.0%
7. Diagnostic Services	76.3%	93.8%	17.5%
8. Medical Emergency Services/Drills	82.6%	54.2%	-28.4%
9. Medical Emergency Equipment	36.2%	36.7%	0.5%
10. Grievance/Appeal Procedure	80.0%	80.0%	0.0%
11. Infection Control	40.0%	87.5%	47.5%
12. Initial Intake Screening/Health Appraisal	83.4%	86.0%	2.6%
13. Licensure and Training	93.3%	100.0%	6.7%
14. Medication Management	69.1%	63.9%	-5.2%
15. Monitoring Logs	60.0%	97.5%	37.5%
16. Observation Unit	N/A	N/A	N/A
17. Patient Refusal of Health Care Treatment/ No Show	N/A	100.0%	N/A
18. Sick Call	96.3%	96.5%	0.2%
19. Specialty/Hospital Services	100.0%	80.0%	-20.0%
20. Staffing	100.0%	100.0%	0.0%
Overall Score:	72.4%	79.7%	7.3%

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 DMCCF 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 **May 8, 2015**.

Corrective Action Items – Delano Modified Community Correctional Facility	
Chapter 1, Question 5	The facility does not have a written policy that addresses the requirements for the release of medical information.
Chapter 1, Question 8	The facility's written policy for Chronic Care is not compliant with IMSP&P.
Chapter 1, Question 17	The facility does not have a written policy related to licensure and training.
Chapter 6, Question 1	The facility does not have an approved Continuous Quality Improvement (CQI) plan.
Chapter 6, Question 3	The facility does not hold CQI meetings quarterly.
Chapter 8, Question 5	The nursing staff do not document on the interdisciplinary progress note to show that a face-to-face evaluation of the inmate-patient was completed upon his return from a community hospital emergency department.
Chapter 8, Question 7	The facility's Emergency Response Review Committee (ERRC) does not meet at least once a month.
Chapter 8, Question 8	The facility's EMRRC meeting minutes do not indicate the committee discussed and/or implemented a quality improvement action after reviewing the results of emergency medical responses and/or drills.
Chapter 8, Question 10	The facility does not document the response times of Basic Life Support (BLS) certified medical staff during emergency medical response and/or drills.
Chapter 8, Question 11	The facility's emergency medical drill documentation reflects medical emergency scenarios, but does not document the drill participants or outcome/effectiveness of the medical care rendered.
Chapter 9, Question 1	Emergency response bags are not being inspected on each shift to ensure the seal is secure.
Chapter 9, Question 2	There is no documentation that the Emergency Medical Response Bag is resupplied and resealed after each medical emergency.
Chapter 9, Question 3	The facility does not have a portable suction device in their medical clinic.
Chapter 9, Question 6	The oxygen tank is not checked on every shift for operational readiness.
Chapter 9, Question 8	There is no documentation that the Automated External Defibrillator is checked every shift for operational readiness.
Chapter 9, Question 10	The facility's first aid kits did not contain all the required items (tape & resuscitation masks).
Chapter 9, Question 11	The facility does not have spill kits in all the designated areas of the facility.

Chapter 10, Question 1	The facility's inmate-patient handbook does not explain the health care appeal process.
Chapter 14, Question 2	The PCP does not consistently document the inmate-patient education for newly prescribed medications.
Chapter 14, Question 9	The registered nurse (RN) does not consistently check the inmate-patient's mouth, hands and cup after administering Directly Observed Therapy (DOT) medications.
Chapter 14, Question 10	The inmate-patients do not take all keep on person (KOP) medications to the designated RN prior to transfer.
Chapter 19, Question 6	The PCP does not consistently review the consultant's report and see the inmate-patients returning from specialty appointments for follow-up within the specified time frame.
*Qualitative Action Item #1 (Chapter 2, Question 8)	The inmate-patient's written requests for release of health care information are not noted in the progress notes of the inmate-patient medical files.
*Qualitative Action Item #2 (Chapter 7, Question 2)	The PCP does not consistently review, initial and date an inmate-patient's diagnostic reports within two days of receipt.
*Qualitative Action Item #3 (Chapter 11, Question 10)	The facility does not have a separate storage area for biohazard materials that is labeled and locked.
*Qualitative Action Item #4 (Chapter 11, Question 12)	The facility does not account for all sharps (needles, scalpels, etc) at the end of each shift.
*Qualitative Action Item #5 (Chapter 12, Question 10)	The MCCF RN does not consistently sign and date the CDCR 7371, Health Care Transfer Information Form.
*Qualitative Action Item #6 (Chapter 12, Question 12)	There was no documentation that the inmate-patients received orientation regarding the procedures on how to access health care during the initial intake screening.
*Qualitative Action Item #7 (Chapter 18, Question 7)	Inmate-patients who were referred to the hub or MCCF PCP by the MCCF RN were not consistently seen within the specified time frame.

*Qualitative action items 1 through 9 are failed questions within the passing (85% or higher) quantitative chapters.

QUANTITATIVE FINDINGS - DETAILED BY CHAPTER

Chapter 1: Administration	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	0.0
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	0.0
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	0.0
18. Does the facility have a written policy and/or procedure related to Emergency Services?	10.0	10.0
Point Totals:	180.0	150.0
Final Score:		83.3%

CHAPTER 1 COMMENTS

1. Question 5 – The facility does not have a written policy and/or procedure related to the release of medical information. This equates to 0.0% compliance.
2. Question 8 – The facility's written policy for chronic care is not compliant with the IMSP&P requirements. This equates to 0.0% compliance.
3. Question 17 – The facility does not have a written policy and/or procedure related to health care staff continued licensure and training. This equates to 0.0% compliance.

Chapter 2: Access to Health Care Information	Point Value	Points Awarded
1. Does the treating physician have access to the inmate-patient's CCHCS Electronic Unit Health Record (eUHR)?	10.0	10.0
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	10.0
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	10.0
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	0.0
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	70.0 (80.0)
Final Score:		87.5%

CHAPTER 2 COMMENTS

1. Question 8 – Of the two requests for release of information received, none of the requests were noted in the progress notes of the inmate-patients' shadow medical files. This equates to 0.0% compliance.
2. Questions 9 through 11 – Not applicable. There were no third party requests for release of medical information during the audit period.

Chapter 3: ADA Compliance	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:	100.0%	

CHAPTER 3 COMMENTS

None.

Chapter 4: Chemical Agent Exposure	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	N/A
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	N/A
Point Totals:	20.0	N/A
Final Score:	N/A	

CHAPTER 4 COMMENTS

- Questions 1 and 2 – Not applicable. Three shadow medical files of inmate-patients who were exposed to chemical agents were reviewed. None of the inmate-patients refused decontamination. Therefore, this chapter could not be evaluated.

Chapter 5: Chronic Care	Point Value	Points Awarded
1. Was the inmate-patient's chronic care follow-up visit completed within the 90-day or less time frame, 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 their chronic care appointments during the audit review period.

Chapter 6: Continuous Quality Improvement (CQI)	Point Value	Points Awarded
1. Does the facility have an approved CQI Plan?	10.0	0.0

2. Does the facility CQI Committee ensure a quorum is established per the approved CQI Plan?	10.0	N/A
3. Is there documentation to support the CQI Committee meets at least quarterly?	10.0	0.0
4. Does the documentation of the CQI monitoring activity include the <i>Aspects of Care Monitoring</i> form, or similar form?	10.0	N/A
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	N/A
6. Is there a documented action and follow-up plan for each identified "opportunity for improvement"?	10.0	N/A
Point Totals:	60.0	0.0 (20.0)
Final Score:		0.0%

CHAPTER 6 COMMENTS

1. Question 1 – The facility does not have an approved CQI plan. This equates to 0.0% compliance.
2. Question 2 – Not applicable. This question automatically fails as a result of failure noted in question 6.1. Under the double-failure rule, the points for this question have therefore been removed from the total points available and the question rendered not applicable.
3. Question 3 – The facility held its first CQI meeting on February 24, 2015. The facility did not hold a CQI meeting for the previous quarter. This equates to 0.0% compliance.
4. Questions 4 through 6 – Not applicable. This question automatically fails as a result of failure noted in question 6.1. Under the double-failure rule, the points for this question have therefore been removed from the total points available and the question rendered not applicable.

<i>Chapter 7: Diagnostic Services</i>	Point Value	Points Awarded
1. Was the diagnostic test provided to the inmate-patient within the time frame 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	30.0
Point Totals:	120.0	112.5
Final Score:		93.8%

CHAPTER 7 COMMENTS

1. Question 2 – Of the four inmate-patient shadow medical files reviewed for diagnostic reports, three had diagnostic reports that were initialed and dated by the PCP within two days of receipt. This equates to 75.0% compliance. Although the facility has shown a slight improvement from the previous audit score of 25.0% compliance, this continues to remain a CAP item.

Chapter 8: Medical Emergency Services/Drills	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	N/A
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	0.0
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	0.0
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	0.0
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	0.0
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	0.0
Point Totals:	270.0	130.0 (240.0)
Final Score:		54.2%

CHAPTER 8 COMMENTS

- Question 4 – Not applicable. Of two cases reviewed where the inmate-patients required services that were beyond the level available at the MCCF, both were retained at the hub until the inmate-patients' medical issues were resolved. Since there were no discharge plans available for review, this question was not evaluated.
- Question 5 – Although the facility's nursing staff complete a face-to-face evaluation of the inmate-patient upon the inmate-patient's return from a community hospital emergency department, it is not documented on a CDCR 7230 Interdisciplinary Progress Notes. This equates to 0.0% compliance.
- Question 7 – The facility conducted their first Emergency Medical Response Review Committee (EMRRC) meeting on February 11, 2015. The facility had not held any EMRRC meeting previously during the audit period. This equates to 0.0% compliance.
- Question 8 – The facility's EMRRC Meeting minutes did not reflect the committee discussed and/or implemented a quality improvement action after reviewing the results of the emergency medical response drills. This equates to 0.0% compliance.
- Question 10 – The facility does not document the response times of BLS certified medical staff during emergency medical response and/or drills. This equates to 0.0% compliance.

6. Question 11 – The facility does not document the response times of ACLS certified medical staff during emergency medical response and/or drills. This equates to 0.0% compliance.

Chapter 9: Medical Emergency Equipment	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	0.0
3. Does the facility have functional Portable suction?	50.0	0.0
4. Is there documentation that the Portable suction in each clinic is checked every shift for operational readiness?	30.0	N/A
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	10.0
10. Do the first aid kits contain all required items?	10.0	0.0
11. Are spill kits located in the designated areas?	10.0	6.3
12. Do the spill kits contain all required items?	10.0	10.0
Point Totals:	320.0	106.3 (290.0)
	Final Score:	36.7%

CHAPTER 9 COMMENTS

- Question 1 – There is no documentation that the Emergency Medical Response Bag is secured with a seal. The Emergency Medical Response Bag is stored in an unlocked box and box and the bag is unsealed. This equates to 0.0% compliance.
- Question 2 – The Emergency Medical Response Bag is inventoried once every day; however, the bag is not sealed after inventory is checked. This equates to 0.0% compliance.
- Question 3 – The facility does not have a portable suction in their medical clinic. This equates to 0.0% compliance.
- Question 4 – Not applicable. This question automatically fails as the result of the failure described in question 9.3 delineated immediately above. Under the double-failure rule, the points for this question have therefore been removed from the total available points, and the question rendered non-applicable.
- Question 6 – The oxygen tank is checked once a day, but not on every shift for operational readiness (at least three-quarters full). This equates to 0.0% compliance.
- Question 8 – The Automated External Defibrillator is checked once a day, but not every shift for operational readiness. This equates to 0.0% compliance.
- Question 10 – Of the eight first aid kits checked, none contained all the required items. All the first aid kits were missing resuscitation masks and three kits did not contain tape. This equates to 0.0% compliance.

8. Question 11 – Of the eight areas requiring a spill kit, only five areas had spill kits. The facility did not have spill kits in the laundry, canteen, or visitation areas. This equates to 62.5% compliance.

<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	0.0
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	10.0
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 time frames?	10.0	10.0
5. Does the Appeals Coordinator log all screened/rejected appeals?	10.0	10.0
Point Totals:	50.0	40.0
Final Score:		80.0%

CHAPTER 10 COMMENTS

1. Question 1 – The facility's inmate-patient handbook does not explain the health care grievance/appeal process. The handbook contains information on the non-health care related appeal process. This equates to 0.0% 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	0.0
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	0.0
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	140.0
Final Score:		87.5%

CHAPTER 11 COMMENTS

1. Question 10 – The central storage area for biohazard materials is not labeled or locked. This equates to 0.0% compliance.
2. Question 12 – The facility does not account for all sharps, (needles, scalpels, etc) by documenting the number at the end of each shift. The facility staff only reconciles the sharps once a day. This equates to 0.0% compliance.

<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 PCP ≤ 14 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 time frame? (Immediately, within 24 hours, or within 72 hours)	30.0	N/A
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	N/A
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	18.0
11. Did the PCP document the health appraisal/H&P on the intake H&P form, CDCR 196B?	30.0	30.0
12. At the initial intake screening, did all inmate-patients receive orientation regarding the procedures for accessing health care?	30.0	0.0
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	258.0 (300.0)
Final Score:		86.0%

CHAPTER 12 COMMENTS

1. Question 3 – Not applicable. During the audit review period, no inmate-patients were referred to the PCP by nursing staff following the Initial Intake Screening. Therefore, this question could not be evaluated.

2. Question 4 – Not applicable. During the audit review period there were no inmate-patients presenting with urgent medical, dental or mental health symptoms requiring immediate referral. Therefore, this question could not be evaluated.
3. Question 5 – Not applicable. During the audit review period there were no inmate-patients presenting with medical, dental or mental health symptoms requiring the nurse to contact the hub institution. Therefore, this question could not be evaluated.
4. Question 6 – Not applicable. During the audit review period, there were no inmate-patients with medical, dental, or mental health symptoms that required a referral for a follow-up appointment. Therefore, this question could not be evaluated.
5. Question 10 – Of the five shadow medical files reviewed, three included the CDCR 7371 form signed by the receiving MCCF nurse. This equates to 60.0% compliance.
6. Question 12 – Of the five shadow medical files reviewed, none of the files included documentation to show that the inmate-patient had received orientation regarding the procedures for accessing health care at the time of initial intake screening. This equates to 0.0% compliance. This is a significant decline from the previous audit rating of 100% compliance.
7. Question 14 – 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 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:		100.0%

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	30.0
2. Did the prescribing PCP document that they explained the medication to the inmate-patient?	30.0	25.0

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	30.0
9. Does the RN check every inmate-patient's mouth, hands and cup after administering DOT medications?	30.0	0.0
10. Does the inmate-patient take all keep on person (KOP) medications to the designated RN prior to transfer?	30.0	0.0
11. Does the RN verify the KOP medications against the current pharmacy medication profile prior to transfer?	30.0	N/A
Point Totals:	270.0	115.0 (180.0)
Final Score:		63.9%

CHAPTER 14 COMMENTS

1. Question 2 – Of the six shadow medical files reviewed, five included documentation showing that the PCP had provided inmate-patient education for the medication. This equates to 83.3% compliance.
2. Question 3 – Not applicable. There were no inmate-patients who had missed three consecutive doses or showed a pattern of missed doses of medications during the audit review period. Therefore, this question could not be evaluated.
3. Question 5 – Not applicable. The review of shadow medical files and medication administration records (MAR) revealed that there had been no inmate-patient no shows for medication administration during the audit review period. Therefore, this question could not be evaluated.
4. Question 6 – Not applicable. The review of shadow medical files and MARs revealed that there had been no inmate-patient refusals for medication administration during the audit review period. Therefore, this question could not be evaluated.
5. Question 7 – Not applicable. The review of shadow medical files and MAR revealed there were no documented medication errors during the audit review period. Therefore, this question could not be evaluated.
6. Question 9 – The facility RN does not consistently follow DOT medication protocols by checking the inmate-patient's hands, mouth and cup to ensure the inmate-patients swallowed their medications when administering DOT medications. This equates to 0.0% compliance.
7. Question 10 – The facility RN stated that the inmate-patients do not take all their KOP medications to the designated RN prior to transfer. This equates to 0.0% compliance. This is a significant decline from the previous audit rating of 100% compliance.
8. Question 11 – Not applicable. This question automatically fails as the result of the failure described in question 10 delineated immediately above. Under the double-failure rule, the points for this question have therefore been removed from the total available points, and the question rendered non-applicable.

Chapter 15: Monitoring Log	Point Value	Points Awarded
1. Are inmate-patients seen within time frames set forth in the sick call policy?	30.0	26.2
2. Are inmate-patients seen within the time frames set forth in the specialty care policy?	30.0	30.0
3. Are inmate-patients seen within the time frames set forth in the emergency/hospital services policy?	30.0	30.0
4. Are inmate-patients seen within time frames as it relates to chronic care policy?	30.0	30.0
5. Are inmate-patients seen within time frames set forth in the initial intake screening/health appraisal policy?	30.0	30.0
Point Totals:	150.0	146.2
Final Score:		97.5%

CHAPTER 15 COMMENTS

- Question 1 – Based on the sick call monitoring logs submitted by facility for the audit review period, a total of 127 sick call appointment requests were referred to PCP for follow-up, of which 111 inmate-patients were seen by an PCP within the specified time frame. This equates to 87.4% compliance.

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, this chapter could not be evaluated.

Chapter 17: Patient Refusal of Health Care Treatment/No Show	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</i> Form?	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 showed for their health care appointments or treatments during the audit review period. Therefore, these questions could not be evaluated.

Chapter 18: Sick Call	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 time frame?	30.0	16.7
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	30.0
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	30.0
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	30.0
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	30.0
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	366.7 (380.0)
Final Score:		96.5%

CHAPTER 18 COMMENTS

1. Question 7 – Of nine inmate-patients who were referred to the hub or MCCF PCP by the MCCF RN, five were seen within the specified time frame. This equates to 55.6% compliance. This is a significant decline from the previous audit rating of 100% compliance.
2. Question 8 – Not applicable. Out of 12 inmate-patient shadow medical files reviewed, none of the inmate-patients had presented to sick call three or more times in a one month period for the same complaint, during the audit review period. Therefore, this question was 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 time frame 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 time frame? (≤ 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. Of the two shadow medical files reviewed for specialty services, one inmate-patient has not returned to the MCCF from their appointment. There were no immediate medication orders or follow-up instructions for the one inmate-patient who returned to the MCCF from a specialty consult appointment. Therefore, this question could not be evaluated.
3. Question 6 – A review of shadow medical files of two inmate-patients who were referred for specialty services revealed one inmate-patient had not yet returned to the MCCF. The other shadow medical file revealed no documentation that the PCP reviewed the consultant's report or saw the inmate-patient who returned to the MCCF from a specialty consult appointment. This equates to 0.0% compliance.

Chapter 20: Staffing	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 medical record. At DMCCF the personnel interviewed included the following:

- E. Komin, – Chief of Corrections
- V. Mitchell – Captain
- T. Martinelli – Medical Doctor
- D. Walker – Nurse Practitioner
- J. Espain – Registered Nurse
- M. Ruiz – Certified Nurse Assistant

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, Operations, Recent Operational Changes, Emergency Medical Response Drill and New CAP Issues.

SUMMARY OF QUALITATIVE FINDINGS

Subsequent to the previous audit, there has been a complete overhaul to the health care staff. The facility has hired a nurse practitioner and additional nursing staff. The audit team observed the DMCCF medical clinic to be clean and well organized. The audit team also observed the health care team to be working very well together. The examination room, supply room and office desk area were well organized and clear of any clutter. This was a major improvement from the previous audit. The audit team observed medical and custody staff to be cooperative with each other with regard to the movement of inmate-patients from housing units to the medical department.

There was a marked improvement in performance in the administration and operations areas, but the delivery function remained status quo, resulting in an increase in the overall compliance score to 79.7%. This score is still below the required compliance score of 85.0%; however the audit team found the current management team engaged and interested in the health care being provided to the inmate-patients housed at this facility. Medical and custody supervisors communicate with each other on a regular basis and resolve any issues as quickly as possible when a problem arises.

PRIOR CAP RESOLUTION

During the August 2014 audit, DMCCF received an overall rating of 72.4% compliance; resulting in a total of 47 CAP items. The August 2014 audit CAP items are as follows:

1. *The facility does not have a written policy and/or procedure related to chronic care. (Chapter 1, Question 8)* During the August 2014 audit, the facility received a rating of 0.0% compliance. During the current audit, the facility again received a rating of 0.0% compliance due to the facility's written policy being non-compliant with IMSP&P requirements. This issue is considered to be unresolved and will continue to be the subject of monitoring during subsequent audits.
2. *The facility does not have a written policy and/or procedure related to History and Physical (H&P) Examination. (Chapter 1, Question 10)* During the August 2014 audit, the facility received a rating of 0.0% compliance. Following the August 2014 audit, the facility has updated its H&P policy to include the required components, resulting in a rating of 100% compliance. This issue is considered resolved.
3. *The facility does not have a written policy and/or procedure related to the American's with Disability Act (ADA). (Chapter 1, Question 14)* During the August 2014 audit, the facility received a rating of 0.0% compliance. Following the August 2014 audit, the facility has updated its ADA policy to include the required components, resulting in a rating of 100% compliance. This issue is considered resolved.
4. *The facility does not have a written policy and/or procedure related to licensure and training. (Chapter 1, Question 17)* During the August 2014 audit, the facility received a rating of 0.0% compliance. During the current audit, the facility again received a rating of 0.0% compliance as the facility's policy does not include all the required components. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.
5. *The facility does not have or maintain a release of information (ROI) log. (Chapter 2, Question 3)* During the August 2014 audit, the facility received a rating of 0.0% compliance. Following the August 2014 audit, the facility implemented an ROI log to track inmate-patient and third party requests for release of health care information. This issue is considered resolved.
6. *The facility does not have 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. (Chapter 3, Question 1)* During the August 2014 audit, the facility received a rating of 0.0% compliance. Following the August 2014 audit, the facility has implemented an ADA policy to include the required components, resulting in a rating of 100% compliance. This issue is considered resolved.
7. *The facility does not have 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. (Chapter 3, Question 2)* During the August 2014 audit, the facility received a rating of 0.0% compliance. Following the August 2014 audit, the facility has implemented an ADA policy to include the required components, resulting in a rating of 100% compliance. This issue is considered resolved.

8. *The facility does not have 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. (Chapter 3, Question 3)* During the August 2014 audit, the facility received a rating of 0.0% compliance. Following the August 2014 audit, the facility has implemented an ADA policy to include the required components, resulting in a rating of 100% compliance. This issue is considered resolved.
9. *The facility does not have a local operating procedure to provide an interim accommodation while an appliance is ordered, repaired, or in the process of being replaced. (Chapter 3, Question 4)* During the August 2014 audit, the facility received a rating of 0.0% compliance. Following the August 2014 audit, the facility has implemented an ADA policy to include the required components, resulting in a rating of 100% compliance. This issue is considered resolved.
10. *The facility does not have a local operating procedure explaining how the facility adds or removes an inmate-patient from the DPP list. (Chapter 3, Question 5)* During the August 2014 audit, the facility received a rating of 0.0% compliance. Following the August 2014 audit, the facility has implemented an ADA policy to include the required components, resulting in a rating of 100% compliance. This issue is considered resolved.
11. *The facility does not have 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 encounter. (Chapter 3, Question 6)* During the August 2014 audit, the facility received a rating of 0.0% compliance. Following the August 2014 audit, the facility has implemented a policy explaining how the facility ensures and documents the establishment of effective communication between health care staff and an inmate-patient during each encounter, resulting in a rating of 100% compliance. This issue is considered resolved.
12. *The facility's shadow files do not have documentation showing that chronic care follow-up visits are completed within the 90-day or less time frame or as ordered by the Primary Care Provider (PCP). (Chapter 5, Question 1)* During the August 2014 audit, the facility received a rating of 60.0% compliance. During the current audit, review of four inmate-patient shadow medical files indicates all four inmate-patients are seen for a chronic care follow-up appointment within the specified time frame, resulting in a rating of 100% compliance. This issue is considered resolved.
13. *The facility does not have an approved Continuous Quality Improvement (CQI) Plan. (Chapter 6, Question 1)* During the August 2014 audit, the facility received a rating of 0.0% compliance. During the current audit, the facility was not able to provide the audit team with the CQI plan for the audit review period, again resulting in a rating of 0.0% compliance. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.
14. *Diagnostic test results are not consistently provided to the inmate-patients within the specified time frame by the PCP. (Chapter 7, Question 1)* During the August 2014 audit, the facility received a rating of 80.0% compliance. During the current audit, review of the shadow medical files indicates the diagnostic test results are consistently provided to the inmate-patients within the specified time frames, resulting in a rating of 100% compliance. This issue is considered resolved.
15. *The PCP does not review, initial, and date inmate-patients' diagnostic reports within two days of receipt. (Chapter 7, Question 2)* During the August 2014 audit, the facility received a rating of

25.0% compliance. During the current audit, the facility received a rating of 75.0% compliance as only three out of four shadow medical files reviewed indicate the PCP reviews, initials, and dates the inmate-patient's diagnostic reports within two days of receipt. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.

16. *The RN does not document their face-to-face evaluation of inmate-patients upon their return to the facility from the community hospital emergency department. (Chapter 8, Question 5)* During the August 2014 audit, the facility received a rating of 0.0% compliance. During the current audit, it was noted that the nursing staff complete their face-to-face evaluation of inmate-patient upon their return to the facility from a community hospital emergency department. However, the face-to-face evaluation is not documented on the CDCR 7230, Interdisciplinary Progress Note, resulting in a rating of 0.0% compliance. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.
17. *The facility does not have an Emergency Medical Response Review Committee (EMRRC). (Chapter 8, Question 7)* During the August 2014 audit, the facility received a rating of 0.0% compliance. During the current audit, the facility again received a rating of 0.0% compliance as the facility did not hold any EMRRC meetings during audit review period. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.
18. *The health care staff do not document that the Emergency Response Bag is checked and secured with a seal during each shift. (Chapter 9, Question 1)* During the August 2014 audit, the facility received a rating of 0.0% compliance. Subsequent to the previous audit, the facility created a checklist to document the bag is being checked; however, the facility only checks the bag once a day and not on each shift. Additionally, the emergency response bag is not secured with a seal, resulting in a rating of 0.0% compliance for this requirement. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.
19. *The health care staff do not document that the Emergency Medical Response Bag is re-supplied and re-sealed after each medical emergency. (Chapter 9, Question 2)* During the August 2014 audit, the facility received a rating of 0.0% compliance. Subsequent to the previous audit, the facility created a checklist to ensure the bag has all required items; however, the emergency response bag is not secured with a seal. Additionally, during the staff interviews, it was learned that the supplies are taken from the bag to use in the clinic for non-emergencies, again resulting in a rating of 0.0% compliance. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.
20. *The facility does not have a portable suction device. (Chapter 9, Question 3)* During the August 2014 audit, the facility received a rating of 0.0% compliance. During the current audit, the facility again received a rating of 0.0% compliance because the facility failed to correct this deficiency by not installing a portable suction device in its medical clinic. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.
21. *The health care staff do not document that the oxygen tank(s) are checked every shift for operational readiness (at least three-quarters full). (Chapter 9, Question 6)* During the August 2014 audit, the facility received a rating of 0.0% compliance. Subsequent to the August 2014 audit, the facility created a checklist to document the oxygen tank is being checked; however, the facility only checks the oxygen tank once a day, not on each shift, again resulting in a rating

of 0.0% compliance. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.

22. *The health care staff do not document that the Automated External Defibrillator (AED) is checked every shift for operational readiness. (Chapter 9, Question 8)* During the August 2014 audit, the facility received a rating of 0.0% compliance. Subsequent to the August 2014 audit, the facility created a checklist to document the AED is being checked; however, the facility only checks the AED once a day, not on each shift, again resulting in a rating of 0.0% compliance. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.
23. *The first aid kits did not contain all the required items. (Chapter 9, Question 10)* During the August 2014 audit, the facility received a rating of 0.0% compliance. During the current audit, the facility again received a rating of 0.0% compliance as all first aid kits inspected were missing a resuscitation mask and tape and none of the kits were sealed. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.
24. *Spill kits are not placed in 100% of the designated areas in the facility. (Chapter 9, Question 11)* During the August 2014 audit, the facility received a rating of 50.0% compliance. During the current audit, the facility received a rating of 62.5% compliance as of the eight areas reviewed, five had a spill kit. The facility did not have a spill kits in the laundry, canteen, or visitation areas. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.
25. *The Delano MCCF Inmate Orientation Manual does not explain the grievance/appeal process in detail. (Chapter 10, Question 1)* During the August 2014 audit, the facility received a rating of 0.0% compliance. The facility's CAP states the handbook was updated; however, a review of the inmate handbook revealed that the handbook does not explain the health care appeal process in detail, again resulting in a rating of 0.0% compliance. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.
26. *The facility does not have a designated area to isolate inmate-patients with a potential communicable disease from the rest of the inmate-patients present in the clinic. (Chapter 11, Question 2)* During the August 2014 audit, the facility received a rating of 0.0% compliance as during the interview process, the nursing staff was unable to identify a designated location/area in the facility to isolate inmate-patients with a potential communicable disease. During the current audit, the facility received a rating of 100% compliance as nursing staff were able to identify a location/area within the facility designated for this purpose. This issue is considered resolved.
27. *Health care staff (RN) does not practice proper hand hygiene. (Chapter 11, Question 3)* During the August 2014 audit, the facility received a rating of 0.0% compliance. During the current audit, the facility received a rating of 100% compliance as health care staff was observed practicing proper hand hygiene. This issue is considered resolved.
28. *Health care staff does not clean the clinic areas after each inmate-patient use. (Chapter 11, Question 6)* During the August 2014 audit, the facility received a rating of 0.0% compliance. During the current audit, the facility received a rating of 100% compliance as health care staff was observed cleaning the clinic areas after each inmate-patient encounter. This issue is considered resolved.

29. *Health care staff does not complete environmental cleaning of “high touch surfaces” within the medical clinic at least once a day. (Chapter 11, Question 7)* During the August 2014 audit, the facility received a rating of 0.0% compliance. During the current audit, the facility received a rating of 100% compliance as health care staff was observed completing environmental cleaning of “high-touch surfaces” within the medical clinic at least once a day. This issue is considered resolved.
30. *The facility’s central storage area for biohazard material is not labeled or locked. (Chapter 11, Question 10)* During the August 2014 audit, the facility received a rating of 0.0% compliance. The facility’s CAP states the biohazard cabinet is labeled and locked. However, during the current audit, it was identified that the central storage area for biohazard material is not labeled or locked, again resulting in a rating of 0.0% compliance. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.
31. *Health care staff does not account for all sharps (needles, scalpels, etc.) by documenting the number at the end of each shift. (Chapter 11, Question 12)* During the August 2014 audit, the facility received a rating of 0.0% compliance. During the current audit, the facility again received a rating of 0.0% compliance as the facility does not account for all sharps, (needles, scalpels, etc) by documenting the number at the end of each shift. The facility only reconciles the sharps once a day. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.
32. *Health care staff does not have a tracking/accountability system in place enabling them to reconcile any and all sharps in the medical clinic. (Chapter 11, Question 13)* During the August 2014 audit, the facility received a rating of 0.0% compliance. During the current audit, the facility received a rating of 100% compliance as the facility produced a log documenting the facility reconciles sharps daily. This issue is considered resolved.
33. *Inmate-patient did not receive a complete H&P exam by a PCP \leq 14 calendar days of arrival at the facility. (Chapter 12, Question 2)* During the August 2014 audit, the facility received a rating of 85.7% compliance. Subsequent to the August 2014, the facility hired a nurse practitioner who provides 20 hours coverage a week. During the current audit, review of the shadow medical files indicates the inmate-patients receive a complete H&P exam within 14 days of arrival at the facility, resulting in a rating of 100% compliance. This issue is considered resolved.
34. *Health care staff neither reordered current prescription medications within 8 hours of inmate-patients’ arrival at the facility, nor were they seen by a PCP within 24 hours. (Chapter 12, Question 8)* During the August 2014 audit, the facility received a rating of 75.0% compliance. During the current audit, review of the shadow medical files indicates there is no interruption in medication doses, resulting in a rating of 100% compliance. This issue is considered resolved.
35. *The facility RN does not consult with the hub (NKSP) RN and/or specialty services schedulers to verify if the arriving inmate-patient has a pending medical appointment. (Chapter 12, Question 9)* During the August 2014 audit, the facility received a rating of 0.0% compliance. During the nursing staff interview, it was reported the health care staff contact the hub institution upon the inmate-patient’s arrival at the facility, to enquire regarding any pending medical appointments, resulting in a rating of 100% compliance. This issue is considered resolved.

36. *The facility RN does not sign and date the CDCR 7371, Health Care Transfer Information Form. (Chapter 12, Question 10)* During the August 2014 audit, the facility received a rating of 71.4% compliance. During the review of the shadow medical files of inmate-patients who had arrived at the facility during the audit period, the nurse-auditor found that the facility RN did not consistently sign and date the CDCR 7371, *Health Care Transfer Information* form, resulting in a rating of 60.0% compliance. This issue is considered unresolved and will continue to be the subject of monitoring during subsequent audits.
37. *Inmate-patients do not receive a complete screening for the signs and symptoms of Tuberculosis (TB) upon arrival at the facility. (Chapter 12, Question 13)* During the August 2014 audit, the facility received a rating of 85.7% compliance. During the current audit, review of the shadow medical files indicates the inmate-patients receive a complete screening for the signs and symptoms of TB upon arrival at the facility, resulting in a rating of 100% compliance. This issue is considered resolved.
38. *Medications are not administered to the inmate-patient as ordered by the PCP. (Chapter 14, Question 1)* During the August 2014 audit, the facility received a rating of 71.4% compliance. During the current audit, a review of seven shadow medical files indicate medications are administered to the inmate-patient as ordered by the PCP, resulting in a rating of 100% compliance. This issue is considered resolved.
39. *There was no documentation in the eUHR/shadow file to show that the PCP explained newly prescribed medications and their side-effects to the inmate-patients. (Chapter 14, Question 2)* During the August 2014 audit, the facility received a rating of 42.9% compliance. During the current audit, of the six shadow medical files reviewed, five include documentation that the PCP explained the newly prescribed medications to the inmate-patient, resulting in a rating of 83.3% compliance. Although a significant improvement from the previous audit, the compliance rating benchmark was not attained. As such, this issue is considered unresolved and will be the subject of monitoring during subsequent audits.
40. *The inmate-patients at the facility do not take all Keep on Person (KOP) medications to the designated RN prior to transferring out of the facility. (Chapter 14, Question 10)* During the August 2014 audit, the facility received a rating of 0.0% compliance in this area. During the current audit, the interviewed RN stated that the inmate-patients do not take all their KOP medications to the designated RN prior to transferring out of the facility, again resulting in 0.0% compliance. This issue remains unresolved and will be the subject of monitoring during subsequent audits.
41. *The facility submits Sick Call monitoring logs with incomplete data. (Chapter 15, Question 1)* During the August 2014 audit, the facility received a rating of 0.0% compliance in this area. During the current audit, the facility's compliance rating increased to 87.4%. As facility attained a rating above the compliance benchmark, this issues is considered resolved.
42. *The facility submits Chronic Care monitoring logs with incomplete data. (Chapter 15, Question 4)* During the August 2014 audit, the facility received a rating of 0.0% compliance in this area. During the current audit, the facility's compliance rating increased to 100%. This issue is considered resolved.
43. *The facility submits Initial Intake Screening monitoring logs with incomplete data. (Chapter 15, Question 5)* During the August 2014 audit, the facility received a rating of 0.0% compliance in

this area. During the current audit, the facility's compliance rating increased to 100%. This issue is considered resolved.

44. *The facility is required to have a system in place to ensure health care staff receives training on new or revised policies that are based on IMSP&P requirements. (Qualitative Action Item #1 - Chapter 13, Question 7)* During the August 2014 audit, the facility received a rating of 0.0% compliance. During the current audit, the auditor interviewed the facility RN regarding the facility's tracking process to track health care staff training on facility's policies and facility RN provided copies of the tracking log that showed the facility currently has a system in place to track the health care staff training resulting in a rating of 100% compliance. This issue is considered resolved.
45. *The RN is required to review all sick call forms within one day of receipt. (Qualitative Action Item #2 - Chapter 18, Question 2)* During the August 2014 audit, the facility received a rating of 82.4% compliance. During the interview with the facility RN, the facility RN reported that the nursing staff collect the sick call slips twice a day and review all the sick call forms on the same day they are received, resulting in a rating of 100% compliance. This issue is considered resolved.
46. *The facility is required to maintain all inmate-patient shadow files in an organized, accurate, and confidential manner. (Qualitative Action Item #2 - Chapter 18, Question 9)* During the August 2014 audit, the facility received a rating of 0.0% compliance as the medical record documents were found loose in the shadow medical files. During the current audit, all papers were secured in an uniform, neat fashion within all shadow medical files, resulting in a rating of 100% compliance. This issue is considered resolved.
47. *The facility is required to update their Infection Control Policy to ensure the policy is in accordance with Chapter 10, Public Health and Infection Control, of the IMSP&P.* The facility has updated their policy 801, Prison Medical Care System Reform, Medical, to include Infection Control; however, the section is not in compliance with IMSP&P.

OPERATIONS

Personnel:

Administration

While conducting an inspection of the facility to check the first aid and spill kits, the HPS I-auditor observed the facility to be clean and well maintained. All staff interactions with the audit team were professional and staff was forthcoming in their responses to auditor's questions. The audit team observed health care staff conduct their day to day operations in the small but clean medical clinic. The health care staff were observed to be interacting and working cohesively amongst themselves and with the custody staff during their daily functions. Staff appeared to be professional and efficient in communicating their requests to the custody staff for bringing the inmate-patients to medical clinic for appointments or for medication pick up.

The facility's policy 801, *Prison Medical Care System Reform-Medical* was updated since the previous audit and it currently includes sections on chronic care, history and physical requirement, licensure and

initial training, emergency medical response committee, continuous quality improvement plan, infection control, and continued training on new and revised policies that are based on CCHCS's Inmate Medical Services Policies & Procedures (IMSP&P). Even though the abovementioned sections were added, they are concise and are not as comprehensive as it is outlined in the IMSP&P and the facility could benefit from revising those sections to include detailed instructions. The facility still does not have a written policy related to the requirements for the release of health information.

Since the previous audit of the facility, there has been a change in administration. The current Chief of Corrections seemed to be very interested and involved in the audit process and was eager to meet with the audit team to discuss the findings at the facility.

DMCCF Health Care Staff - Nursing

The nurse-auditor observed the medication passes, nursing sick call processes, chronic care visits, emergency medical response drill, nursing staff's rounds to the housing units to collect sick call forms, nursing staff's inspection of emergency response equipment for operational readiness. The nurse-auditor also reviewed shadow medical files and interviewed the facility RN on various medical processes. During discussion of TB screening, the facility RN reported that they complete a TB test on every inmate-patient, who has not been identified as TB positive, upon their arrival to DMCCF. The nurse-auditor informed the facility RN that a TB screening is required to be administered only for the newly arriving inmate-patients at their facility.

The facility RN reported that sick call slips are picked up from the housing units by nursing staff twice a day; however, it has not been the nurses' routine to make rounds in Receiving and Release to check the temporary holding cells. The nurse-auditor informed the facility RN of the necessity of making nursing rounds to the holding cells daily. The facility RN reported she would instruct nursing staff to make rounds in Receiving and Release at least once a day. This process will be monitored by the audit team during subsequent audits to ensure compliance.

The emergency medical response bag is stored in the main clinic inside a box. The bag is not sealed with a seal and is inventoried only once a day to ensure it contains all the required items. The facility RN reported that the nursing staff sometimes take supplies out of the emergency medical response bag for use during the day. The nurse-auditor informed the facility RN that the bag is required to be sealed, and the bag is required to be checked on each shift and appropriately documented ensuring the seal is intact. The facility RN stated that the facility was in the process of ordering the required seals for the emergency medical response bag and assured the auditor that she will instruct health care staff not to utilize the items in the bag for daily use and they check the bag on each shift to ensure that the seal is intact.

Emergency medical equipment, oxygen tanks and AED are currently being checked only once daily for operational readiness. The nurse-auditor informed the facility RN that the equipment is required to be checked and documented on each shift for operational readiness.

The hazardous waste is stored in the health care supplies room located inside the medical office. The room is not labeled as containing hazardous waste and is left unlocked during business hours. It is recommended the facility find an alternate location for the biohazardous waste, a room that is properly

identified and locked at all times. Additionally, the biohazardous storage area shall not be situated in close proximity to facility staff or health care supplies.

DMCCF Health Care Staff – Primary Care Provider

The physician-auditor interviewed both the facility physician and the NP. The facility physician acts as the Medical Director and provides oversight and mentors the NP. The physician-auditor reviewed eight shadow medical files (4 chronic care, 2 sick call, and 2 H&P) completed by the facility physician and the NP and found no major deviations from the standard of care for either the facility physician or the nurse practitioner. They appeared to work well together, with health care staff, and with custody. The facility physician stated that the facility Chief was very attentive to all of health care staffs' needs. During the physician-auditor's interview with the NP, she indicated she was not familiar with Title 15 and its application to medical necessity. The physician-auditor discussed Title 15 and medical necessity as it applies to the CDCR inmate-patients with the NP. A copy of Title 15 was provided to the NP and she agreed to review the requirements. The facility physician was familiar with Title 15 and did not require any remedial training or review. Due to the changes made to health care staffing at DMCCF following the previous audit, it appears to have resulted in an overall improvement of health care delivery at the facility as witnessed during the current audit.

RECENT OPERATIONAL CHANGES

The Facility's nursing staff are scheduled to start performing lab draws onsite beginning April 1, 2015. The facility has signed a contract with Quest Diagnostics, a health care diagnostics company, for the pickup of lab specimens from DMCCF. This will eliminate the need to transport the inmate-patients to the hub institution for laboratory services and is expected to reduce the number of inmate-patient refusals for these types of appointments.

EMERGENCY MEDICAL RESPONSE DRILL

An emergency medical response drill was conducted during the onsite audit on March 3, 2015 which involved a patient in cardiac arrest. The mock medical emergency drill was staged in the hallway outside the medical clinic. The RN and CNA attended and actively participated in the drill. Although the physician was present at the facility, he arrived at the scene when the drill was already in progress and he failed to participate in the drill; he was merely an observer the entire time. Although the custody staff were on scene, they did not participate in the drill. Due to health care staff not bringing the emergency medical bag or equipment to the scene, if the medical emergency had been real, the care provided would not have been sufficient to sustain life.

The audit team recommended that the facility conduct frequent emergency medical drills and provide adequate emergency medical response training to all health care staff in order to prepare them to effectively manage emergency medical responses. PPCMU recommends that the facility consider this as high priority in order to achieve effective outcomes during actual emergencies.

The facility's emergency medical response drill reports did not contain all required information. The auditor informed the physician that the reports needed to be comprehensive and include all aspects of the drill. A sample of emergency medical response drill report was provided to the facility physician for reference.

CONCLUSION

DMCCF's current audit findings revealed that the facility is continuing to perform poorly in delivering health care services to the inmate-patients housed in this facility. This is clearly evidenced by the consistently low compliance score with only a marginal improvement of 7.3% from the previous audit score. Although the facility succeeded in addressing 28 of the 47 CAP items from the previous audit, the facility has failed to address a number of key issues identified in areas such as; administration, health care delivery, diagnostic services, emergency services and drills, emergency equipment, etc. It is imperative that the facility work with all diligence to resolve the outstanding corrective action items from the previous and current audits and strive to maintain a minimum compliance rating of 85.0%.

In order for DMCCF's medical department to meet CCHCS's expectations regarding health care delivery to CDCR inmate-patients, there must be identifiable efforts demonstrated to meet compliance with CCHCS's standards of care as stated in IMSP&P. DMCCF health care staff were enthusiastic about receiving feedback from the CCHCS audit team, and acknowledged their need to adhere to contractual obligations in providing adequate inmate-patient health care. The audit team will continue to monitor DMCCF as they work to resolve the outstanding CAP items and continue to improve their compliance score by providing adequate and consistent health care services to the inmate-patient population housed at this facility.

STAFFING UTILIZATION

Prior to the onsite audit at DMCCF, 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 per week, four hours a day.

DMCCF is currently staffed with one nurse practitioner who is onsite 5 days a week, 4 hours a day, 20 hours a week and one physician who is onsite 2 days a week and provides oversight to the nurse practitioner. The facility currently has six registered nurses (RN) providing coverage at the facility 24 hours/7 days a week. DMCCF is within current contractual guidelines to provide onsite physician and nursing coverage.

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 a random sample of the inmate-patient population and one or more of the Inmate Advisory Council (IAC) executive body members.

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:

Eight inmate-patients were randomly chosen for interview prior to the onsite audit. All inmate-patients appeared to be genuine and forthcoming in their responses to the questions asked by the audit team.

1. Regarding question 1 – All eight inmates interviewed were aware of the sick call process at the facility and had no negative responses.

2. Regarding question 2 – All inmates reported they know where to obtain the sick call forms. Two of the inmates reported they sometimes have difficulty obtaining a sick call form. They stated the forms are not always on the wall outside the dormitories and not always available at the officer's desk inside the housing pod. During the onsite audit, there was a large supply of sick call forms in the racks in the hallway outside both housing areas.

In addition to the above responses, two inmate-patients stated that the inmate-patient population at DMCCF is hesitant to submit sick call requests because of the perception that if they were required to be sent to the hub facility for receiving care, they would be retained at the hub. The physician-auditor believes the inmate-patients who are retained at the hub have a medical issue which mandates the inmate-patients remain at the hub since the DMCCF is not equipped to handle the medical issue. However, the audit team is concerned the perception may cause inmate-patients who require medical treatment to refrain from submitting a sick call request.

3. Regarding question 3 – All inmates reported they knew where to submit the completed sick call forms.
4. Regarding question 4 – All inmate-patients reported if they needed assistance completing a sick call form or any other type of form, they would ask another inmate-patient or custody staff for assistance.
5. Regarding question 5 – Two inmate-patients stated they were not aware of the health care grievance/appeal process. The HPS I-auditor explained the appeal process to those inmate-patients. The other six inmate-patients were aware of the health care appeal process and had no negative comments regarding the health care appeal process at this facility.
6. Regarding question 6 – One inmate-patient reported the 602-HC forms are not always available on the wall outside the housing units. During the onsite audit, there was a large supply of the 602-HC forms in the racks in the hallway outside both housing areas.
7. Regarding question 7 – The six inmate-patients stated they were aware of where to submit the completed 602-HC forms.
8. Regarding question 8 – All inmate-patients reported if they needed assistance completing a 602-HC, health care appeal form or any other type of form they would ask another inmate-patient or custody staff for assistance.
9. Regarding questions 9 through 23 –Not applicable. There were no inmate-patients with qualifying disabilities at DMCCF during the review period for this audit.

Delano Modified Community Correctional Facility
Health Care Monitoring Audit - Corrective Action Plan
Audit Dates: 03-03-2015
CAP Date: April 8, 2015



Reference Chap/Q		Specific Nature of Non-Compliance	Facility's Proposed Action Plan	Anticipated Completion Date	Assigned Personnel	Action Plan Status
1	5	The facility does not have a written policy that addresses the requirements for the release of medical information.				Not Completed / In Progress / Completed [DATE]
1	8	The facility's written policy for Chronic Care is not compliant with IMSP&P.				Not Completed / In Progress / Completed [DATE]
1	17	The facility does not have a written policy related to licensure and training.				Not Completed / In Progress / Completed [DATE]
6	1	The facility does not have an approved Continuous Quality Improvement (CQI) plan.				Not Completed / In Progress / Completed [DATE]
6	3	The facility does not hold CQI meetings quarterly.				Not Completed / In Progress / Completed [DATE]
8	5	The nursing staff do not document on the interdisciplinary progress note to show that a face-to-face evaluation of the inmate-patient was completed upon his return from a community hospital emergency department.				Not Completed / In Progress / Completed [DATE]
8	7	The facility's Emergency Response Review Committee (ERRC) does not meet at least once a month.				Not Completed / In Progress / Completed [DATE]
8	8	The facility's EMRRC meeting minutes do not indicate the committee discussed and/or implemented a quality improvement action after reviewing the results of emergency medical responses and/or drills.				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
8	10	The facility does not document the response times of Basic Life Support (BLS) certified medical staff during emergency medical response and/or drills.			Not Completed / In Progress / Completed [DATE]
8	11	The facility's emergency medical drill documentation reflects medical emergency scenarios, but does not document the drill participants or outcome/effectiveness of the medical care rendered.			Not Completed / In Progress / Completed [DATE]
9	1	Emergency response bags are not being inspected on each shift to ensure the seal is secure.			Not Completed / In Progress / Completed [DATE]
9	2	There is no documentation that the Emergency Medical Response Bag is resupplied and resealed after each medical emergency.			Not Completed / In Progress / Completed [DATE]
9	3	The facility does not have a portable suction device in their medical clinic.			Not Completed / In Progress / Completed [DATE]
9	6	The oxygen tank is not checked on every shift for operational readiness.			Not Completed / In Progress / Completed [DATE]
9	8	There is no documentation that the Automated External Defibrillator is checked every shift for operational readiness.			Not Completed / In Progress / Completed [DATE]
9	10	The facility's first aid kits did not contain all the required items (tape & resuscitation masks).			Not Completed / In Progress / Completed [DATE]
9	11	The facility does not have spill kits in all the designated areas of the facility.			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
10	1	The facility's inmate-patient handbook does not explain the health care appeal process.			Not Completed / In Progress / Completed [DATE]
14	2	The PCP does not consistently document the inmate-patient education for newly prescribed medications.			Not Completed / In Progress / Completed [DATE]
14	9	The registered nurse (RN) does not consistently check the inmate-patient's mouth, hands and cup after administering Directly Observed Therapy (DOT) medications.			Not Completed / In Progress / Completed [DATE]
14	10	The inmate-patients do not take all keep on person (KOP) medications to the designated RN prior to transfer.			Not Completed / In Progress / Completed [DATE]
19	6	The PCP does not consistently review the consultant's report and see the inmate-patients returning from specialty appointments for follow-up within the specified time frame.			Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #1 (Ch 2, Q. 8)	The inmate-patient's written requests for release of health care information are not noted in the progress notes of the inmate-patient medical files.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #2 (Ch 7, Q.2)	The PCP does not consistently review, initial and date an inmate-patient's diagnostic reports within two days of receipt.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #3 (Ch.11, Q.10)	The facility does not have a separate storage area for biohazard materials that is labeled and locked.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #4 (Ch.11, Q.12)	The facility does not account for all sharps (needles, scalpels, etc) at the end of each shift.				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 #5 (Ch.12, Q.10)	The MCCF RN does not consistently sign and date the CDCR 7371, Health Care Transfer Information Form.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #6 (Ch.12, Q.12)	There was no documentation that the inmate-patients received orientation regarding the procedures on how to access health care during the initial intake screening.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #7 (Ch.18, Q.7)	Inmate-patients who were referred to the hub or MCCF PCP by the MCCF RN were not consistently seen within the specified time frame.				Not Completed / In Progress / Completed [DATE]
E. Komin, Chief Delano Modified Community Correctional Facility		J. Espain, Supervising Registered Nurse Delano Modified Community Correctional Facility			