

March 2, 2016

Brian Koehn, Warden
Florence Correctional Center
1100 Bowling Road
Florence, AZ 85132

Dear Warden Koehn,

The staff from California Correctional Health Care Services (CCHCS) completed an onsite health care monitoring audit at Florence Correctional Center (FCC) between December 28 and 29, 2015. The purpose of this audit was to ensure that FCC is meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006.

On February 12, 2016, a draft report was sent to your management providing the opportunity to review and dispute any findings presented in the draft report. Neither an acceptance nor dispute letter was received from your facility by the specified date: therefore, the CCHCS concluded you accepted and agreed with the findings presented in the report.

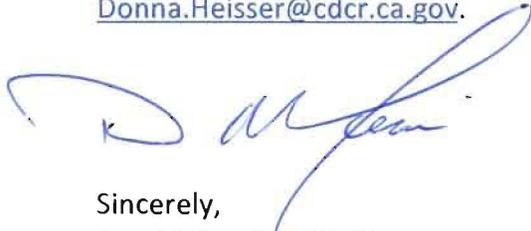
As such, attached you will find the final audit report in which FCC received an overall audit rating of **adequate**. The report contains an executive summary table, an explanation of the methodology behind the audit, findings detailed by chapters of the *Private Prison Compliance and Health Care Monitoring Audit* and findings of the clinical case reviews conducted by CCHCS clinicians.

The audit findings reveal that during the audit review period, FCC was providing adequate health care to CDCR inmate-patients housed at the facility. However, a number of minor deficiencies were identified in the following program components and require facility's immediate attention and resolution:

- Internal Monitoring and Quality Management
- Emergency Services
- Health Appraisal/Health Care Transfer Process
- Medication Management
- Quality of Nursing Performance

The deficient program areas listed above can be brought to compliance by the facility's strict adherence to the established policies and procedures outlined in the *Inmate Medical Services Policies and Procedures* and the contract.

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



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

Enclosure



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CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT



Florence Correctional Center

December 28-29, 2015

TABLE OF CONTENTS

INTRODUCTION	3
EXECUTIVE SUMMARY.....	3
BACKGROUND AND PROCESS CHANGES	5
OBJECTIVES, SCOPE, AND METHODOLOGY	6
IDENTIFICATION OF CRITICAL ISSUES.....	11
AUDIT FINDINGS – DETAILED BY QUALITY INDICATOR.....	13
1. ADMINISTRATIVE OPERATIONS	13
2. INTERNAL MONITORING & QUALITY MANAGEMENT.....	14
3. LICENSING/CERTIFICATIONS, TRAINING, & STAFFING	17
4. ACCESS TO CARE.....	18
5. CHRONIC CARE MANAGEMENT	20
6. COMMUNITY HOSPITAL DISCHARGE	22
7. DIAGNOSTIC SERVICES.....	22
8. EMERGENCY SERVICES.....	24
9. HEALTH APPRAISAL/HEALTH CARE TRANSFER	25
10. MEDICATION MANAGEMENT	28
11. OBSERVATION CELLS	30
12. SPECIALTY SERVICES	32
13. PREVENTIVE SERVICES.....	33
14. EMERGENCY MEDICAL RESPONSE/DRILLS & EQUIPMENT	35
15. CLINICAL ENVIRONMENT	37
16. QUALITY OF NURSING PERFORMANCE.....	38
17. QUALITY OF PROVIDER PERFORMANCE.....	41
PATIENT INTERVIEWS	63

DATE OF REPORT

March 2, 2016

INTRODUCTION

As a result of an increasing patient population and a limited capacity to house patients, the California Department of Corrections and Rehabilitation (CDCR) entered into contractual agreements with private prison vendors to house California patients. Although these patients 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 the effectiveness, efficiency and compliance of the health care processes implemented at each contracted facility to facilitate patient access to health care. This audit instrument is intended to measure the facility's compliance with various elements of patient access to health care and to assess the quality of health care services provided to the patient population housed in these facilities.

This report provides the findings associated with the onsite audit conducted between December 28 and 29, 2015, at Florence Correctional Center (FCC) located in Florence, Arizona, as well as findings associated with the review of various documents and patient medical records for the review period of June through November 2015. At the time of the audit, CDCR's *Weekly Population Count*, dated December 18, 2015, indicated a budgeted bed capacity of 600 beds, of which 256 were occupied with CDCR patients.

EXECUTIVE SUMMARY

From December 28 through 29, 2015, the CCHCS audit team conducted an onsite health care monitoring audit at FCC. The audit team consisted of the following personnel:

B. Barnett, MD, JD, MBA, CCHP, Chief Medical Consultant
L. Pareja, RN, MSN, Nurse Consultant, Program Review
V. Lastovskiy, Health Program Specialist I

The audit included two primary sections: a *quantitative* review of established performance measures and a *qualitative* review of health care staff performance and quality of care provided to the patient population at FCC. The end product of the quantitative review is expressed as a compliance score, while the end product of clinical case reviews is a quality rating.

The CCHCS rates each of the operational areas based on case reviews conducted by CCHCS physicians and registered nurses, medical record reviews conducted by registered nurses, and onsite reviews

conducted by CCHCS physician, registered nurse, and Health Program Specialist I auditors. The ratings for every applicable indicator may be derived from the clinical case review results alone, the medical record and/or onsite audit results alone, or a combination of both of these information sources (as shown in the *Executive Summary Table* below).

Based on the quantitative and the clinical case reviews completed for the 16 operational areas/quality indicators during this audit, FCC achieved an overall point value of **1.0**, resulting in an overall audit rating of **adequate**.

The completed quantitative reviews, a summary of clinical case reviews with the quality ratings and a list of critical issues identified during the audit are attached for your review. The *Executive Summary Table* below lists all the quality indicators/components the audit team assessed during the audit and provides the facility's overall quality rating for each operational area.

Executive Summary Table

Operational Area/Quality Indicator	Case Review Rating	Quantitative Review Score	Quantitative Review Rating	Overall Indicator Rating	Points Scored
1. Administrative Operations	N/A	99.0%	Proficient	Proficient	2.0
2. Internal Monitoring & Quality Management	N/A	84.7%	Inadequate	Inadequate	0.0
3. Licensing/Certification, Training & Staffing	N/A	100%	Proficient	Proficient	2.0
4. Access to Care	Adequate	97.1%	Proficient	Adequate	1.0
5. Chronic Care Management	Adequate	84.6%	Inadequate	Adequate	1.0
6. Community Hospital Discharge	N/A	N/A	N/A	N/A	N/A
7. Diagnostic Services	Adequate	86.3%	Adequate	Adequate	1.0
8. Emergency Services	Inadequate	N/A	N/A	Inadequate	0.0
9. Health Appraisal/Health Care Transfer	Inadequate	76.0%	Inadequate	Inadequate	0.0
10. Medication Management	Inadequate	83.8%	Inadequate	Inadequate	0.0
11. Observation Cells	Adequate	95.0%	Proficient	Adequate	1.0
12. Specialty Services	Adequate	100%	Proficient	Adequate	1.0
13. Preventive Services	N/A	90.0%	Proficient	Proficient	2.0
14. Emergency Medical Response/Drills & Equipment	N/A	94.7%	Proficient	Proficient	2.0
15. Clinical Environment	N/A	97.5%	Proficient	Proficient	2.0
16. Quality of Nursing Performance	Inadequate	N/A	N/A	Inadequate	0.0
17. Quality of Provider Performance	Adequate	N/A	N/A	Adequate	1.0
Average Score					1.0
Overall Audit Rating					Adequate

NOTE: For specific information regarding any non-compliance findings indicated in the tables above, please refer to the Identification of Critical Issues (located on page 11 of this report), or to the detailed audit findings - by quality indicator (located on page 13) sections of this report.

BACKGROUND AND PROCESS CHANGES

In April of 2001, inmates, represented by the Prison Law Office, filed a class-action lawsuit, known as *Plata vs. Schwarzenegger*, alleging their constitutional rights had been violated as a result of the CDCR health care system's inability to properly care for and treat patients within its custody. In June of 2002, the parties entered into an agreement (Stipulation for Injunctive Relief) and CDCR agreed to implement comprehensive new health care policies and procedures at all institutions over the course of several years.

In October 2005 the Federal Court declared that California's health care delivery system was "broken beyond repair," and continued to violate inmates' constitutional rights. Thus, the court imposed a receivership to raise the delivery of health care in the prisons to a constitutionally adequate level. The court ordered the Receiver to manage CDCR's delivery of health care and restructure the existing day-to-day operations in order to develop a sustainable system that provides constitutionally adequate health care to inmates. The court's intent is to remove the receivership and return operational control to CDCR as soon as the health care delivery system is stable, sustainable and provides for constitutionally adequate levels of health care.

The *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* was developed by the CCHCS in an effort to evaluate the effectiveness, efficiency and compliance of the health care processes implemented at each contracted facility to facilitate patient access to health care. This audit instrument is intended to measure facility's compliance with various elements of patient access to health care, and also to identify areas of concern, if any, to be addressed by the facility.

The standards being audited within the *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* are based upon relevant Department policies and court mandates, including, but not limited to, the following: *Inmate Medical Services Policies and Procedures* (IMSP&P), California Code of Regulations (CCR), Title 8 and Title 15; *Department Operations Manual*; court decisions and remedial plans in the *Plata* and *Armstrong* cases, and other relevant Department policies, guidelines, and standards or practices which the CCHCS has independently determined to be of value to health care delivery.

It should be noted that, subsequent to the previous audit, major revisions and updates have been made to the *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* and assessment processes. These revisions are intended to (a) align with changes in policies which took place during the previous several years, (b) increase sample sizes where appropriate to obtain a "snapshot" that more accurately represents typical facility health care operations, and (c) to present the audit findings in the most fair and balanced format possible.

Several questions have been removed where clear policy support does not exist, or where related processes have changed making such questions immaterial to measuring quality of health care services provided to patients. A number of questions have also been added in order to separate multiple requirements previously measured by a single question, or to measure an area of health care services not previously audited.

Additionally, clinical case review section has been added to the audit instrument. This will help CCHCS to better assess and evaluate the timeliness and quality of care provided by nurses and physicians at the contract facilities. The ratings obtained from these reviews will be utilized to determine the facility's overall performance for all *medical quality indicators* section. The resulting quality ratings from the case reviews will be incorporated with the quantitative review ratings to arrive at the overall audit rating and will serve as the sole decisive factor for determining compliance for some of the operational areas whereas for some of the other operational areas, case review ratings will play a dominant role in determining the overall compliance.

The revisions to the instrument and the added case review processes will likely produce ratings that may appear inconsistent with previous ratings, and will require corrective action for areas not previously identified. Accordingly, prior audit scores should not be used as a baseline for current scores. If progress and improvement are to be measured, the best tools for doing so will be the resolution of the critical issues process, and the results of successive audits. In an effort to provide the contractors with ample time to become familiar with the new audit tool, a copy of the *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* was provided for their perusal prior to the onsite audit. This transparency afforded each contract facility the opportunity to make the necessary adjustments within their existing processes to become familiar with the new criteria being used to evaluate their performance.

OBJECTIVES, SCOPE, AND METHODOLOGY

In designing *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide*, CCHCS reviewed the Office of the Inspector General's medical inspection program and the IMSP&P to develop a process to evaluate medical care delivery at all of the in-state modified community correctional facilities and California out-of-state correctional facilities. CCHCS also reviewed professional literature on correctional medical care, consulted with clinical experts, met with stakeholders from the court, the Receiver's office, and CDCR to discuss the nature and the scope of the audit program to determine its efficacy in evaluating health care delivery. With input from these stakeholders, CCHCS developed a health care monitoring program that evaluates medical care delivery by combining clinical case reviews of patient medical records, and objective tests of compliance with policies and procedures

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

Quantitative Review

The *quantitative* review uses a standardized audit instrument, which measures compliance against established standards at each facility. The audit instrument calculates an overall percentage score for each of the operational areas/components in the *Administrative Quality Indicators and Medical Quality Indicators* section as well as individual ratings for each chapter of the audit instrument. Additionally, a brief narrative is provided addressing each standard being measured which received less than a 100% compliance rating.

To maintain a metric-oriented monitoring program that evaluates medical care delivery consistently at each correctional facility, CCHCS identified 14 medical and 3 administrative indicators of health care to

measure. The medical components cover clinical categories directly relating to the health care provided to patients, whereas the administrative components address the organizational functions that support a health care delivery system.

The 14 medical program components are: *Access to Care, Chronic Care Management, Community Hospital Discharge, Diagnostic Services, Emergency Services, Health Appraisal/Health Care Transfer, Medication Management, Observation Cells, Specialty Services, Preventive Services, Emergency Medical Response/Drills and Equipment, Clinical Environment, Quality of Nursing Performance and Quality of Provider Performance*. The three administrative components are: *Administrative Operations, Internal Monitoring and Quality Management and Licensing/Certifications, Training and Staffing*.

Every question within the chapter for each program component is calculated as follows:

- Possible Score = the sum of all *Yes* and *No* answers
- Score Achieved = the sum of all *Yes* answers
- Compliance Score (Percentage) = Score Achieved/Possible Score

The compliance score for each question is expressed as a percentage rounded to the nearest tenth. For example, a question scored 13 ‘Yes’, 3 ‘N/A’, and 4 ‘No’.

Compliance Score = 13 ‘Yes’ / 17 (13 ‘Yes’ + 4 ‘No’) = .764 x 100 = 76.47 rounded up to 76.5%.

The chapter scores are calculated by taking the average of all the compliance scores for all applicable questions within that chapter. The outcome is expressed as a percentage rounded to the nearest tenth.

Although the resulting scores for all chapters in the quantitative review are expressed as percentages, the clinical case reviews are reported as quality ratings. In order to maintain uniformity while reporting ratings for all operational areas/components, the quantitative scores for all chapters in Sections I and II are converted into quality ratings which range from *proficient, adequate, or inadequate*. See Table below for the breakdown of percentages and its respective quality ratings.

Percentile Score	Associated Rating	Numerical Value
90.0% and above	Proficient	2
85.0% to 89.9%	Adequate	1
Less than 85.0%	Inadequate	0

For example, if the three chapters under Section 1 scored 75.0%, 92.0%, and 89.0%, based on the above criteria, the chapters would receive ratings as follows:

- Chapter 1 – 75.0% = Inadequate
- Chapter 2 – 92.0% = Proficient
- Chapter 3 – 89.0% = Adequate

Similarly, all chapter scores for Section II are converted to quality ratings. The resultant ratings for each chapter are reported in the *Executive Summary Table* of the final audit report. It should be noted that the chapters and questions that are found not applicable to the facility being audited are excluded from these calculations.

Qualitative Review

The *qualitative* portion of the audit consists of case reviews conducted by CCHCS clinicians. The CCHCS clinicians include physicians and registered nurses. The clinicians evaluate 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. The intention of utilizing the case reviews is to determine how the various medical system components inter-relate and respond to stress, exceptionally high utilization, or complexity.

This methodology is useful for identifying systemic areas of concern that may compel further investigation and quality improvement. Typically, individuals selected for the case review are those who have received multiple or complex services or have been identified with poorly controlled chronic conditions. The cases are analyzed for documentation related to chronic care, specialty care, diagnostic services, medication management and urgent/emergent encounters. The CCHCS clinicians review the documentation to ensure that the above mentioned services were provided to the patients in accordance with the standards and scope of practice and the IMSP&P guidelines.

The CCHCS clinical case reviews are comprised of the following components:

1. Nurse Case Review

The CCHCS registered nurses perform two types of case reviews:

- a. Detailed reviews - A retrospective review of ten selected patient health records is completed in order to evaluate the quality and timeliness of care provided by the facility's nursing staff during the audit review period. A majority of the patients selected for retrospective review are the ones with a high utilization of nursing services, as these patients are most likely to be affected by timely appointment scheduling, medication management, and referrals to health care providers.
- b. Focused reviews – Five cases are selected from the audit review period of which three cases consist of patients who were transferred into the facility. The cases are reviewed for appropriateness of initial nurse health screening, referral, timeliness of provider evaluations and continuity of care. The remaining two cases selected for review are patients, who were transferred out of the facility with pending specialty or chronic care appointments. These cases are reviewed to ensure that transfer forms contain all necessary documentation.

2. Physician Case Review

The CCHCS physician completes a detailed retrospective review of 15 patient health records in order to evaluate the quality and timeliness of care provided to the patient population housed at that facility.

Overall Quality Indicator Rating

The overall quality of care provided in each health care operational area (or indicator) is determined by reviewing the rating obtained from clinical case reviews and the ratings obtained from quantitative reviews. The final outcome for each operational area is based on the critical nature of the deficiencies identified during the case reviews and the standards that were identified as deficient in the quantitative reviews. For all those chapters under the *Medical Quality Indicator* section, whose compliance is evaluated utilizing both quantitative and clinical case reviews, more weight is assigned to the rating results from the clinical case reviews, as it directly relates to the health care provided to patients. However, the overall quality rating for each operational area is not determined by clinical case reviews alone. This is determined on a case by case basis by evaluating the deficiencies identified and their direct impact on the overall health care delivery at the facility. The physician and nurse auditors discuss the ratings obtained as a result of their case reviews and ratings obtained from quantitative review to arrive at the overall rating for each operational area.

Based on the collective results of the case reviews and quantitative reviews, each quality indicator is rated as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*.

Overall Audit Rating

Once a consensus rating for an applicable quality indicator is determined based on the input from all audit team members, each chapter/quality indicator is assigned a numerical value based on a threshold value range.

The overall rating for the audit is calculated by taking the sum of all quality rating points scored on each chapter and dividing by the total number of applicable chapters. The resultant numerical value is rounded to the nearest tenth and compared to the threshold value range. The final overall rating for the audit is reported as *proficient*, *adequate*, or *inadequate* based on where the resultant value falls among the threshold value ranges.

In order to provide a consistent means of determining the overall audit rating (e.g., *inadequate*, *adequate*, or *proficient*) threshold value ranges have been identified whereby these quality ratings can be applied consistently. These thresholds are constant, and do not change from audit to audit, or from facility to facility. These rating thresholds are established as follows:

- **Proficient** - Since the cut-off value for a proficient rating in the quantitative review is 90.0% and the highest available point value for quality rating is 2, the threshold value range is calculated by multiplying the highest available points by 90.0%, which is: $2 \times 90.0\% = 1.8$. This value is a *constant* and has been determined to be the minimum value required to achieve a rating of *proficient*. Therefore, any overall score/value of 1.8 or higher will be rated as *proficient*. This is designed to mirror the performance standard established in the quantitative review (i.e., 90% of the maximum available point value of 2).
- **Adequate** - A threshold value of 1.0 has been determined to be the minimum value required to achieve a quality rating of *adequate*. Therefore, any value falling between 1.0 and 1.7 will be rated as *adequate*.
- **Inadequate** - A threshold value falling between the range of 0.0 and 0.9 will be assigned a rating of *inadequate*.

Average Threshold Value Range	Rating
1.8 to 2.0	Proficient
1.0 to 1.7	Adequate
0.0 to 0.9	Inadequate

$$\text{Overall Audit Rating} = \frac{\text{Sum of All Points Scored on Each Chapter}}{\text{Total Number of Applicable Chapters}}$$

Scoring for Non-Applicable Questions and Double-Failures:

Questions that do not apply to the facility are noted as Not Applicable (N/A). For the purpose of chapter compliance calculations, N/A questions will have zero (0) points available. Where a single deviation from policy would result in multiple question failures (i.e., “double-failure”), the question most closely identifying the primary policy deviation will be scored zero (0) points, and any resultant failing questions will be noted as N/A.

Resolution of Critical Issues

Although the facility will not be required to submit a corrective action plan to CCHCS for review, the facility will be required to address and resolve all standards rated by the audit that have fallen below the 85.0% compliance or as otherwise specified in the methodology. The facility will also be expected to address and resolve any critical issues identified during the clinical case reviews and any deficiencies identified via the observations/inspections conducted during the onsite visit.

IDENTIFICATION OF CRITICAL ISSUES

The table below reflects all quantitative analysis standards in which the facility's compliance fell below acceptable compliance levels, based on the methodology previously described. The table also includes any *qualitative* critical issues or concerns identified by the audit team which rise to the level at which they have the potential to adversely affect patient's access to health care services.

Critical Issues – Florence Correctional Center	
Question 2.4	The facility does not consistently submit the specialty care and hospital stay/emergency department monitoring logs by the scheduled date.
Question 2.5	The facility does not accurately document all the dates on the sick call monitoring log.
Question 2.6	The facility does not accurately document all the dates on the specialty care monitoring log.
Question 2.8	The facility does not accurately document all the dates on the chronic care monitoring log.
Question 4.8	The nursing staff does not consistently document that effective communication was established and that education was provided to the patient related to treatment plan. <i>This is a new critical issue.</i>
Question 5.2	The patient's chronic care medications are not consistently received by the patient without interruption.
Question 7.2	The provider does not consistently review, date, and sign the patients' diagnostic test report within two business days of facility's receipt of results.
Question 7.3	The written notification of the diagnostic test results is not given to the patient within two business days of facility's receipt of results.
Question 9.2	The registered nurse does not consistently document an assessment of the patient was completed if the patient answered 'yes' to any of the medical problems listed on the <i>Initial Health Screening</i> form. <i>This is a new critical issue.</i>
Question 9.9	The patients do not consistently receive a health appraisal within seven calendar days of their arrival at the facility.
Question 9.10	The patients arriving at the facility with existing medication orders do not consistently receive their prescribed medications timely.
Question 9.12	The facility's nursing staff are not all fully aware of the steps involved in the inter-facility transfer process. <i>This is a new critical issue.</i>
Question 10.1	The providers do not consistently educate the patients on the newly prescribed medications.
Question 10.5	The medication nurses do not consistently conduct mouth checks on all patients during administration of direct observation therapy medications. <i>This is a new critical issue.</i>
Question 10.6	The medication nurses do not consistently document the administration of medication to patient once the medication is given to the patient. <i>This is a new critical issue.</i>



Question 10.10	The key to the locked narcotic storage unit is not maintained by only one licensed nursing staff member. <i>This is a new critical issue.</i>
Question 11.4	One of the facility observation cell's call system is not functioning. <i>This is a new critical issue.</i>
Question 13.7	The facility does not consistently offer colorectal cancer screening to all patients 50 to 75 years of age.
Question 14.7	The Emergency Medical Response Bags are not consistently re-supplied and re-sealed before the end of the shift, if the emergency medical response and/or drill warranted an opening of the bag. <i>This is a new critical issue.</i>
Question 15.1	Not all of the facility's packaged sterilized reusable medical instruments are within the expiration dates shown on the sterile packaging. <i>This is a new critical issue.</i>
Question 15.2	The facility does not consistently complete the weekly spore testing for its autoclave located in dental clinic. <i>This is a new critical issue.</i>

NOTE: A discussion of the facility's progress toward resolution of all critical issues identified during *previous* health care monitoring audits is included in the *Prior Critical Issue Resolution* portion of this report.

AUDIT FINDINGS – DETAILED BY QUALITY INDICATOR

1. ADMINISTRATIVE OPERATIONS

This indicator determines whether the facility’s policies and local operating procedures (LOP) are in compliance with IMSP&P guidelines and that contracts/agreements for bio-medical equipment maintenance and hazardous waste removal are current. This indicator also focuses on the facility’s effectiveness in filing, storing, and retrieving medical records and medical-related information, as well as maintaining compliance with all Health Insurance Portability and Accountability Act requirements.

This quality indicator is evaluated by CCHCS auditors through the review of patient medical records and the facility’s policies and local operating procedures. No clinical case reviews are conducted for this indicator and therefore, the overall rating is based entirely on the results of the quantitative review.

Case Review Rating:
Not Applicable

**Quantitative Review
Score [Rating]:**
99.0% [Proficient]

Overall Rating:
Proficient

The facility received a compliance score of 99.0% in the *Administrative Operations* indicator, equating to the overall rating of *proficient*. Refer to the *Comments* section, following the table below, for information on the one deficiency identified in this area.

Quantitative Review Results

The table below reflects the findings/results associated with the quantitative review. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Administrative Operations		Yes	No	Compliance
1.1	Does health care staff have access to the facility’s health care policies and procedures and know how to access them?	5	0	100%
1.2	Does the facility have written health care policies and/or procedures that are in compliance with <i>Inmate Medical Services Policies and Procedures</i> guidelines?	14	1	93.3%
1.3	Does the facility have current contracts/agreements for routine oxygen tank maintenance service, hazardous waste removal, and repair, maintenance, inspection, and testing of biomedical equipment?	3	0	100%
1.4	Does the patient orientation handbook/manual or similar document explain the sick call and health care grievance/appeal processes?	2	0	100%
1.5	Does the facility’s health care staff access the California Department of Corrections and Rehabilitation patient’s electronic medical record?	6	0	100%
1.6	Does the facility maintain a Release of Information log that contains all the required data fields?	1	0	100%

1.7	Are all patients' written requests for health care information documented on a CDCR Form 7385, <i>Authorization for Release of Information</i> , and scanned/filed into the patient's medical record?	3	0	100%
1.8	Are all written requests from third parties for release of patient medical information accompanied by a CDCR Form 7385, <i>Authorization for Release of Information</i> , from the patient and scanned/filed into the patient's medical record?	N/A	N/A	N/A
Overall Quantitative Review Score:				99.0%

Comments:

1. Question 1.2 – Of the 15 LOPs reviewed, an LOP related to Americans with Disabilities Act (ADA) was found non-compliant. During the previous audit, FCC was made aware of the requirement to draft and maintain an LOP specific to its facility with regards to ADA process. During the current onsite audit, FCC was unable to provide the audit team with an ADA LOP specific to its facility; it continues to utilize the Contract Bed Unit's OP 613. The facility staff stated that all changes to the policies occur at the corporate level and this process is outside of facility's control. This equates to 93.3% compliance.
2. Question 1.8 – Not Applicable (N/A). There were no third party requests for release of patient health care information received during the audit review period; therefore, this question could not be evaluated.

2. INTERNAL MONITORING & QUALITY MANAGEMENT

This indicator focuses on whether the facility completes internal reviews and holds committee meetings in compliance with the policy. The facility's quality improvement processes are evaluated by reviewing minutes from Quality Management Committee (QMC) meetings to determine if the facility identifies opportunities for improvement, implements action plans to address the identified deficiencies and continuously monitors the quality of health care provided to patients. Also, CCHCS auditors evaluate whether the facility promptly processes patient first level health care appeals and appropriately addresses and responds to all appealed issues.

Case Review Rating:
Not Applicable

Quantitative Review Score [Rating]:
84.7% [*Inadequate*]

Overall Rating:
Inadequate

In addition, the facilities are required to utilize monitoring logs (provided by PPCMU) to document and track all patient medical encounters such as initial intake, health appraisal, sick call, chronic care, emergency/hospital services and specialty care services. These logs are reviewed by PPCMU staff on a monthly or a weekly basis to ensure accuracy, timely submission and whether the facility meets time frames specified in IMSP&P for each identified medical service. Rating of this quality indicator is based entirely on the quantitative review results from the assessment of patient medical records, QMC meeting minutes, patient first level health care appeals and responses and the facility's monitoring logs.

FCC received a marginally inadequate compliance score of 84.7% in the *Internal Monitoring and Quality Management* indicator. Eight of the 13 questions assessed in this component scored in the *proficient* range, one question scored in the *adequate* range, and four questions scored in the *inadequate* range (below 85.0% compliance). The low-scoring questions were all in the monitoring logs section. Although

FCC continues to struggle to submit the weekly monitoring logs on time and to accurately record the dates of service provided to patients, there has been significant improvement in this area within the last five months.

For example, during the first three months of the audit review period (June through August 2015), FCC was found incorrectly filling out the chronic care monitoring logs; therefore, 94.3% (28) of the entries reviewed during that period scored 0.0%, contributing to a very low rating for this question. In September 2015, PPCMU distributed updated versions of all the monitoring logs with a detailed monitoring log instruction guide to all contract facilities. Following the implementation of the new monitoring logs, significant improvement in data entry was evident on all the monitoring logs, predominantly on the chronic care log. Review of a random sample of entries documented on the chronic care log for the past five months (September 2015 through January 2016) showed that over 75.0% of entries were documented correctly and accurately. Furthermore, a couple of days prior to the onsite visit, an HPS I auditor contacted the staff members, assigned to completing the specialty care and chronic care logs at FCC, and provided additional training over the phone.

Overall, the quantitative review showed most deficiencies were minor and easily correctable. Although the quantitative review score of 84.7% was very close to the adequate range, the facility did not achieve a compliance score of 85.0% or higher in this operational area. As a result, the facility's overall performance in this indicator was rated *inadequate*.

Quantitative Review Results

The table below reflects the findings/results associated with the quantitative review. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Internal Monitoring & Quality Management		Yes	No	Compliance
2.1	Does the facility hold a Quality Management Committee a minimum of once per month?	6	0	100%
2.2	Does the Quality Management Committee's review process include documented corrective action plan for the identified opportunities for improvement?	6	0	100%
2.3	Does the Quality Management Committee's review process include monitoring of defined aspects of care?	6	0	100%
2.4	Does the facility submit all monitoring logs (sick call, specialty care, hospital stay/emergency department, chronic care and initial intake screening) by the scheduled date per Private Prison Compliance and Monitoring Unit program standards?	63	27	70.0%
2.5	Are the dates documented on the sick call monitoring log accurate?	32	14	69.6%
2.6	Are the dates documented on the specialty care monitoring log accurate?	15	23	39.5%
2.7	Are the dates documented on the hospital stay/emergency department monitoring log accurate?	8	0	100%
2.8	Are the dates documented on the chronic care monitoring log accurate?	22	38	36.7%
2.9	Are the dates documented on the initial intake screening monitoring log accurate?	24	4	85.7%
2.10	Are the CDCR Forms 602-HC, <i>Patient-Inmate Health Care Appeals</i> , readily available to patients in all housing units?	2	0	100%

2.11	Are patients able to submit the CDCR Forms 602-HC, <i>Patient-Inmate Health Care Appeals</i> , on a daily basis in all housing units?	5	0	100%
2.12	Does the facility maintain a CCHCS Health Care Appeals log and does the log contain all the required information?	1	0	100%
2.13	Are the first level health care appeals being processed within specified time frames?	1	0	100%
Overall Quantitative Review Score:				84.7%

Comments:

- Question 2.4 – During the audit review period of June through November 2015, 90 submissions of monitoring logs were required. Of the 90 monitoring logs submitted, 63 were timely. None of the weekly monitoring logs were submitted for October 27, 2015. This equates to 70.0% compliance. See table below for additional information and details.

Type of Monitoring Log	Required Frequency of Submission	Number of Required Submissions for the Audit Review Period	Number of Timely Submissions	Number of Late Submissions
Sick Call	weekly	26	24	2
Specialty Care	weekly	26	13	13
Hospital Stay/Emergency Department	weekly	26	14	12
Chronic Care	monthly	6	6	0
Initial Intake Screening	monthly	6	6	0
Totals:		90	63	27

- Question 2.5 – A total of 46 entries were randomly selected from the weekly sick call monitoring logs to assess the accuracy of the dates reported on the log. Of the 46 entries reviewed, 32 were found to be accurate with dates matching the dates of service reflected in the patients’ medical records. Discrepancies identified within the remaining 14 entries were mostly within the dates the sick call request was received and reviewed and the LIP appointment dates. Several entries recorded on the log could not be validated as no sick call request forms could be located/found in the patients’ medical records. This equates to 69.6% compliance.
- Question 2.6 – A total of 38 entries were randomly selected from the weekly specialty care monitoring logs to assess the accuracy of the dates reported on the log. Of the 38 entries reviewed, 15 were found to be accurate with dates matching the dates of service reflected in the patients’ medical records. Discrepancies identified within the remaining 23 entries were mostly within the dates of provider referral to specialty services. Additionally, it should be noted that specialty care logs were not submitted on the following weeks: August 4, 2015; October 27, 2015; November 10, 2015; November 17, 2015; and November 24, 2015. This equates to 39.5% compliance.
- Question 2.8 – A total of 60 entries were randomly selected from the monthly chronic care monitoring logs to assess the accuracy of the dates reported on the log. Of the 60 entries reviewed, 22 were found to be accurate with dates matching the dates of service reflected in the patients’ medical records. This equates to 36.7% compliance. The chronic care monitoring logs for the months of June, July, and August 2015 were not filled out correctly. Substantial improvement was evident in chronic care logs submitted for the months of September, October, and November 2015; however, there is still room for improvement in data entry and data accuracy.
- Question 2.9 – Due to the limited number of intakes that occurred at FCC during the audit review period, a total of 28 entries were selected from the monthly initial intake screening monitoring logs to validate

the dates reported on the log. Of the 28 entries reviewed, 24 were found to be accurate and matching the dates of service reflected in the patients' medical records. This equates to 85.7% compliance.

3. LICENSING/CERTIFICATIONS, TRAINING, & STAFFING

This indicator will determine whether the facility adequately manages its health care staffing resources by evaluating whether: job performance reviews are completed as required; professional licenses and/or certifications are current; and training requirements are met. The CCHCS auditors will also determine whether clinical and custody staff are current with emergency response certifications and if the facility is meeting staffing requirements as specified in their contract. Additionally, CCHCS will review and determine whether the facility completes a timely peer review of its medical providers (physicians, nurse practitioners, physician assistants).

Case Review Rating:

Not Applicable

Quantitative Review

Score [Rating]:

100% [Proficient]

Overall Rating:

Proficient

This indicator is evaluated by CCHCS auditors through the review of facility's documentation of health care staff licenses, medical emergency response certifications, health care staff training records, and staffing information. No clinical case reviews are conducted for this indicator and therefore, the overall rating is based entirely on the results of the quantitative review.

The facility received a compliance score of 100% in *Licensing/Certifications, Training, and Staffing* indicator, equating to an overall rating of *proficient*. There were no deficiencies identified for any questions of this indicator. The facility maintains logs tracking health care staff's current licensing, emergency response certifications, and training information. Also, there were no staff vacancies identified at FCC during the current audit.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review.

Licensing/Certifications, Training, & Staffing		Yes	No	Compliance
3.1	Are all health care staff licenses current?	12	0	100%
3.2	Are health care and custody staff current with required medical emergency response certifications?	260	0	100%
3.3	Did all health care staff receive training on the facility's policies based on Inmate Medical Services Policies and Procedures requirements?	14	0	100%
3.4	Is there a centralized system for tracking licenses, certifications, and training for all health care staff?	2	0	100%
3.5	Does the facility have the required provider staffing complement per contractual requirement?	2	0	100%
3.6	Does the facility have the required nurse staffing complement per contractual requirement?	22	0	100%

3.7	Does the facility have the required clinical support staffing complement per contractual requirement? (COCF Only)?	3	0	100%
3.8	Does the facility have the required management staffing complement per contractual requirement? (COCF Only)	2	0	100%
3.9	Are the peer reviews of the facility's providers completed within the required time frames?	1	0	100%
Overall Quantitative Review Score:				100%

Comments:

The facility was found 100% compliant on all requirements and standards measured in this indicator.

4. ACCESS TO CARE

This indicator evaluates the facility's ability to provide patient population with timely and adequate medical care. The areas of focus include but are not limited to nursing practice and documentation, timeliness of clinical appointments, acute and chronic care follow-ups, face-to-face nurse appointments, provider referrals from nursing lines, and timely triage of sick call requests submitted by patients. Additionally, the auditors perform onsite inspections of housing units and log books to determine if patients have a means to request medical services and that there is continuous availability of CDCR Forms 7362, *Health Care Services Request*.

Case Review Rating:
Adequate

Quantitative Review Score [Rating]:
97.1% [*Proficient*]

Overall Rating:
Adequate

For *Access to Care* indicator, the case review and quantitative review processes yielded different results. The case review received an *adequate* rating while the quantitative review resulted in overall score of 97.1% compliance, equating to a quality rating of *proficient*. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the magnitude of all deficiencies identified in both processes and their potential impact on patient's health care condition. Taking into account all the findings related to *Access to Care*, CCHCS clinicians rated this indicator *adequate*.

Case Review Results

The CCHCS clinicians reviewed a total of 47 encounters/clinical visits related to *Access to Care* and found seven minor nursing deficiencies, all related to appropriate documentation or lack thereof. The nursing deficiencies identified include:

- Missing or incomplete documentation of wound care and daily wound checks.
- Missing documentation of pain scale.
- Missing or incomplete documentation of nursing diagnosis.
- No documentation of time frame for provider referral.
- Incomplete nursing assessment.

- No documentation of patient’s signed refusal for coccidioidomycosis (valley fever) testing.
- Missing documentation reflecting the patient was referred to the appropriate provider regarding the patient’s eye problem (Case 10).

As these deficiencies were minor in nature and unlikely to contribute to patient harm, the case review resulted in an *adequate* rating for this indicator.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which may consist of onsite inspections/observations, review of patient medical records, and/or review of various documents and tracking logs. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Access to Care		Yes	No	Compliance
4.1	Does the registered nurse review the CDCR Form 7362, <i>Health Care Services Request</i> , or similar form on the day it is received?	27	0	100%
4.2	Following the review of the CDCR Form 7362, or similar form, does the registered nurse complete a face-to-face evaluation of a patient within the specified time frame?	27	0	100%
4.3	Does the registered nurse document the patient's chief complaint in the patient's own words?	29	0	100%
4.4	Does the registered nurse document the face-to-face encounter in Subjective, Objective, Assessment, Plan, and Education (SOAPE) format?	30	0	100%
4.5	Is the focused subjective/objective assessment conducted based upon the patient’s chief complaint?	29	1	96.7%
4.6	Does the registered nurse document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data?	27	3	90.0%
4.7	Does the registered nurse implement a plan based upon the documented subjective/objective assessment data that is within the nurse’s scope of practice or supported by the nursing sick call protocols?	29	1	96.7%
4.8	Did the registered nurse document that effective communication was established and that education was provided to the patient related to the treatment plan?	25	5	83.3%
4.9	If the registered nurse determines a referral to the primary care provider is necessary, is the patient seen within the specified time frame?	21	0	100%
4.10	If the registered nurse determines the patient’s health care needs are beyond the level of care available at the facility, does the nurse contact or refer the patient to the hub institution? (MCCF Only)	N/A	N/A	N/A
4.11	If the patient presented to sick call three or more time for the same medical complaint, does the registered nurse refer the patient to the primary care provider?	4	0	100%
4.12	Does nursing staff conduct daily rounds in segregated housing units? (COCF only)	30	0	100%
4.13	Does nursing staff conduct daily rounds in segregated housing units to collect CDCR Forms 7362, <i>Health Care Services Request</i> , or similar forms? (COCF only)	28	2	93.3%

4.14	Are CDCR Forms 7362, <i>Health Care Services Request</i> , or similar forms readily accessible to patients in all housing units?	2	0	100%
4.15	Are patients in all housing units able to submit the CDCR Forms 7362, <i>Health Care Services Request</i> , or similar forms on a daily basis?	5	0	100%
Overall Quantitative Review Score:				97.1%

Comments:

For questions 4.1 through 4.11, a random sample of 30 patient medical records were reviewed for the audit review period of June through November 2015.

1. Question 4.5 – Twenty-nine patient medical records reviewed reflect that a RN conducted a focused subjective/objective assessment based on the patient’s chief complaint. For the one non-compliant case, nursing assessment was not performed. This equates to 96.7% compliance.
2. Question 4.6 – Twenty-seven patient medical records included documentation of a nursing diagnosis related to subjective/objective assessment data. The three non-compliant cases did not include such documentation. This equates to 90.0% compliance.
3. Question 4.7 – Twenty-nine patient medical records reflect that a plan was implemented by an RN based upon the subjective/objective assessment data. This equates to 96.7% compliance.
4. Question 4.8 – Twenty-five patient medical records reflect that effective communication was established and education related to the treatment plan was provided to the patient. The five non-compliant cases did not include such documentation. This equates to 83.3% compliance.
5. Question 4.10 – This standard is not applicable to out-of-state correctional facilities.
6. Question 4.13 – Of the 30 days reviewed for documentation showing health care staff conducting rounds to collect sick call requests in segregated housing units, 28 days were found compliant. No documentation was found of nursing rounds having been conducted on November 6 and November 25, 2015. This equates to 93.3% compliance.

5. CHRONIC CARE MANAGEMENT

For this indicator, the CCHCS clinicians evaluate the facility’s ability to provide timely and adequate medical care to patients with chronic care conditions. These conditions affect (or have the potential to affect) a patient’s functioning and long-term prognosis for more than six months.

Case Review Results

The CCHCS clinicians reviewed 20 encounters related to Chronic Care Management and found four minor deficiencies. Two of the four deficiencies were with regards to health information management. One case was missing documentation describing how effective communication was established with a Spanish speaking patient and the other case was missing documentation on the type of lab drawn during the patient’s chronic care visit. The other two

Case Review Rating:
Adequate

Quantitative Review Score [Rating]:
84.6% [Inadequate]

Overall Rating:
Adequate

deficiencies were related to medication management where medications were continued/ordered without adequate indication for such action. The case review rating for this indicator was adequate.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which may consist of onsite inspections/observations, review of patient medical records, and/or review of various documents and tracking logs. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Chronic Care Management		Yes	No	Compliance
5.1	Is the patient's chronic care follow-up visit completed as ordered?	29	1	96.7%
5.2	Are the patient's chronic care medications received by the patient without interruption within the required time frame?	16	12	57.1%
5.3	If a patient refuses his/her chronic care keep-on-person medications, is the refusal documented on the CDCR Form 7225, <i>Refusal of Examination and/or Treatment</i> , or similar form?	1	0	100%
5.4	If a patient does not show or refuses the nurse administered/direct observation therapy chronic care medication for three consecutive days or 50 percent or more doses in a week, is the patient referred to a primary care provider?	Not Applicable		
5.5	If a patient does not show or refuses the nurse administered/direct observation therapy chronic care medication for three consecutive days or 50 percent or more doses in a week, is the patient seen by a primary care provider within seven calendar days of the referral?	Not Applicable		
5.6	If a patient does not show or refuses his/her insulin, is the patient referred to a primary care provider for medication non-compliance?	Not Applicable		
Overall Quantitative Review Score:				84.6%

Comments:

For questions 5.1 through 5.6, a random sample of 30 patient medical records were reviewed for the audit review period of June through November 2015.

1. Question 5.1 – Twenty-nine patient medical records include documentation that a patient's chronic care follow-up visit was completed as ordered by provider. One patient was ordered a three month follow-up, but was not seen for six months. This equates to 96.7% compliance.
2. Question 5.2 – Sixteen patient medical records show that the patient received his chronic care medication without interruption and 12 were found not compliant with this requirement. This equates to 57.1% compliance. See below for additional information regarding the 12 non-compliant record reviews:
 - Record 1 - A patient was prescribed three different medications; however, review of the keep-on-person (KOP) medication report for the period of December 2014 to June 2015 does not reflect that the patient received any refills of his KOP medications.
 - Record 2 – No documentation on the MAR and Medication Refill history report that the patient received Hydrochlorothiazide (HCTZ) and Lisinopril from February 2015 to June 2015.
 - Record 3 – The patient did not receive Pravastatin Sodium from May to June 2015 and from August to September 2015.

- Records 4 through 10 – According to the KOP reports reviewed, there is no documentation/data reflecting that the patients received their KOP medications.
 - Record 11 – The prescribed medication (Pravastatin) was not dispensed on a monthly basis as ordered. The patient did not receive his Pravastatin in May, June, August, and September 2015.
 - Record 12 – The patient did not receive his Lisinopril timely and the MAR and refill history reflect no medication was received by patient from May through August 2015.
3. Questions 5.4 and 5.5 – Not applicable. The patients selected for review were either not prescribed NA/DOT medications or have not refused their chronic care medication for three consecutive days or 50% or more doses in one week period; therefore, these questions could not be evaluated.
 4. Question 5.6 – Not applicable. According to the CCA’s Citrix insulin report, there were no California patients prescribed insulin during the audit review period; therefore, this question could not be evaluated.

6. COMMUNITY HOSPITAL DISCHARGE

This indicator evaluates the facility’s ability to complete timely follow-up appointments on patients discharged from a community hospital admission. Some areas of focus are the nurse face-to-face evaluation of the patient upon the patient’s return from a community hospital or hub institution, timely review of patient’s discharge plans, and timely delivery of prescribed medications.

During the audit review period of June through November 2015, a total of seven patients were sent out to community hospital emergency department (ED) for higher level of care; however, none were admitted to the hospital. All patients were seen and treated by an ED provider and returned to FCC’s custody on the same day. As there were no valid cases available to assess the facility clinical staff’s performance in this area during the current audit, this indicator was *not rated*.

Case Review Rating:

Not Applicable

Quantitative Review

Score [Rating]:

Not Applicable

Overall Rating:

Not Applicable

7. DIAGNOSTIC SERVICES

For this indicator, the CCHCS clinicians assess several types of diagnostic services such as radiology, laboratory, and pathology. The auditors review the patient medical records to determine whether radiology and laboratory services were timely provided, whether the primary care provider timely reviewed the results, and whether the results were communicated to the patient within the required time frame. The case reviews also take into account the appropriateness, accuracy, and quality of the diagnostic tests ordered and the clinical response to the results.

Case Review Rating:

Adequate

Quantitative Review

Score [Rating]:

86.3% [*Adequate*]

Overall Rating:

Adequate

Case Review Results

During the review of 15 cases, there were very few instances/encounters found relative to *Diagnostic Services*. Of the 10 diagnostic related events reviewed, CCHCS physicians found two deficiencies; both related to unnecessary lab tests ordered by the provider. As these deficiencies were minor in nature and did not significantly affect patient care, the case review resulted in an adequate rating for this indicator.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which may consist of onsite inspections/observations, review of patient medical records, or review of various documents and tracking logs. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

<i>Diagnostic Services</i>		Yes	No	Compliance
7.1	Is the diagnostic test completed within the time frame specified by the primary care provider?	22	0	100%
7.2	Does the primary care provider review, sign, and date all patient's diagnostic test report(s) within two business days of receipt of results?	18	4	81.8%
7.3	Is the patient given written notification of the diagnostic test results within two business days of receipt of results?	15	7	68.2%
7.4	Is the patient seen by the primary care provider for clinically significant/abnormal diagnostic test results within 14 days of the provider's review of the test results?	20	1	95.2%
Overall Quantitative Review Score:				86.3%

Comments:

For questions 7.1 through 7.4, a random sample of 22 patient medical records were reviewed for the audit review period of June through November 2015.

1. Question 7.2 – Eighteen patient medical records include documentation that the provider reviewed, signed, and dated the patient's diagnostic test report within two business day of receipt of results. For the two non-compliant cases, the diagnostic test results were not reviewed and signed by the provided within two business days; one report was reviewed by PCP eight days later and the other report four days later. This equates to 81.8% compliance.
2. Question 7.3 – Fifteen patient medical records were found compliant with this requirement. For the three non-compliant cases, no written notification was found in the patient's medical record and for the remaining four cases, no written notification of the diagnostic test results was provided to the patient within two business days of facility's receipt of results. This equates to 68.2% compliance.
3. Question 7.4 – One of the 22 cases reviewed was found not applicable to this question as the patient did not require a follow-up appointment with the provider. Twenty patient medical records included documentation that the patient was seen by the provider for clinically significant/abnormal diagnostic test results within 14 days and one case was found non-compliant with this requirement. This equates to 95.2% compliance.

8. EMERGENCY SERVICES

This indicator evaluates the emergency medical response system and the facility's ability to provide effective and timely emergency medical responses, assessment, treatment and transportation 24 hours per day. The CCHCS clinicians assess the timeliness and adequacy of the medical care provided based on the patient's emergency situation, clinical condition, and need for a higher level of care.

This quality indicator is evaluated by CCHCS clinicians entirely through the review of patient medical files and facility's documentation of emergency medical response process. No quantitative results are conducted for this indicator and therefore, the overall rating is based on the findings of the clinical case reviews.

Case Review Rating:

Inadequate

Quantitative Review

Score [Rating]:

Not Applicable

Overall Rating:

Inadequate

Case Review Results

The findings of the clinical case review reveal the facility performed very poorly as it relates to *Emergency Services* indicator. Overall, the CCHCS clinicians found the quality of physician and nursing care in emergency services was *inadequate*.

From June to November 2015, facility realized approximately a 50% reduction in CDCR patient population; therefore, a limited number of encounters in this area were available for evaluation. Nevertheless, of the seven cases (resulting in 20 urgent/emergent encounters) reviewed by both CCHCS nurse consultant and physician auditors, eight deficiencies were identified, mainly in nursing care. Specific examples of deficiencies and areas of concern identified by CCHCS nurse consultant are as follows:

- In Case 1, the patient was escorted to Main clinic for follow-up care following an altercation. The RN documented 'yes' for pain; however, there was no documentation of pain scale or description of pain. The anatomical form described injury to left orbit and mouth; however, no documentation by nursing of visual field assessment or assessment of the mouth and teeth. Additionally, the attending nurse did not document the treatment provided for actively bleeding facial lacerations. There was no documentation of the time the patient left the facility and the condition of the patient at the time of transfer.
- In Case 2, a patient complained of pain sensation upon inhalation. The patient was assessed by RN at 2130 hours in the housing unit. The provider was notified at 2200 hours and directed patient to be sent to community hospital emergency department (ED). The responding RN failed to conduct complete assessment of the patient's chief complaint; heart sounds were not assessed and oxygen not applied. Additionally, there was no documentation of the patient being monitored from 2130 hours to 2317 hours, the time when patient was transported to ER, as well as no documentation of the patient's condition at time of transfer. There was a six hour delay in RN's documentation of the patient's assessment. Furthermore, upon patient's return from the community ED the following day, there was no documentation of RN's assessment or

notation of firm mass on inferior right knee, as well as no documentation of education provided to patient following the community hospital ED visit.

- In Case 3, the RN failed to document any treatment provided to patient for laceration to upper lip with active bleeding. In the same case, upon return from community hospital ED, there was no documentation of patient's wound or of education provided to patient on wound care.
- In Case 6, the patient was escorted to Main clinic for assessment following an altercation. The nursing staff did not document the vital signs or any treatment provided to the wounds or abrasions.

Specific examples of deficiencies identified by CCHCS physician are as follows:

- In Cases 1 and 8, there were no hospital records found in the patient's medical record that described the treatment and care provided by community hospital ED physician during the patient's visit for higher level of care.
- In Cases 9 and 15, the patient did not see a provider for over a week upon return from community hospital ED. Additionally, no progress notes were completed by providers before the patient was sent to ED.

The CCHCS clinician recommendations regarding the FCC's physician and nursing staff performance improvement are discussed in indicators 16 and 17, *Quality of Nursing Performance* and *Quality of Physician Performance*, respectively.

9. HEALTH APPRAISAL/HEALTH CARE TRANSFER

This indicator determines whether the facility adequately manages patients' medical needs and continuity of patient care during inter- and intra-facility transfers by reviewing the facility's ability to timely: perform initial health screenings, complete required health screening assessment documentation (including tuberculin screening tests), and deliver medications to patients received from another facility. Also, for those patients who transfer out of the facility, this indicator reviews the facility's ability to document transfer information that includes pre-existing health conditions, pending specialty and chronic care appointments, medication transfer packages, and medication administration prior to transfer.

Case Review Rating:

Inadequate

Quantitative Review

Score [Rating]:

76.0% [*Inadequate*]

Overall Rating:

Inadequate

The facility performed very poorly both in the quantitative and clinical case review sections. The deficiencies were mainly due to incomplete nursing documentation, delay in administering the prescribed medications to patients upon their arrival at the facility, failure to assess the patient during the Health Screening Process, and the provider failing to complete the health appraisals timely. As a result, FCC received an *inadequate* rating in *Health Appraisal/Health Care Transfer* indicator.

Case Review Results

During the audit review period, there were only a few cases where the patients transferred into and out of the facility; therefore, limiting the number of cases available for evaluation. Of the 21 patient encounters/visits reviewed, related to Health Appraisal/Health Care Transfer Process, five deficiencies were found, all in nursing care.

Overall, FCC nursing staff's performance was *inadequate* in both the transfer-in and transfer-out processes. There were two cases (Cases 13 and 14) where no documentation could be found in the patient's medical record reflecting the screening for signs and symptoms of tuberculosis was completed by an RN upon the patient's arrival at the facility. The deficiencies found with patients transferring out of FCC were due to incomplete nursing documentation of significant medical information on the CDCR 7371, *Health Care Transfer Information*, form.

- In Case 2, the Transfer Summary did not include documentation of patient's firm mass on inferior right knee.
- In Cases 9 and 10, the RN did not document patient's enrollment in the chronic care program.

It is imperative for the nursing staff who complete the Initial Health Screening forms for newly arrived patients and/or the Health Care Transfer Information forms for patients transferring out, to adequately answer all form questions and to include a detailed response to each question. This will help eliminate any confusion and delay in providing adequate care to patients during the inter-facility transfer process.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which may consist of onsite inspections/observations, review of patient medical records, and/or review of various documents and tracking logs. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Health Appraisal/Health Care Transfer		Yes	No	Compliance
9.1	Does the patient receive an initial health screening upon arrival at the receiving facility by licensed health care staff?	15	0	100%
9.2	If "YES" is answered to any of the medical problems on the <i>Initial Health Screening</i> form (CDCR 7277/7277A or similar form), does the registered nurse document an assessment of the patient?	1	3	25.0%
9.3	If a patient presents with emergent or urgent symptoms during the initial health screening, does the registered nurse refer the patient to the appropriate provider?			Not Applicable
9.4	If a patient is not enrolled in the chronic care program but during the initial health screening was identified as having a chronic disease/illness, does the registered nurse refer the patient to the primary care provider to be seen within the required time frame??			Not Applicable
9.5	If a patient was referred to an appropriate provider during the initial health screening, was the patient seen within the required time frame?			Not Applicable

9.6	If a patient was enrolled in a chronic care program at a previous facility, is the patient scheduled and seen by the receiving facility's primary care provider within the time frame ordered by the sending facility's chronic care provider?	10	0	100%
9.7	If a patient was referred by the sending facility's provider for a medical, dental, or a mental health appointment, is the patient seen within the time frame specified by the provider?	Not Applicable		
9.8	Does the patient receive a complete screening for the signs and symptoms of tuberculosis upon arrival?	15	0	100%
9.9	Does the patient receive a complete health appraisal within seven calendar days of arrival?	7	8	46.7%
9.10	If a patient had an existing medication order upon arrival at the facility, were the nurse administered medications administered without interruption and keep-on-person medications received within one calendar day of arrival?	9	2	81.8%
9.11	When a patient transfers out of the facility, are the scheduled specialty services appointments that were not completed, documented on a <i>Health Care Transfer Information Form</i> (CDCR 7371) or a similar form?	7	1	87.5%
9.12	Does the Inter-Facility Transfer Envelope contain all the patient's medications, current Medication Administration Record and Medication Profile?	2	1	66.7%
Overall Quantitative Review Score:				76.0%

Comments:

For questions 9.1 through 9.10, a random sample of 15 patient medical records were reviewed for the audit review period of June through November 2015.

1. Question 9.2 – Eleven out of the 15 randomly selected cases did not meet the criterion for this question; therefore, compliance with this requirement was based on the remaining four cases. Of the four patient medical records reviewed, one case included documentation of a RN completing an assessment of the patient's medical problem. The other three cases did not include documentation of the RN's assessment of patient's medical problem. This equates to 25.0% compliance.
2. Question 9.3 – Not applicable. None of the 15 patients selected for review, to determine compliance with this requirement, presented with emergent or urgent symptoms during the initial health screening; therefore, this question could not be evaluated.
3. Question 9.4 – Not applicable. None of the 15 patients selected for review met the criterion for this question; therefore, this question could not be evaluated.
4. Question 9.5 – Not applicable. None of the 15 patients selected for review, to determine compliance with this requirement, were referred to provider during the initial health screening; therefore, this question could not be evaluated.
5. Question 9.7 – Not applicable. None of the 15 patients selected for review, to determine compliance with this requirement, had a pending appointment scheduled by sending facility's provider; therefore, this question could not be evaluated.
6. Question 9.9 – Seven patient medical records reviewed included documentation that the patient was seen by a provider within seven calendar days of arrival to the facility and eight cases were found non-compliant with this requirement. This equates to 46.7% compliance.
7. Question 9.10 – Four patients out of the 15 randomly selected were found not applicable to this question as these patients had no existing medication orders upon arrival at the receiving facility; therefore, compliance with this requirement was based on the remaining 11 cases. Of the 11 patient medical records reviewed, 9 included documentation that a patient received his prescribed medication timely. For

the remaining two cases, the auditor was unable to verify that the patients received their KOP medications. This equates to 81.8% compliance.

8. Question 9.11 – Of the eight patient medical records reviewed for the audit review period, seven included documentation of the patient’s pending scheduled specialty service appointments, which were not completed at the sending facility, on the Health Care Transfer Information Form. For the one non-compliant case, the patient’s scheduled gastroenterology appointment was not documented on the transfer form. This equates to 87.5% compliance.
9. Question 9.12 – There were no patients scheduled to be transferred out of the facility at the time of the onsite audit; therefore, compliance for this requirement was based on nursing staff interviews. Of the three nursing staff members interviewed regarding the process for securing the patient’s NA/DOT medications, current MAR, and Medication Profile in the transfer envelope prior to an inter-facility transfer, two nursing staff members described the process correctly. This equates to 66.7% compliance.

10. MEDICATION MANAGEMENT

For this indicator, CCHCS clinicians assess the facility’s process for medication management which includes timely filling of prescriptions, appropriate dispensing of medications, appropriate medication administration (evaluated by direct observation of pill calls), completeness in documentation of medications administered to patients, and appropriate maintenance of medication administration records. This indicator also factors in the appropriate storing and maintenance of refrigerated drugs, vaccines and narcotic medications.

Case Review Rating:
Inadequate
Quantitative Review
Score [Rating]:
83.8% [*Inadequate*]
Overall Rating:
Inadequate

This indicator is one of the other areas where FCC performed poorly. Although the compliance results were very close to the adequate range, the case review findings showed that there is much room for improvement in many areas related to *Medication Management*. Taking into account the findings of the quantitative and case review processes, FCC received an overall rating of *inadequate* performance in *Medication Management* indicator.

Case Review Results

The CCHCS clinicians reviewed a total of 59 encounters related to medication management and found 27 deficiencies, all in nursing care. The majority of the nursing deficiencies were similar to the ones already identified in other program areas and were relative to inadequate and lack of nursing documentation. Below is a list of deficiencies found by the CCHCS nurse consultant auditor:

- In Case 7, the nurses failed to provide medication to patient as ordered by provider. The nursing documentation reflected the patient was a ‘no show’ for medication while the patient was housed in an observation cell. In the same case, the prescribed medication was not given to the patient on the ordered frequency (given once a day instead of twice a day). Furthermore, there was incorrect documentation of the time the medication was administered to the patient and

additional six instances where time of medication administration documented on the MAR did not reconcile with the RN's documentation.

- In Cases 3, 5 and 7, the auditor could not locate documentation that the patient received or refused his prescribed medication.
- In Case 3, the RN failed to document the location of Tdap injection.
- In Cases 5, 9, and 10, there was a delay in administering the prescribed medication to the patient.

The CCHCS nurse consultant recommendations pertaining to FCC's nursing staff performance improvement are discussed in *Quality of Nursing Performance* section of the report (Chapter 16).

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which may consist of onsite inspections/observations, review of patient medical records, and/or review of various documents and tracking logs. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Medication Management		Yes	No	Compliance
10.1	Does the prescribing primary care provider document that the patient was provided education on the newly prescribed medications?	15	3	83.3%
10.2	Is the initial dose of the newly prescribed medication administered to the patient as ordered by the provider?	16	2	88.9%
10.3	Does the nursing staff confirm the identity of a patient prior to the delivery and/or administration of medications?	4	0	100%
10.4	Does the same medication nurse who administers the nurse administered/direct observation therapy medication prepare the medication just prior to administration?	4	0	100%
10.5	Does the medication nurse directly observe a patient taking direct observation therapy medication?	3	1	75.0%
10.6	Does the medication nurse document the administration of nurse administered/direct observation therapy medications on the Medication Administration Record once the medication is given to the patient?	3	1	75.0%
10.7	Are medication errors documented on the Medication Error Report form?	3	0	100%
10.8	Are refrigerated drugs and vaccines stored in a separate refrigerator that does not contain food and/or laboratory specimens?	1	0	100%
10.9	Does the health care staff monitor and maintain the appropriate temperature of the refrigerators used to store drugs and vaccines twice daily?	60	0	100%
10.10	Does the facility employ medication security controls over narcotic medications assigned to its clinic areas?	0	2	0.0%
10.11	Are the narcotics inventoried at the beginning and end of each shift by licensed health care staff?	120	0	100%
10.12	Do patients, housed in Administrative Segregation Unit, have immediate access to the Short Acting Beta agonist inhalers and/or nitroglycerine tablets? (COCF only)	N/A	N/A	N/A
Overall Quantitative Review Score:				83.8%

Comments:

1. Question 10.1 – Of the 18 patient medical records reviewed, 15 included documentation that the provider educated the patient on the newly prescribed medication(s), and 3 cases did not include such documentation. This equates to 83.3% compliance.
2. Question 10.2 – Of the 18 patient medical records reviewed, 16 included documentation reflecting the initial dose of the newly prescribed medications was administered to the patients as ordered by the provider. The two non-compliant cases reflect the patient receiving the prescribed medication late or not as ordered by provider. This equates to 88.9% compliance.
3. Question 10.5 – Of the four medication nurses observed during administration of DOT medications to patients, one was observed not consistently conducting mouth checks on all patients. This equates to 75.0% compliance.
4. Question 10.6 – Of the four medication nurses observed during administration of DOT medications to patients, one nurse was observed not documenting the administration of medication to patient once the medication was given to the patient. The observed medication nurse did not document blood sugar and insulin given to the patient until after the second patient was done. This equates to 75.0% compliance.
5. Question 10.10 – During the onsite health care staff interviews, it was found that more than one staff member has a key to the locked narcotic storage unit. One key is held by the pharmacy manager and the other one by the charge nurse. This practice is not in compliance with IMSP&P guideline which states in part, “There shall be only one key available to the controlled storage unit which must be carried by an assigned, responsible licensed nursing staff member.” This equates to 0.0% compliance. To help ensure adequate medication controls, CCHCS recommends the facility ensure that only one licensed nursing staff member maintain control of a particular narcotics storage area and maintain a different access key for each location.
6. Question 10.12 – N/A. At the time of the audit, there were no patients housed in ASU who were prescribed inhalers; therefore, this question could not be evaluated.

11. OBSERVATION CELLS

This quality indicator applies only to California out-of-state correctional facilities. The CCHCS auditors examine whether the facility follows appropriate policies and procedures when admitting patients to onsite inpatient cells. All aspects of medical care related to patients housed in observations cells are assessed, including quality of provider and nursing care.

For this indicator, the case review and quantitative review processes yielded different results. The quantitative review resulted in overall score of 95.0%, equating to a quality rating of *proficient*, while the case review resulted in an *adequate* rating. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the magnitude of all deficiencies identified in both processes and their potential impact on patient’s health care condition. Taking into consideration the findings related to *Observation Cells*, CCHCS clinicians rated this indicator *adequate*.

Case Review Rating:

Adequate

Quantitative Review

Score [Rating]:

95.0% [Proficient]

Overall Rating:

Adequate

Case Review Results

Of the 58 encounters reviewed by CCCHS clinicians, six minor deficiencies were found in nursing care and all were attributed to the same case. The CCHCS physician case reviews did not identify any lapses in care provided by the FCC's physicians. After further evaluation, the nursing deficiencies were determined to be minor in nature and unlikely to contribute to patient harm, therefore, the case review resulted in *adequate* rating for this indicator. Specific examples of nursing deficiencies identified in Case 7 are as follows:

- The patient was seen in Main clinic for second degree burns from hot water and placed into an observation cell for wound care and monitoring for nine days. After nine days, the patient was released to general population with orders to continue with twice a day application of silver sulfadiazine cream, twice a day of oral antibiotics, and daily wound assessments by an RN. During the patient's nine day stay in an observation cell:
 - the nursing staff failed, on two occasions, to document whether any wound care was provided;
 - the nursing staff failed, on three occasions, to complete an assessment of the wound and to document the description of the wound size or drainage; and
 - no documentation could be located in the patient's medical record of patient's refusal or administration of Tdap vaccine while the patient was housed in an observation cell.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which may consist of onsite inspections/observations, review of patient medical records, and/or review of various documents and tracking logs. Following this table is a brief narrative addressing the standard being measured which received less than a 100% compliance rating.

Observation Cells (COCF only)		Yes	No	Compliance
11.1	Is the patient assessed by a registered nurse every eight hours or more frequently as ordered by the primary care provider when housed in an observation cell?	6	0	100%
11.2	Does the primary care provider document the need for the patient's placement in the observation cell and a brief admission history and physical examination within 24 hours of placement?	6	0	100%
11.3	Does a licensed clinician conduct daily face-to-face rounds on patients housed in observation cell for suicide precaution/watch or awaiting transfer to a Mental Health Crisis Bed?	1	0	100%
11.4	Is there a functioning call system or a procedure in place where the patient housed in an observation cell has the ability to get the attention of health care staff immediately?	4	1	80.0%
Overall Quantitative Review Score:			95.0%	

Comments:

1. Question 11.4 – Of the five observation cells inspected during the onsite visit, four were found with a fully functional call system. One of the observation cell’s call light was found non-operational. This equates to 80.0% compliance.

12. SPECIALTY SERVICES

For this indicator, CCHCS clinicians determine whether patients are receiving approved specialty services timely, whether the provider reviews related specialty service reports timely and documents their follow-up action plan for the patient, and whether the results of the specialists’ reports are communicated to the patients. For those patients who transferred from another facility, the auditors assess whether the approved or scheduled specialty service appointments are received/completed within the specified time frame.

Case Review Rating:

Adequate

Quantitative Review

Score [Rating]:

100% [Proficient]

Overall Rating:

Adequate

For *Specialty Services* indicator, the case review and quantitative review processes yielded different results. The quantitative review resulted in overall score of 100%, equating to a quality rating of *proficient*, while the case review resulted in an *adequate* rating. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the magnitude of the deficiencies identified during case reviews and their potential impact on patient’s health care condition. The case review results show four deficiencies were minor and did not significantly impact the patient’s access to health care. As a result, the CCHCS clinicians determined the appropriate overall rating for this indicator was *adequate*.

Case Review Results

The CCHCS clinicians reviewed 16 events related to *Specialty Services* and found four deficiencies; two were associated with nursing care and two were associated with physician care. Three of the four deficiencies involved the health information management process and one was related to appropriateness of medical action. As these deficiencies were minor in nature and did not significantly affect patient care, the case review resulted in *adequate* rating for this indicator.

With regards to nursing deficiencies, in Case 2, nursing staff failed to document that education was provided to the patient regarding the treatment plan. In the same case, there was no documentation of nursing staff completing an assessment of the patient upon his return from specialty care visit.

As it relates to physician deficiencies, in Case 9, there were no notes from specialty consultant available in the patient’s medical record for FCC physician to review prior to a patient’s follow-up appointment with provider. The FCC’s physician failed to contact the specialty consultant to obtain the missing report or have the findings communicated to the provider. In Case 10, the patient was referred to the podiatrist, who makes an incorrect diagnosis; however, CCHCS physician’s review found that the podiatrist visit was not warranted and was unnecessary. In spite of ordering an unnecessary referral and

consultation, the facility physician failed to contact the podiatrist to discuss the findings and subsequently reiterated the incorrect diagnosis to patient during a follow-up visit.

Quantitative Review Results

The table below reflects the findings/results associated with the quantitative review. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Specialty Services		Yes	No	Compliance
12.1	Is the primary care provider's request for specialty services approved or denied within the specified time frame? (COCF Only)	24	0	100%
12.2	Is the patient seen by the specialist for a specialty services referral within the specified time frame? (COCF Only)	25	0	100%
12.3	Upon return from the hub, a specialty consult appointment or community emergency department visit, does a registered nurse complete a face-to-face assessment prior to the patient's return to the assigned housing unit?	25	0	100%
12.4	Upon return from the hub, a specialty consult appointment or community emergency department visit, does a registered nurse notify the primary care provider of any immediate orders or follow-up instructions provided by the hub, a specialty consultant, or emergency department physician?	3	0	100%
12.5	Does the primary care provider review the specialty consultant's report, hub provider's report or the community emergency department provider's discharge summary and complete a follow-up appointment with the patient within the required time frame?	25	0	100%
Overall Quantitative Review Score:				100%

Comments:

For questions 12.1 through 12.5, a random sample of 25 patient medical records were reviewed for the audit review period of June through November 2015. The facility was found 100% compliant on all requirements and standards measured in this indicator.

13. PREVENTIVE SERVICES

This indicator assesses whether the facility offers or provides various preventive medical services to patients meeting certain age and gender requirements. These include cancer screenings, tuberculosis evaluation, influenza and chronic care immunizations.

This quality indicator is evaluated by CCHCS auditors entirely through the review of patient medical records. No clinical case reviews are conducted for this indicator and therefore, the overall rating is based on the results of the quantitative review.

The facility received a compliance score of 90.0% in *Preventive*

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
90.0% [Proficient]
Overall Rating:
Proficient

Services indicator, which equates to an overall rating of proficient. It should be noted that out of seven compliance tests conducted, five were found not applicable. Of the five tests/questions found not applicable, three did not have any patients housed at FCC who met the criteria for the test and the other two questions are assessed once per calendar year during the audit review period when the facility provides TB testing and screening to its patient population. Refer to the *Comments* section, following the table below, for additional information and details.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Preventive Services		Yes	No	Compliance
13.1	<i>For patients prescribed anti-Tuberculosis medication(s):</i> Does the facility administer the medication(s) to the patient as prescribed?			Not Applicable
13.2	<i>For patients prescribed anti-Tuberculosis medication(s):</i> Does the nursing staff notify the primary care provider or a public health nurse when the patient misses or refuses anti-TB medication?			Not Applicable
13.3	<i>For patients prescribed anti-Tuberculosis medication(s):</i> Does the facility monitor the patient monthly while he/she is on the medication(s)?			Not Applicable
13.4	Do patients receive a Tuberculin Skin Test annually?			Not Applicable
13.5	Are the patients screened annually for signs and symptoms of tuberculosis?			Not Applicable
13.6	<i>For all patients:</i> Were the patients offered an influenza vaccination for the most recent influenza season?	21	0	100%
13.7	<i>For all patients 50 to 75 years of age:</i> Are the patients offered colorectal cancer screening?	16	4	80.0%
13.8	<i>For female patients 50 to 74 years of age:</i> Is the patient offered a mammography at least every two years?			Not Applicable
13.9	<i>For female patients 21 to 65 years of age:</i> Is the patient offered a Papanicolaou test at least every three years?			Not Applicable
Overall Quantitative Review Score:				90.0%

Comments:

1. Questions 13.1 through 13.3 – Not applicable. There were no patients who were prescribed TB medications during the audit review period of June through November 2015; therefore, these questions could not be evaluated.
2. Questions 13.4 and 13.5 – Per the methodology, these questions are evaluated once per calendar year and during the audit review period when the annual TB testing occurs per the master calendar on Lifeline. As the audit review period for FCC's current audit did not encompass the month when FCC provided annual TB testing and screening to its CDCR patient population, these questions could not be evaluated for compliance with this requirement.

3. Question 13.7 – Of the 20 patient medical records reviewed, 16 included documentation that the patient was offered colorectal cancer screening. This equates to 80.0% compliance.
4. Questions 13.8 and 13.9 – Not applicable. These questions only apply to correctional facilities housing female patients population.

14. EMERGENCY MEDICAL RESPONSE/DRILLS & EQUIPMENT

For this indicator, the CCHCS auditors review the facility’s emergency medical response documentation to assess the response time frames of facility’s health care staff during medical emergencies and/or drills. The CCHCS auditors also inspect emergency medical response bags and various medical equipment to ensure regular inventory and maintenance of equipment is occurring.

This indicator is evaluated by CCHCS nurses entirely through the review of emergency medical response documentation, inspection of emergency medical response bags and crash carts (COCF only), and inspection of medical equipment located in the clinics. No clinical case reviews are conducted for this indicator and therefore, the overall rating is based on the results of the quantitative review.

Case Review Rating:

Not Applicable

Quantitative Review

Score [Rating]:

94.7% [Proficient]

Overall Rating:

Proficient

The facility received a *proficient* rating with a score of 94.7% in the *Emergency Medical Response/Drills & Equipment* indicator. This is a significant improvement from the previous audit’s score of 77.5% compliance in this area. Refer to the *Comments* section, following the table below, for additional information and details on the deficiencies identified during the quantitative review of this indicator.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Emergency Medical Response/Drills & Equipment		Yes	No	Compliance
14.1	Does the facility conduct emergency medical response drills quarterly on each shift when medical staff is present?	6	0	100%
14.2	Does a Basic Life Support certified health care staff respond without delay after emergency medical alarm is sounded during an emergency medical response (man-down) and/or drill?	23	0	100%
14.3	Does a registered nurse or a primary care provider respond within eight minutes after emergency medical alarm is sounded for an emergency medical response (man-down) and/or drill?	23	1	95.8%
14.4	Does the facility hold an Emergency Medical Response Review Committee a minimum of once per month?	6	0	100%

14.5	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required documents?	6	0	100%
14.6	Is the facility's clinic Emergency Medical Response Bag secured with a seal?	60	0	100%
14.7	If the emergency medical response and/or drill warrant an opening of the Emergency Medical Response Bag, is the bag re-supplied and re-sealed before the end of the shift?	1	6	14.3%
14.8	If the emergency medical response bag has not been used for emergency medical response and/or drill, is it being inventoried at least once a month?	6	0	100%
14.9	Does the facility's Emergency Medical Response Bag contain only the supplies identified on the Emergency Medical Response Bag Checklist in compliance with Inmate Medical Services Policies and Procedures requirements?	1	0	100%
14.10	Is the facility's Medical Emergency Crash Cart secured with a seal? (COCF Only)	60	0	100%
14.11	If the emergency medical response and/or drill warrant an opening and use of the medical emergency crash cart, is the crash cart re-supplied and re-sealed before the end of the shift? (COCF Only)	N/A	N/A	N/A
14.12	If the medical emergency crash cart has not been used for a medical emergency and/or drill, was it inventoried at least once a month? (COCF Only)	6	0	100%
14.13	Does the facility's crash cart contain all the medications as required/approved per <i>Inmate Medical Services Policies and Procedures</i> ? (COCF Only)	1	0	100%
14.14	Does the facility's crash cart contain the supplies identified on the facility's crash cart checklist? (COCF Only)	1	0	100%
14.15	Does the facility have a functional Automated External Defibrillator with electrode pads located in the medical clinic?	1	0	100%
14.16	Does the facility have a functional 12-lead electrocardiogram machine with electrode pads? (COCF Only)	1	0	100%
14.17	Does the facility have a functional portable suction device?	1	0	100%
14.18	Does the facility have a portable oxygen system that is operational ready?	2	0	100%

Overall Quantitative Review Score: 94.7%

Comments:

1. Question 14.2 - For the audit review period of June through November 2015, FCC conducted a total of 24 emergency medical responses/drills. During one of the actual emergency responses, it was found that the Basic Life Support (BLS) certified health care staff did not respond to the medical emergency within four minutes after the alarm was sounded. However, per the double failure rule, this non-compliant incident was not included in the compliance rating of this question as it was rated for compliance in Question 14.3.
2. Question 14.3 – For the audit review period of June through November 2015, FCC conducted 20 emergency medical response drills and responded to 4 actual medical emergencies. During one of the actual medical emergency responses, the RN was notified at 1800 hours but the patient was not seen by a RN until 20 minutes later. Per IMSP&P guideline for responding to emergencies, “the response time for health care staff shall not exceed eight (8) minutes” for responding to medical emergencies. This equates to 95.8% compliance.
3. Question 14.7 – Of the 24 emergency medical responses/drills reviewed, 7 warranted an opening of the Emergency Medical Response (EMR) Bag. The EMR Bag logs reviewed for the seven incidents reflect only one bag was restocked/resealed before the end of the shift. This equates to 14.3% compliance.
4. Question 14.11 – N/A. Of the 24 emergency medical responses/drills reviewed, not one warranted opening of the medical emergency crash carts; therefore, this question could not be evaluated.

15. CLINICAL ENVIRONMENT

This indicator measures the general operational aspects of the facility's clinic(s). CCHCS auditors, through staff interviews and onsite observations/inspections, determine whether health care management implements and maintains practices that promote infection control through general cleanliness, adequate hand hygiene protocols, and control of blood-borne pathogens and contaminated waste. Rating of this quality indicator is based entirely on the quantitative review results from the visual observations auditors make at the facility during their onsite visit, as well as review of various logs and documentation reflecting maintenance of clinical environment and equipment.

Case Review Rating:
Not Applicable
**Quantitative Review
Score [Rating]:**
97.5% [*Proficient*]
Overall Rating:
Proficient

The facility received a compliance score of 97.5% in the *Clinical Environment* indicator, equating to an overall rating of *proficient*. This is a significant improvement from the previous audit rating of 88.1% compliance in this area. The facility received 100% compliance in 15 of the 17 standards/requirements measured; meaning the facility is performing at a *proficient* level in those areas. In the other two areas FCC scored below the compliance benchmark of 85.0%. Refer to *Comments* section following the table below for additional information on the deficiencies.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Clinical Environment		Yes	No	Compliance
15.1	Are packaged sterilized reusable medical instruments within the expiration dates shown on the sterile packaging?	9	2	81.8%
15.2	If autoclave sterilization is used, is there documentation showing weekly spore testing?	3	1	75.0%
15.3	Are disposable medical instruments discarded after one use into the biohazard material containers?	1	0	100%
15.4	Does clinical health care staff adhere to universal hand hygiene precautions?	6	0	100%
15.5	Is personal protective equipment readily accessible for clinical staff use?	1	0	100%
15.6	Is the reusable non-invasive medical equipment disinfected between each patient use when exposed to blood-borne pathogens or bodily fluids?	3	0	100%
15.7	Does the facility utilize a hospital grade disinfectant to clean common clinic areas with high foot traffic?	2	0	100%
15.8	Is environmental cleaning of common clinic areas with high foot traffic completed at least once a day?	60	0	100%
15.9	Is the biohazard waste bagged in a red, moisture-proof biohazard bag and stored in a labeled biohazard container in each exam room?	5	0	100%
15.10	Is the clinic's generated biohazard waste properly secured in the facility's central storage location that is labeled as a "biohazard" area?	2	0	100%

15.11	Are sharps/needles disposed of in a puncture resistant, leak-proof container that is closeable, locked, and labeled with a biohazard symbol?	5	0	100%
15.12	Does the facility store all sharps/needles in a secure location?	1	0	100%
15.13	Does the health care staff account for and reconcile all sharps at the beginning and end of each shift?	60	0	100%
15.14	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	2	0	100%
15.15	Is the facility's biomedical equipment serviced and calibrated annually?	23	0	100%
15.16	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	5	0	100%
15.17	Does the clinic visit location ensure the patient's visual and auditory privacy?	5	0	100%

Overall Quantitative Review Score: 97.5%

Comments:

1. Question 15.1 – Of the 11 medical instruments in the pharmacy inspected during the onsite visit, 9 were found within the expiration dates shown on the sterile packaging and 2 have expired on December 4, 2015. This equates to 81.8% compliance.
2. Question 15.2 – FCC has one autoclave, which is located in the dental clinic. Documentation of weekly spore testing reviewed for the month of November 2015 indicate that although the dental clinic was open November 22 through 24, 2015, no spore testing was completed during that week. This equates to 75.0% compliance.

16. QUALITY OF NURSING PERFORMANCE

The goal of this indicator is to provide a qualitative evaluation of the overall quality of health care provided to the patients by the facility's nursing staff. Majority of the patients selected for retrospective chart review are the ones with high utilization of nursing services, as these patients are most likely to be affected by timely appointment scheduling, medication management, and referrals to health care providers.

Case Review Rating:
Inadequate

Quantitative Review Score [Rating]:
Not Applicable

Overall Rating:
Inadequate

Case Review Results

The *Quality of Nursing Performance* at FCC was rated *inadequate*. This determination was based upon the detailed case review of all the nursing services provided to 10 patients housed at FCC during the audit period of June through November 2015. Of the 10 detailed case reviews conducted by CCHCS nurse consultant, one was found proficient, three adequate, and six inadequate. Of 189 nursing encounters/visits assessed within the 10 detailed case reviews, 53 deficiencies were related to nursing care and performance. Majority of the deficiencies involved the health information management, nursing assessment, and the medication management processes. The nursing services found to be inadequate/deficient at FCC include:

- Incomplete subjective and objective assessments of patients receiving urgent care services (identified in Cases 1 and 2).

- Missing and/or incomplete documentation of nursing actions taken to address urgent care needs (identified in Cases 1, 2, 3, and 6).
- Missing and/or incomplete documentation of condition of patient upon transfer to a higher level of care (identified in Cases 1 and 2).
- Missing and/or incomplete documentation of screening of a patient for TB upon arrival at FCC (identified in Cases 13 and 14; refer to pages 25 and 26 for additional information).
- Medications not administered as ordered (identified in Cases 3, 5, and 7).
- Delays in administration of medications (identified in Cases 5, 9, and 10).
- Missing and/or incomplete documentation of wound description and care provided (identified in Cases 3, 6, and 7).

Case Number	Deficiencies
Case 1	Inadequate. A twenty-nine year old patient was escorted to Main clinic for follow-up care following an altercation. The RN documented 'yes' for pain; however, there was no documentation of pain scale or description of pain. The anatomical form described injury to left orbit and mouth; however, no documentation by nursing of visual field assessment or assessment of the mouth and teeth. Additionally, the attending nurse did not document the treatment provided for actively bleeding facial lacerations. There was no documentation of the time the patient left the facility and the condition of the patient at the time of transfer.
Case 2	Inadequate. A twenty-seven year old with history of pulmonary emboli. On August 8, 2015, the patient complained of pain sensation upon inhalation. The patient was assessed by RN at 2130 hours in the housing unit. The provider was notified at 2200 hours and directed patient to be sent to community hospital ED. The responding RN failed to conduct complete assessment of the patient's chief complaint; heart sounds were not assessed and oxygen not applied. Additionally, there was no documentation of the patient being monitored from 2130 hours to 2317 hours, the time when patient was transported to ED, as well as no documentation of the patient's condition at time of transfer. There was a six hour delay in RN's documentation of the patient's assessment. Furthermore, upon patient's return from the community ED the following day, there was no documentation of RN's assessment or notation of firm mass on inferior right knee, as well as no documentation of education provided to patient following the community hospital ED visit.
Case 3	Adequate. A twenty-six year old who presented to medical as a result of laceration to upper lip. The nursing staff provided emergent care and sent the patient to community hospital ED for further assessment and treatment. The RN failed to document any treatment provided to patient for laceration to upper lip with active bleeding. Upon return from community hospital ED, there was no documentation of patient's wound or of education provided to patient on wound care. Additionally, the auditor was unable to locate documentation in the patient's medical record showing the patient received his prescribed medications.
Case 4	Adequate. A twenty-seven year old who had minimal contact with medical staff until August 2015 when the patient reported an injury to his right knee playing basketball. The only deficiency identified during the chart review of this case was there was no documentation in the patient's medical record of Colace medication having been administered to patient as ordered by provider.



Case 5 *Inadequate.* A forty-five year old enrolled in asthma, diabetes mellitus (DM), and cardiovascular chronic care programs. The patient was prescribed Alvesco and Ventolin inhalers, Metformin, Lisinopril, Omeprazole and Cetirizine medications. There was a four day delay in patient receiving his Metformin medication and no documentation in the patient's medical record of patient either receiving or refusing his Cetirizine medication.

Case 6 *Adequate.* A forty-two year old patient was escorted to Main clinic for assessment following an altercation. The nursing staff did not document the vital signs or any treatment provided to the wounds or abrasions. Additionally, there was no documentation of location of Tdap injection administered by RN as ordered by provider.

Case 7 *Inadequate.* A thirty-six year old patient was seen in Main clinic for second degree burns from hot water. The patient was placed in observation cell for wound care and monitoring for nine days. During the patient's nine day stay in an observation cell, the nursing staff failed, on two occasions, to document whether any wound care was provided and on three occasions, failed to complete an assessment of the wound and to document the description of the wound size or drainage. Also, no documentation could be located in the patient's medical record of patient's refusal or administration of Tdap vaccine while the patient was housed in an observation cell.

After nine days, the patient was released to general population with orders to continue with twice a day application of silver sulfadiazine cream, twice a day of oral antibiotics, and daily wound assessments by an RN. The nurses failed to provide medication to patient as ordered by provider. The nursing documentation reflected the patient was a 'no show' for medication while the patient was housed in an observation cell. Additionally, the prescribed medication was not given to the patient on the ordered frequency (given once a day instead of twice a day). Furthermore, there was incorrect documentation of the time the medication was administered to the patient and additional six instances where time of medication administration documented on the MAR did not reconcile with the RN's documentation.

Case 9 *Inadequate.* A fifty-nine year old with history of Hepatitis C, hypertension, DM and dyslipidemia and enrolled in Hepatitis C, DM, and cardiovascular disease chronic care programs. The patient was prescribed ASA, Glipizide, Enalapril/Lisinopril, Metformin, Metoprolol, Pravastatin, and Ranitidine medications. There were multiple delays identified in patient receiving his newly prescribed medications as well as delays ranging from 3 to 14 days, in patient receiving his KOP medications.

Case 10 *Inadequate.* A forty-six year old patient enrolled in pulmonary and cardiovascular disease chronic care programs. The patient was prescribed Terazosin. There was a delay in patient receiving his 30 day medication supply. Additionally, during the sick call visit, the nurse failed to document pain scale assessment. Also, there was missing documentation of patient's enrollment in the chronic care programs on the Transfer Summary form.

The nursing staff should be very diligent in their documentation of the medication administration times and dates. One of the essential and basic principles of nursing practice is adequate and accurate documentation. Anything not documented is considered not done. Therefore, it is imperative the nursing documentation is accurate, complete, timely, valid, relevant, and legible. Additionally, nursing staff must be very conscientious and follow the providers' orders correctly and thoroughly, especially as it relates to medication administration.

Following are some recommendations provided by CCHCS on how the nursing performance at FCC may be improved:

- Consider implementing a process where nursing, providers, and custody meet at the beginning of the work day to discuss:
 - patients to be seen that day;
 - patients currently in observation cells;
 - patients who were sent out or returned from a community hospital ED visit or hospitalization;
 - patients seen on an urgent basis in the last 24 hours;
 - patients non-compliant with medications or ordered treatments/therapies;
 - new arrivals with chronic health conditions; and
 - any restrictions on patient movement by custody.
- Utilize the urgent/emergent care templates in Allscripts electronic health record when conducting patient assessments.
- Utilize the emergency care templates to describe the nursing services provided and the patient's response. Such as cleaning a wound, treatments provided, immobilizing an extremity and administration of pain medication.
- Expand the emergency care template to include a section that describes the condition of the patient at the time of transfer to a higher level of care. For example, transfer to community emergency department.
- Implement the use of a wound care form. The form can provide structure for describing the wound's size and condition, treatment ordered, treatment provided, and patient's response to the treatment.
- Implement a process that ensures chronic care medications are ordered and received by the patient prior to the patient finishing the previous month's supply.
- Implement a process to ensure nursing documents the administration of all medications. This is to include the one time medications ordered by provider, prescribed wound care medications, and vaccinations.

The facility management staff is expected to take immediate action to resolve the deficiencies identified above. The facility is strongly encouraged to implement oversight and monitoring strategies for clinical nurse supervisor to evaluate nursing performance in assigned clinical areas and quality of nursing documentation.

17. QUALITY OF PROVIDER PERFORMANCE

In this indicator, the CCHCS physicians provide a qualitative evaluation of the adequacy of provider care at the facility. Appropriate evaluation, diagnosis, and management plans are reviewed for programs

including, but not limited to, nursing sick call, chronic care programs, specialty services, emergency services, and specialized medical housing.

Case Review Results

Based on the 15 in-depth case reviews completed by CCHCS clinician, the facility provider performance was *adequate*. Because of the small number of 250 California patients housed at FCC, of which none are deemed to have substantial medical needs, there was limited data available for review. Of the 15 detailed case reviews conducted by CCHCS physician, four were found proficient and therefore are not documented below. The remaining 11 case reviews were found to contain 10 deficiencies related to provider performance out of a total of 59 physician encounters/visits assessed. These deficiencies were determined to be minor in nature and unlikely to contribute to patient harm. The physician services found to be inadequate/deficient at FCC include:

Case Review Rating:
Adequate
**Quantitative Review
Score [Rating]:**
Not Applicable
Overall Rating:
Adequate

- Chronic care medications continued/ordered without adequate indication for such action (identified in Cases 4 and 13).
- Missing documentation of hospital records in the patient’s medical record (identified in Cases 1 and 8).
- Patients not seen timely by a provider upon return from community hospital ED (identified in Cases 9 and 15).

Case Number	Deficiencies
Case 1	Adequate. A twenty-nine year old patient presented to medical after altercation with appropriate referral to community hospital ED because of symptoms suggesting concussion and possible facial fracture. There were no hospital records found in the patient’s medical record that described the treatment and care provided by community hospital ED physician during the patient’s visit for higher level of care.
Case 4	Adequate. A forty-one year old patient enrolled in Hepatitis C and cardiovascular disease chronic care programs. During the chronic care visits, the patient’s blood pressure measured consistently below 120 systolic. Reduction or discontinuation of blood pressure medication should have been considered.
Case 8	Adequate. A twenty-four year old presented to medical with acute left shoulder injury and transferred to community hospital ED for further evaluation and treatment. There were no hospital records found in the patient’s medical record that described the treatment and care provided by community hospital ED physician during the patient’s visit for higher level of care.
Case 9	Adequate. A twenty-nine year old with chronic wrist pain from malunion of radial fracture. Patient was taken to surgery timely following orthopedic evaluation. There were no medical records or notes from specialty consultant found in patient’s medical record. Additionally, the patient was not seen by a provider for over a week upon return from community hospital ED. Also, no progress notes were completed by a provider before the patient was sent to ED.

- Case 10** ***Adequate.*** A sixty-two year old with diagnosed asthma, constipation, hyperlipidemia, and back pain visits podiatry for foot swelling. Podiatry makes diagnosis of reflex sympathetic dystrophy (RSD) with no history or physical findings that indicate that diagnosis is correct. The facility's provider failed to contact the specialty consultant to discuss the diagnosis and reiterated the incorrect diagnosis to the patient during the follow-up visit.
- Case 12** ***Adequate.*** A thirty-eight year old patient followed for hypertension and Hepatitis C with borderline elevation of blood pressure (140/90) and a body mass index (BMI) over 28. A full panel of laboratory tests was ordered by provider, which was determined to be unnecessary by the CCHCS physician. The patient was encouraged to take his medication; however, the elevated blood pressure (140/90) can be managed without drugs. There was insufficient attention provided to lifestyle change and likely benefit of bringing BMI to normal (under 25) range.
- Case 13.** ***Inadequate.*** A thirty-seven year old patient enrolled in DM chronic care program. The patient was prescribed Metformin medication for controlling blood sugar level; however, there was no indication to continue a relatively high dose of Metformin (500 mg twice daily) with blood sugar level (HbA1c) of 5.8, which is within normal range. The patient appears to be overmedicated.
- Case 14** ***Adequate.*** A twenty-seven year old patient weighing 358 pounds (BMI 51.4) has putative past history of pulmonary embolism (PE). The patient presented to medical with complains of pain with inhalation and was ordered by the provider to be transferred to ED to rule out PE. Although the patient was at relatively high risk for PE, it does not merit trip to ED for symptoms and findings inconsistent with that diagnosis (no apparent distress and normal physical exam reported by nursing). The PCP should have assessed the patient before sending him out to acute hospital. Very large weight makes transport more dangerous than likelihood of PE with normal respiratory rate and negative physical exam. Symptom of pain with respiration only is vague and does not suggest by itself need for emergency hospital transport. However, given the patient's past history, trip to ER in this case was understandable.
- Case 15** ***Adequate.*** A twenty-three year old was sent to community hospital ED for scalp laceration, head contusion, and nausea resulting from altercation. There were no progress notes documenting the provider completed an exam before sending the patient to hospital or upon the patient's return to the facility.

In general, medical services provided by the physician and nurse practitioner met the standards of care applied in California prisons; however, a few of the charts reviewed suggested aspects of care that might benefit from further attention. There is some room for improvement in oversight of physician extenders. Coordination of nursing, custodian, and physician and outside specialty services providers can also be improved. In a couple of cases, apparent lack of communication between the physician and the nurse practitioner increased the risk of adverse clinical outcomes.

Following are some recommendations provided by CCHCS physician on how to further improve the provider's performance at FCC:

- Document weekly meeting between the primary care provider and the nurse practitioner to review challenging cases and provide continuing education.
- The supervising physician should review monitoring logs to identify patients needing further consideration.
- Complete peer review among the facility's providers.



- Implement logs to document after hours phone call contact with providers.
- Encourage nurses to seek contemporaneous advice of physical examination of patients with new symptoms or worsening condition.
- Encourage nurses to feel free to refer to the provider or nurse practitioner any patient who is requesting further care from a provider, even if the RN feels he/she has provided sufficient care to the patient.
- The supervising physician should ensure notes from community hospital ED physicians and specialists are documented /scanned into the patient's electronic medical record.
- Patients with borderline indications for pharmacological therapy should be re-evaluated before continuing medications prescribed in the past. Examples include a patient on anti-hypertensive agent with normal blood pressure and a patient prescribed 1000 mg of Metformin despite having blood sugar (HbA1c) level of 5.8, which is within the normal range.
- The supervising physician should feel free to contact CCHCS headquarters in Elk Grove, California to discuss cases of interest or need for specialty services if he/she runs into problems along those lines and need further advice.

PRIOR CRITICAL ISSUE RESOLUTION

The previous audit resulted in the identification of 60 quantitative critical issues; however, four of the critical issues are no longer rated by the Health Care Operations Monitoring Audit.

During the current audit, auditors found 37 of the 56 outstanding issues resolved, with the remaining 19 not resolved to within the established compliance threshold. It should be noted that 7 of the 19 critical issues could not be evaluated at this time due to lack of valid cases available for review/assessment of that specific requirement. Below is a discussion of each previous critical issue:

1. Question 1.4 (Formerly Question 1.1.18) - *THE FACILITY'S PATIENT ORIENTATION HANDBOOK/MANUAL DOES NOT ADDRESS THE HEALTH CARE GRIEVANCE/APPEAL PROCESS.*

Prior Compliance	Current Compliance	Status
0.0%	100%	Resolved

During the previous audit, the facility's patient orientation handbook/manual did not address the health care grievance/appeal process at all. Subsequent to the previous audit, the facility updated and revised their *Health Care Orientation* and *CA Inmate Orientation to FCC* handbooks to include information on the first, second, and third level health care appeal processes. During the current audit, FCC was found fully compliant with this requirement. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

2. Question 1.4 (Formerly Question 1.1.19) – *THE FACILITY'S PATIENT ORIENTATION HANDBOOK/MANUAL DOES NOT CLEARLY ADDRESS THE SICK CALL PROCESS.*

Prior Compliance	Current Compliance	Status
0.0%	100%	Resolved

The findings of the June 2015 audit reflected the facility's patient orientation handbook/manual did not accurately address the sick call process. Subsequent to the previous audit, the facility updated their *Health Care Orientation* and *CA Inmate Orientation to FCC* handbooks to include additional details on the FCC's sick call process. The facility was found fully compliant with this requirement during the current audit. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

3. Question 2.4 (Formerly Question 1.3.1) – *THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE SICK CALL MONITORING LOGS TIMELY.*

Prior Compliance	Current Compliance	Status
47.6%	92.3%	Resolved

The previous audit findings showed that during the six month period, 47.6% of the sick call monitoring logs were submitted on time. The current audit findings reflect that from June through November 2015, 92.3% of the submissions were timely. The findings show that FCC has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

4. Formerly Question 1.3.2 – *THE SICK CALL MONITORING LOG SUBMITTED BY THE FACILITY DOES NOT CONSISTENTLY CONTAIN ALL THE REQUIRED INFORMATION.*

This specific requirement is no longer rated by the Private Prison Compliance and Health Care Monitoring Audit.

5. Question 2.5 (Formerly Question 1.3.3) – *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATES ON THE SICK CALL MONITORING LOG.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
63.6%	69.6%	Unresolved

A random sample of 110 entries was selected for review during the previous audit, of which 70 were accurately recorded on the sick call log. A random sample of 46 entries was selected for review during the current audit, of which 32 were found to have been accurately recorded on the log, resulting in 69.6% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

6. Question 2.4 (Formerly Question 1.3.4) – *THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE SPECIALTY CARE MONITORING LOGS TIMELY.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
57.1%	50.0%	Unresolved

The previous audit findings showed that within the six month review period, 57.1% of the specialty care monitoring logs were submitted on time. The current audit findings reflect a decline; from June through November 2015, only 50.0% of the submissions were timely. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

7. Formerly Question 1.3.5 – *THE SPECIALTY CARE MONITORING LOGS SUBMITTED BY THE FACILITY DOES NOT CONSISTENTLY CONTAIN ALL THE REQUIRED INFORMATION.*

This specific requirement is no longer rated by the Private Prison Compliance and Health Care Monitoring Audit.

8. Question 2.6 (Formerly Question 1.3.6) – *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATES ON THE SPECIALTY CARE MONITORING LOG.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
77.3%	39.5%	Unresolved

A random sample of 66 entries was selected for review during the previous audit, 51 of which were accurately recorded on the specialty care monitoring log. A random sample of 38 entries was selected for review during the current audit, 15 of which were found to have been accurately recorded on the log, resulting in 39.5% compliance. This represents a 37.8 percentage point decline in compliance. In September 2015, PPCMU distributed an updated version of the specialty care monitoring log to all contract facilities; however, FCC was found utilizing the old version of the log up to the date of the onsite audit. Apparently, there was a breakdown in communication between management staff and staff responsible for completing

the monitoring logs as the updated version of the log did not make it to the assigned staff for immediate implementation. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

9. Question 2.4 (Formerly Question 1.3.7) – *THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE HOSPITAL STAY/EMERGENCY DEPARTMENT MONITORING LOGS TIMELY.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
57.1%	53.8%	Unresolved

The June 2015 audit findings showed that within the six month review period, 57.1% of the hospital stay/emergency department monitoring logs were submitted on time. The current audit findings reflect a slight decline in compliance. From June through November 2015, 53.8% of the hospital stay/emergency department logs submitted to PPCMU were received on time. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

10. Formerly Question 1.3.8 – *THE HOSPITAL STAY/EMERGENCY DEPARTMENT MONITORING LOG SUBMITTED BY THE FACILITY DOES NOT CONSISTENTLY CONTAIN ALL THE REQUIRED INFORMATION.*

This specific requirement is no longer rated by the Private Prison Compliance and Health Care Monitoring Audit.

11. Question 2.7 (Formerly Question 1.3.9) – *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATES ON THE HOSPITAL STAY/EMERGENCY DEPARTMENT MONITORING LOG.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
66.7%	100%	Resolved

During the previous audit, FCC received a rating of 66.7% compliance as only four out of six entries reviewed were accurately recorded on the log. During the current audit, FCC was found 100% compliant with this requirement. There were only eight entries recorded on the log for the audit review period of June through November 2015 and all were found to be accurately recorded. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

12. Question 2.4 (Formerly Question 1.3.10) – *THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE CHRONIC CARE MONITORING LOGS TIMELY.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
80.0%	100%	Resolved

The previous audit findings showed that the facility didn't consistently submit the chronic care monitoring logs on time, resulting in 80.0% compliance. The current audit findings show that of the six monthly chronic care logs required to have been submitted from June through November 2015, all were submitted on time, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

13. Question 2.8 (Formerly Question 1.3.12) – *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATES ON THE CHRONIC CARE MONITORING LOG.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	36.7%	Unresolved

During the previous audit, FCC was not accurately and correctly recording the required data on the chronic care logs, resulting in 0.0% compliance. A random sample of 60 entries was selected for review during the current audit, of which 22 were found to have been accurately recorded on the log, resulting in 36.7% compliance. It was found that chronic care logs submitted in the months of June, July, and August 2015 were not filled out correctly. Although significant improvement was evident in logs submitted in the months of September, October, and November 2015, there were 11 discrepancies found between the dates recorded on the logs and dates of services as reflected in patients' medical record. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

14. Question 2.4 (Formerly Question 1.3.13) – *THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE INITIAL INTAKE SCREENING MONITORING LOGS TIMELY.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
60.0%	100%	Resolved

The June 2015 audit findings showed that within the six month review period, 60.0% of the initial intake screening monitoring logs were submitted on time. The current audit findings reflect a significant improvement where 100% of the initial intake screening monitoring logs submitted from June through November 2015 were submitted on time. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

15. Question 2.9 (Formerly Question 1.3.15) – *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATES ON THE INITIAL INTAKE SCREENING MONITORING LOG.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
52.9%	85.7%	Resolved

A random sample of 17 entries was selected for review during the previous audit, 9 of which were accurately recorded on the initial intake screening monitoring log. A random sample of 28 entries was selected for review during the current audit, 24 of which were found to have been accurately recorded on the log, resulting in 85.7% compliance. The findings show that FCC has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

16. Question 1.5 (Formerly Question 1.4.1) – *THE FACILITY STAFF ARE NOT ALL ACCESSING THE PATIENT'S CDCR ELECTRONIC MEDICAL RECORD.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
20.0%	100%	Resolved

The findings of the June 2015 audit showed facility's compliance at 20.0% with this requirement. Of five health care staff required to have access to the CDCR's electronic Unit Health Record (eUHR), only one health care staff member was able to demonstrate access. The current audit findings showed that FCC's health care staff regularly accessed the eUHR during the six month audit review period, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

17. Question 1.7 (Formerly Question 1.4.6) – *THE FACILITY IS NOT DOCUMENTING PATIENTS' WRITTEN REQUEST FOR HEALTH CARE INFORMATION ON THE CDCR FORM 7385, AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	100%	Resolved

The previous audit findings showed that none of the seven requests received for release of health care information were documented on the CDCR Form 7385, resulting in 0.0% compliance. During the current audit review period, there were three requests received for release of health care information. All three requests were documented on the CDCR Form 7385 and scanned/filed into patient's electronic medical record, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

18. Question 2.10 (Formerly Question 1.6.1) – *THE FACILITY'S ADMINISTRATIVE SEGREGATION UNIT DOES NOT HAVE CDCR-602 HC FORMS AVAILABLE TO THE PATIENT POPULATION.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
66.7%	100%	Resolved

During the June 2015 onsite visit, three housing units were inspected to ensure that the CDCR 602-HC forms were readily available to patients in those housing units. ASU was found missing the CDCR 602-HC forms, which resulted in 66.7% compliance. Inspection of the housing units during the December 2015 onsite visit showed an ample supply of CDCR 602-HC forms readily available to patient population, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

19. Question 2.12 (Formerly Question 1.6.4) – *THE FACILITY DOES NOT MAINTAIN A FIRST LEVEL HEALTH CARE APPEALS LOG.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	100%	Resolved

The facility received a rating of 0.0% compliance during the previous audit due to the facility not maintaining a Health Care Appeals Tracking log to keep track of all the health care appeals received from its CDCR patient population. During the current onsite visit, FCC provided the audit team with a copy of the Health Care Appeals Tracking log listing all the first level appeals received, resulting in 100% compliance. It should be noted that the first level health care appeals are completed timely. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

20. Question 3.4 (Formerly Question 1.7.2) – *THE FACILITY DOES NOT HAVE A PROPER CENTRALIZED TRACKING SYSTEM FOR TRACKING HEALTH CARE STAFF LICENSES.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	100%	Resolved

During the previous audit, the facility did not have a system in place to track licenses for all health care staff, resulting in 0.0% compliance. As part of the pre-audit documentation submission process, FCC provided a tracking log listing all health care staff licensing and certifications data, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

21. Question 3.4 (Formerly Question 1.7.6) – *THE FACILITY DOES NOT HAVE A PROPER CENTRALIZED TRACKING SYSTEM FOR TRACKING HEALTH CARE STAFF TRAINING.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	100%	Resolved

Findings of the previous audit showed the facility did not have a centralized system in place to track training provided for all health care staff, which resulted in 0.0% compliance. As part of the pre-audit documentation submission process, FCC provided tracking logs for all health care staff listing the types and dates training completed by health care staff, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

22. Question 5.2 (Formerly Question 2.2.2) – *THE PATIENT'S CHRONIC CARE KEEP ON PERSON MEDICATIONS ARE NOT CONSISTENTLY BEING RECEIVED BY THE PATIENT WITHOUT INTERRUPTION.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
42.1%	57.1%	Unresolved

During the previous audit, eight of the 11 medical records reviewed reflected patients' chronic care keep on person (KOP) medications were not consistently received by the patient without interruption. These findings resulted in 42.1% compliance. Note, this question was miscalculated and compliance percentage of 34.8 erroneously reported in the June 2015 final audit report. The correct score for this question should have been reported as 42.1% compliance. During the current audit's electronic medical record review, 28 medical records were evaluated. Of the 28 patient medical records reviewed, 16 included documentation that the patient received the prescribed chronic care KOP medications on time and without interruption, resulting in 57.1% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

23. Question 5.3 (Formerly Question 2.2.3) – *THE NURSING STAFF DOES NOT DOCUMENT THE PATIENT'S REFUSAL OF KEEP ON PERSON CHRONIC CARE MEDICATIONS ON THE CDCR FORM 7225, OR SIMILAR FORM.*



<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	100%	Resolved

The June 2015 audit findings showed that the patients’ refusals of KOP chronic care medications were not documented on the CDCR Form 7225, resulting in 0.0% compliance. During the current audit, review of one sample available reflected the patient’s refusal of KOP chronic care medication was now being documented on the CDCR Form 7225, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

24. Question 5.6 (Formerly Question 2.2.7) – *THE PATIENTS THAT DO NOT SHOW OR REFUSE THEIR INSULIN ARE NOT BEING REFERRED TO THE PROVIDER FOR MEDICATION NON-COMPLIANCE.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	N/A	Unresolved

Two patient medical records reviewed, during the previous audit, showed that the patients were not referred to the provider when a patient refused his insulin medication, which resulted in 0.0% compliance. During the current audit, this requirement could not be evaluated as there were no CDCR patients prescribed insulin from June through November 2015. This critical issue is considered unresolved and will continue to be monitored in subsequent audits.

25. Question 7.2 (Formerly Question 2.3.2) – *THE FACILITY IS NOT CONSISTENTLY REVIEWING, SIGNING, AND DATING ALL PATIENT DIAGNOSTIC REPORTS WITHIN THE SPECIFIED TIME FRAME.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
80.0%	81.8%	Unresolved

During the June 2015 audit, 16 of the 20 patient medical records reviewed included documentation of the provider timely reviewing, signing, and dating patients’ diagnostic reports, which resulted in 80.0% compliance. The current medical record findings showed that 18 of the 22 patient medical records reviewed were in compliance with this requirement, resulting in 81.8% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

26. Question 7.3 (Formerly Question 2.3.3) – *PATIENTS DO NOT CONSISTENTLY RECEIVE WRITTEN NOTIFICATION OF DIAGNOSTIC TEST RESULTS WITHIN THE SPECIFIED TIME FRAME.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
50.0%	68.2%	Unresolved

Previous audit findings showed that 10 of the 20 patient medical records reviewed included documentation of the patient receiving written notification of diagnostic test results within two days of facility’s receipt of results, resulting in 50.0% compliance. The current audit findings reflect a marginal improvement; 15 of the 22 patient medical records reviewed included documentation that the patient received written notification of diagnostic test results, resulting in 68.2% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

27. Question 14.1 (Formerly Question 2.4.3) – *THE FACILITY IS NOT CONSISTENTLY CONDUCTING EMERGENCY MEDICAL RESPONSE (MAN-DOWN) DRILLS QUARTERLY ON EACH SHIFT.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
33.3%	100%	Resolved

Of the three emergency medical response drills required to have been completed by facility during the previous audit, only one was conducted. This resulted in 33.3% compliance. Current audit findings showed that FCC conducted 20 emergency medical response drills within the six month period, resulting in 100% compliance with this requirement. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

28. Question 14.2 (Formerly Question 2.4.4) – *THE FACILITY DOES NOT CONSISTENTLY DOCUMENT THE RESPONSE TIMES OF BASIC LIFE SUPPORT (BLS) CERTIFIED MEDICAL STAFF DURING EMERGENCY MEDICAL RESPONSE AND/OR DRILLS.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
83.3%	100%	Resolved

During the previous audit, six emergency medical responses were reviewed. One incident showed that nursing staff failed to respond to the emergency within four minutes, resulting in 83.3% compliance. During the current audit, documentation of the 24 emergency medical responses and drills was reviewed. All emergency incidents included documentation that the BLS certified health care staff responded without delay after the emergency alarm was sounded, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

29. Question 14.3 (Formerly Question 2.4.5) – *THE FACILITY DOES NOT CONSISTENTLY DOCUMENT THE RESPONSE TIMES OF ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFIED MEDICAL STAFF DURING EMERGENCY MEDICAL RESPONSE AND/OR DRILLS.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
83.3%	95.8%	Resolved

One of the six emergency medical responses reviewed during the previous audit, showed that nursing staff failed to respond to the emergency within eight minutes. Furthermore, the supporting documentation showed that there had been a delay in response for over 30 minutes, resulting in 83.3% compliance. During the current audit, documentation of the 24 emergency medical responses and drills was reviewed. Of the 24 emergency incidents reviewed, one incident reflected a delay in RN's response to an emergency for over 20 minutes, resulting in 95.8% compliance. The findings show that FCC has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

30. Question 14.5 (Formerly Question 2.4.7) – *THE EMERGENCY MEDICAL RESPONSE REVIEW COMMITTEE (EMRRC) DOES NOT CONSISTENTLY REVIEW/EVALUATE EACH MEDICAL RESPONSE AND/OR EMERGENCY MEDICAL DRILL THAT IS SUBMITTED TO THE COMMITTEE FOR REVIEW.*



<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	100%	Resolved

During the previous audit, this question was rated 0.0% compliant as all emergency medical response incident packages submitted to EMRRC were missing the CDCR Form 837, *Emergency Medical Drills/Incident Report*, from custody staff. Subsequent to the previous audit, there was a change in methodology where CCHCS no longer requires the facility to include the CDCR Form 837 in the incident package when submitting the emergency documentation to CCHCS for review. The six incident packages submitted to EMRRC for review, from June through November 2015, were performed timely and included all the required documents, resulting in 100% compliance. This critical issue is considered resolved.

31. Question 14.9 (Formerly Question 2.4.11) – *THE EMERGENCY MEDICAL RESPONSE (EMR) BAGS DO NOT CONTAIN ALL THE SUPPLIES IDENTIFIED ON THE FACILITY’S EMR BAG CHECKLIST.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	100%	Resolved

During the June 2015 onsite visit, the inspected EMR bag included all the required items on the checklist along with extra supplies not listed on the checklist. This resulted in 0.0% compliance. During the December 2015 onsite visit, the inspected EMR bag contained only the supplies/items identified on the EMR Bag Checklist, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

32. Question 14.14 (Formerly Question 2.4.17) – *THE FACILITY’S CRASH CARTS DO NOT CONTAIN ALL THE SUPPLIES IDENTIFIED ON THE FACILITY’S CRASH CART CHECKLIST.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	100%	Resolved

The crash cart inspected during the June 2015 onsite visit did not contain all the supplies identified on the facility’s crash cart checklist. Additionally, the crash cart was supplied with extra items and supplies not listed on the checklist, resulting in 0.0% compliance. The one crash cart inspected during the December 2015 onsite visit, contained all the required supplies as identified on the facility’s crash cart checklist, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

33. Question 14.18 (Formerly Question 2.4.20) – *ONE OF THE FACILITY’S PORTABLE OXYGEN SYSTEMS WAS LESS THAN THREE-FOURTHS FULL.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
50.0%	100%	Resolved

Of the two portable oxygen tanks inspected during the June 2015 onsite visit, one oxygen tank was found less than $\frac{3}{4}$ full, resulting in 50.0% compliance. The two portable oxygen tanks inspected during the December 2015 onsite visit were found full and operationally ready,

resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

34. Question 15.4 (Formerly Question 2.6.4) – *THE FACILITY’S MEDICAL STAFF DOES NOT PRACTICE PROPER HAND HYGIENE.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
25.0%	100%	Resolved

During the June 2015 onsite visit, four nurses were observed providing medical services to patients. Only one nurse was observed utilizing universal and standard precautions for hand hygiene, resulting in 25.0% compliance. During the current audit’s onsite visit, six nurses were observed for this requirement and all were found practicing proper hand hygiene. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

35. Question 15.6 (Formerly Question 2.6.6) – *THE FACILITY’S NURSING STAFF IS NOT CONSISTENTLY DISINFECTING REUSABLE MEDICAL EQUIPMENT AFTER EACH PATIENT USE.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
33.3%	100%	Resolved

During the previous audit’s onsite visit, three nurses were observed during the sick call process. Only one of the three nurses observed was cleaning all non-invasive medical equipment after each patient use, which resulted in 33.3% compliance. During the December 2015 onsite visit, three nurses were observed and all were found to properly disinfect the reusable non-invasive medical equipment between each patient use, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

36. Question 15.11 (Formerly Question 2.6.12) – *THE EXAM ROOM IN THE FOX UNIT DOES NOT HAVE A SHARPS CONTAINER.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
75.0%	100%	Resolved

During the June 2015 onsite visit, the exam room in the Fox unit did not have a sharps container, which resulted in 75.0% compliance. The exam rooms inspected during the December 2015 onsite visit included a sharps container in every exam room, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

37. Question 9.5 (Formerly Question 2.7.5) – *THE PATIENTS ARRIVING AT THE FACILITY WHO ARE REFERRED TO MEDICAL, DENTAL, OR MENTAL HEALTH PROVIDER BY A NURSE ARE NOT CONSISTENTLY SEEN BY THE FACILITY’S PROVIDER WITHIN THE SPECIFIED TIME FRAME.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
50.0%	N/A	Unresolved

During the previous audit, of the 17 cases selected, only two were applicable to this question. Of the two applicable cases reviewed, one included documentation of the patient having been seen by the facility's provider within the specified time frame, which resulted in 50.0% compliance. During the current audit, this requirement could not be evaluated as none of the 15 patients selected for review were referred to provider during the initial health screening process. This critical issue is considered unresolved and will continue to be monitored in subsequent audits.

38. Question 9.10 (Formerly Question 2.7.6) – *THE PATIENTS ARRIVING AT THE FACILITY WITH EXISTING MEDICATION ORDERS ARE NOT CONSISTENTLY RECEIVING THEIR NURSE ADMINISTERED (NA)/DIRECT OBSERVATION THERAPY (DOT) AND/OR KEEP-ON-PERSON (KOP) MEDICATION WITHOUT INTERRUPTION.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
83.3%	81.8%	Unresolved

The previous audit findings showed that of the six patient medical records reviewed, five included documentation that the patient received his NA/DOT and/or KOP medications without interruption upon arrival to the facility. The current audit's findings showed that of the 11 patient medical records reviewed, 9 were found compliant with this requirement, resulting in 81.8% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

39. Question 9.7 (Formerly Question 2.7.7) – *THE PATIENTS ARRIVING AT THE FACILITY WITH AN EXISTING REFERRAL OR A SCHEDULED MEDICAL, DENTAL, OR MENTAL HEALTH APPOINTMENT ARE NOT SEEN BY THE FACILITY'S PROVIDER WITHIN THE SPECIFIED TIME FRAME.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
50.0%	N/A	Unresolved

During the June 2015 audit, of the 17 cases selected, only two were applicable to this question. Of the two applicable cases reviewed, one included documentation of the patient having been seen by the facility's provider within the specified time frame, which resulted in 50.0% compliance. During the current audit, this requirement could not be evaluated as none of the 15 patients selected for review had a pending appointment scheduled by the sending facility. This critical issue is considered unresolved and will continue to be monitored in subsequent audits.

40. Question 9.9 (Formerly Question 2.7.8) – *THE PROVIDERS DO NOT CONSISTENTLY COMPLETE A HEALTH APPRAISAL WITHIN FOURTEEN CALENDAR DAYS OF PATIENT'S ARRIVAL AT THE FACILITY.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
55.6%	46.7%	Unresolved

Nine cases were reviewed during the June 2015 audit. Five of the nine patient medical records reviewed included documentation that the patient received a complete health appraisal by a provider within 14 calendar days. Remaining four cases were non-compliant due to no documentation having been found in the patients' medical records indicating the health

appraisal was completed either at La Palma Correctional Center (LPCC) (where the patients had initially arrived from California) or FCC, resulting in 55.6% compliance. Of the 15 cases reviewed during the current audit, 7 included documentation that the patient was seen by provider within seven calendar days of arrival to FCC, resulting in 46.7% compliance. It should be noted that prior to and during the previous audit's exit meeting, the facility was made aware of the change in the policy for the providers to complete a health appraisal within seven calendar days of patient's arrival at the facility versus the 14 calendar days. Subsequently, this requirement was reiterated during the monthly medical conference calls with CCA and out-of-state correctional facilities. The facility is strongly encouraged to take immediate action to successfully resolve this issue. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

41. Question 9.11 (Formerly Question 2.7.11) – *THE FACILITY DOES NOT CONSISTENTLY DOCUMENT ON THE CDCR FORM 7371 ANY SCHEDULED SPECIALTY APPOINTMENTS FOR THOSE PATIENTS TRANSFERRING OUT OF THE FACILITY.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
75.0%	87.5%	Resolved

During the previous audit, four patient medical records were reviewed. Of the four cases reviewed, three included documentation of the patients' scheduled specialty appointments on the transfer form (CDCR Form 7371). The one non-compliant case was a result of the patient's MRI appointment not having been documented on the transfer form, resulting in 75.0% compliance. During the current audit, seven of the eight patient medical records reviewed included documentation of the patients' pending specialty appointments recorded on the transfer form, resulting in 87.5% compliance. The findings show that FCC has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

42. Question 10.1 (Formerly Question 2.8.1) – *THE PROVIDERS DO NOT CONSISTENTLY EDUCATE THE PATIENTS ON THE NEWLY PRESCRIBED MEDICATIONS.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
69.6%	83.3%	Unresolved

The findings of the previous audit showed providers did not consistently educate the patients on the newly prescribed medications. Sixteen of the 23 patient medical records reviewed were found compliant with this requirement, resulting in 69.6% compliance. The findings of the current audit reflect improvement in this area where 15 of 18 patient medical records reviewed were found compliant with this requirement, resulting in 83.3% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

43. Question 10.2 (Formerly Question 2.8.2) – *THE NURSING STAFF DOES NOT CONSISTENTLY ADMINISTER THE INITIAL DOSE OF THE NEWLY PRESCRIBED MEDICATION TO THE PATIENT AS ORDERED BY THE PROVIDER.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
65.2%	88.9%	Resolved



Twenty-three patient medical records were reviewed during the previous audit. Fifteen of the 23 records included documentation that the initial dose of the newly prescribed medication was administered to the patient as ordered by provider, resulting in 65.2% compliance. Deficiencies were a result of the missing documentation in the medical record and delay in administering the prescribed medication to the patient. During the current audit, 16 of 18 patient medical records evaluated were found compliant with this requirement, resulting in 88.9% compliance. The two non-compliant cases were a result of the patient receiving the prescribed medication late or not as ordered by the provider. The findings show that FCC has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

44. Question 11.1 (Formerly Question 2.9.1) – *THE FACILITY DOES NOT CONSISTENTLY DOCUMENT THAT THEY ARE CHECKING PATIENTS THAT ARE HOUSED IN THE OBSERVATION UNIT AT THE BEGINNING OF EACH SHIFT OR AS ORDERED BY THE PROVIDER.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
25.0%	100%	Resolved

Of the four patient medical records reviewed during the June 2015 audit, one included documentation the patient was checked by an RN at the beginning of each shift when housed in an observation cell, resulting in 25.0% compliance. During the current audit, six patient medical records were reviewed, and all were found compliant with this requirement. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

45. Question 11.2 (Formerly Question 2.9.2) – *THE PROVIDERS ARE NOT DOCUMENTING THE NEED FOR A PATIENT’S PLACEMENT IN THE OBSERVATION UNIT WITHIN THE SPECIFIED TIME FRAME.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	100%	Resolved

During the previous audit, none of the four patient medical records reviewed showed the provider documented the need for patients’ placement in the observation cell within 24 hours of the patient’s placement. Three cases reflected the provider documented on the progress notes several days after the patients’ placement in medical observation cell and the remaining one case did not have any documentation in the medical record regarding patient’s placement. These findings resulted in 0.0% compliance. During the current audit, six patient medical records were reviewed and all were found compliant with this requirement. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

46. Question 13.1 (Formerly Question 2.11.1) – *THE PATIENTS WITH PRESCRIBED ANTI-TB MEDICATIONS ARE NOT CONSISTENTLY RECEIVING THE MEDICATIONS AS PRESCRIBED BY PROVIDERS.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
81.8%	N/A	Unresolved

This requirement was rated 81.8% compliant during the June 2015 audit. Of the 11 patient medical records reviewed, 9 included documentation the patients were administered anti-TB

medications as prescribed by provider. This requirement could not be evaluated during the current audit as there were no patients at FCC who were prescribed TB medications from June through November 2015. Since no findings are available to assess the facility's compliance with this requirement, this critical issue remains unresolved and will continue to be monitored in subsequent audits.

47. Question 13.2 (Formerly Question 2.11.2) – *THE NURSING STAFF DOES NOT CONSISTENTLY NOTIFY THE PROVIDER WHEN A PATIENT MISSES OR REFUSES HIS ANTI-TB MEDICATION.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	N/A	Unresolved

During the previous audit, only two cases of 15 reviewed were found applicable to this question. Of the two patient medical records assessed, none included documentation that nursing staff notified the provider or a public health nurse when a patient refused his TB medication. This resulted in 0.0% compliance. During the current audit, this requirement could not be evaluated as there were no patients at FCC who were prescribed TB medications from June through November 2015. Since no findings are available to assess the facility's compliance with this requirement, this critical issue remains unresolved and will continue to be monitored in subsequent audits.

48. Question 13.3 (Formerly Question 2.11.3) – *THE FACILITY DOES NOT CONSISTENTLY PERFORM MONTHLY TB MONITORING OF PATIENT ON ANTI-TB MEDICATIONS.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
54.5%	N/A	Unresolved

The June 2015 audit findings showed that of 11 patient medical records reviewed, 6 included documentation that the facility monitored the patient monthly while he was on TB medication. This resulted in 54.5% compliance. This requirement; however, could not be evaluated during the December 2015 audit as there were no patients at FCC who were prescribed TB medications from June through November 2015. Since no findings are available to assess the facility's compliance with this requirement, this critical issue remains unresolved and will continue to be monitored in subsequent audits.

49. Question 13.5 (Formerly Question 2.11.4) – *THE FACILITY DOES NOT ANNUALLY SCREEN ALL THE PATIENTS FOR SIGNS AND SYMPTOMS OF TUBERCULOSIS.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
20.0%	N/A	Unresolved

Of the 20 patient medical records reviewed during the previous audit, only 4 reflected the patients were screened for TB signs and symptoms within the past year, which resulted in 20.0% compliance. During the current audit, this question was not evaluated. Per the revised audit instruction guide and methodology, this question is evaluated once per calendar year during the audit review period when the annual TB testing occurs per the master calendar on *Lifeline*. As the audit review period of June through November 2015 for FCC's current audit did not encompass the month when FCC provided annual TB testing and screening to its CDCR patient

population, this question was not evaluated for compliance at this time. This critical issue remains unresolved and will be assessed in subsequent audits.

50. Question 13.7 (Formerly Question 2.11.7) – *THE FACILITY DOES NOT CONSISTENTLY OFFER COLORECTAL CANCER SCREENING TO PATIENTS 50 TO 75 YEARS OF AGE.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
5.6%	80.0%	Unresolved

Findings of the June 2015 audit showed that of the 18 patient medical records reviewed, one included documentation that the patient was offered colorectal cancer screening, which equated to 5.6% compliance. The current audit findings showed that of the 20 patient medical records reviewed, 16 were found compliant with this requirement, resulting in 80.0% compliance. Although a significant improvement from the previous audit, the facility did not achieve a rating equal to/above the compliance benchmark of 85.0%; therefore, this critical issue is considered unresolved and will be monitored in subsequent audits.

51. Question 4.1 (Formerly Question 2.12.1) – *THE NURSING STAFF DOES NOT CONSISTENTLY REVIEW ALL SICK CALL REQUESTS WITHIN THE SPECIFIED TIME FRAME.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
52.0%	100%	Resolved

During the previous audit, 25 patient medical records were reviewed for compliance with this requirement. Of these, 13 included documentation the RN reviewed the patient's sick call request on the day it was received, which resulted in 52.0% compliance. The current audit findings showed that of the 27 patient medical records reviewed, all were found compliant with this requirement, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

52. Question 4.2 (Formerly Question 2.12.2) – *THE PATIENTS DO NOT CONSISTENTLY HAVE A FACE-TO-FACE EVALUATION WITH A NURSE WITHIN THE NEXT BUSINESS DAY FOR NON-EMERGENT HEALTH CARE NEEDS.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
75.0%	100%	Resolved

Findings of the previous audit showed that following the RN's review of a patient's sick call request, the RN did not complete a face-to-face evaluation of the patient within the specified time frame. Eighteen of the 24 patient medical records reviewed included documentation the patient was seen by an RN within 24 hours, which equated to 75.0% compliance. The findings of the current review showed that of 27 patient medical records reviewed, all included documentation the patients were seen by an RN within 24 hours or sooner, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

53. Question 4.6 (Formerly Question 2.12.7) – *THE NURSING STAFF DOES NOT CONSISTENTLY DOCUMENT A NURSING DIAGNOSIS RELATED TO/EVIDENCE FROM THE DOCUMENTED SUBJECTIVE/OBJECTIVE ASSESSMENT DATA.*



<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
76.0%	90.0%	Resolved

Of the 25 patient medical records reviewed during the June 2015 audit, 19 included documentation that the RN documented a nursing diagnosis related to the documented subjective/objective assessment data, which resulted in 76.0% compliance. During the current audit, 30 patient medical records were reviewed, 27 of which were found compliant with this requirement. The findings show that FCC has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

54. Question 4.9 (Formerly Question 2.12.11) – *THE PATIENTS ARE NOT CONSISTENTLY SEEN BY A MEDICAL PROVIDER WITHIN THE SPECIFIED TIME FRAME WHEN REFERRED BY A NURSE.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
81.3%	100%	Resolved

During the June 2015 audit, 16 patient medical records were evaluated for compliance. Of these, 13 included documentation the patients were timely seen by a medical provider, following the RN’s referral. This resulted in 81.3% compliance. The medical record review completed during the December 2015 audit showed that out of 21 patients referred by an RN to a provider, all were seen within the required time frame, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

55. Formerly Question 2.12.14 – *THE PATIENTS ARE NOT CONSISTENTLY SEEN FOR A FOLLOW-UP APPOINTMENT WITHIN THE SPECIFIED TIME FRAME.*

This specific requirement is no longer rated in the compliance portion of the Private Prison Compliance and Health Care Monitoring Audit; therefore, no compliance score is available. However, this requirement will be assessed during the case reviews completed by CCHCS clinicians and addressed in the *Case Review Findings* section of the applicable quality indicator.

56. Question 4.12 (Formerly Question 2.12.16) – *THE NURSING STAFF DO NOT CONSISTENTLY DOCUMENT DAILY ROUNDS IN THE ADMINISTRATIVE SEGREGATION UNIT.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
83.8%	100%	Resolved

The review of the Isolation Logbook, during the June 2015 onsite visit, showed nursing staff conducted 26 of the 31 required daily rounds in the restricted housing unit, which resulted in 83.8% compliance. During the December 2015 onsite visit, an Isolation Logbook was evaluated for the month of November 2015. It was found nursing staff conducted daily rounds on all days in the FCC’s restricted housing unit, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

57. Question 4.13 (Formerly Question 2.12.17) – *THERE IS NO EVIDENCE THAT THE NURSING STAFF CONDUCTS DAILY ROUNDS IN ADMINISTRATIVE SEGREGATION UNITS TO PICK-UP SICK CALL SLIPS.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
54.8%	93.9%	Resolved

During the June 2015 onsite visit, Isolation Logbook was reviewed to determine whether nursing staff conducted daily rounds in restricted housing unit to pick up sick call slips. Of the 31 days reviewed for the month of May 2015, 17 days reflected documentation of nursing staff picking up sick call slips daily, which resulted in 54.8% compliance. During the current audit's onsite visit in December 2015, an Isolation Logbook was reviewed for daily rounds conducted during the month of November 2015. Of the 30 days reviewed, 28 included documentation of the nursing staff picking up sick call slips in the restricted housing unit, resulting in 93.9% compliance. The findings show that FCC has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

58. Question 4.14 (Formerly Question 2.12.18) – *THE FACILITY'S ADMINISTRATIVE SEGREGATION UNIT (ASU) DOES NOT HAVE CDCR FORMS 7362, HEALTH CARE SERVICES REQUEST, OR SIMILAR FORMS, AVAILABLE TO THE PATIENT POPULATION.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
66.7%	100%	Resolved

During the inspection of the three housing units, conducted during the previous audit's onsite visit, ASU did not have sick call forms available to its patient population. This resulted in 66.7% compliance. The inspection of the restricted housing unit during the December 2015 onsite visit showed an ample supply of sick call forms was available for patient use, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

59. Question 15.16 (Formerly Question 2.12.20) – *THE FACILITY DOES NOT PROVIDE ALL THE CLINICS WITH PROPER EQUIPMENT, SUPPLIES, AND ACCOMMODATIONS FOR PATIENT VISITS.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
66.7%	100%	Resolved

During the June 2015 onsite visit, three exam rooms were inspected, two of which had the proper equipment, supplies, and accommodations for patient visits. The exam room in Fox Unit lacked a sharps container, tongue depressor and lubricant jelly. This resulted in 66.7% compliance. During the December 2015 onsite visit, five exam rooms were inspected. All five exam rooms had the essential core medical equipment and supplies available for patient visits, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

60. Question 15.14 (Formerly Question 2.12.21) – *THE FOX UNIT EXAM ROOM DOES NOT HAVE SHELVES OR CABINETS TO ADEQUATELY STORE NON-MEDICATION SUPPLIES.*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
66.7%	100%	Resolved

The findings of the June 2015 onsite visit showed that of the three exam rooms inspected, two were able to store non-medication supplies. The Fox Unit exam room did not have shelves and cabinets to store non-medication supplies, resulting in 66.7% compliance. The findings of the December 2015 onsite visit showed that both the Main clinic and Fox Unit followed adequate protocols for managing and storing bulk medical supplies, resulting in 100% compliance. The findings show that FCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

NEW CRITICAL ISSUES

There were no additional new critical issues identified during this audit besides the issues already addressed in the *Audit Findings – Detailed by Quality Indicator* section of the report.

CONCLUSION

During the current audit, the facility's overall performance was rated adequate. Of the 16 quality indicators evaluated, CCHCS found five *proficient*, seven *adequate*, and four *inadequate* (see Executive Summary Table on page 4). The facility should be commended for making considerable progress and successfully resolving 37 of 56 deficiencies identified in the previous audit. Seven of the 19 outstanding critical issues could not be evaluated at this time as there were no valid samples available for review and will be monitored in subsequent audits. The remaining 12 unresolved issues are non-complex, easily correctable and are within the management's scope of control to ensure compliance.

The facility is also expected to resolve any critical issues that were identified during the current audit as a result of the observations/inspections conducted onsite, review of the patient's medical records for the previous six months, review of the administrative operations, and clinical case reviews. The outstanding and new deficiencies were addressed and shared with the facility's executive and health care management staff during the audit's exit meeting.

PATIENT INTERVIEWS

The intent of this portion of the audit is to elicit substantive responses from the patient population, 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. This is accomplished via interview of all the ADA patients housed at the facility, the Inmate Advisory Council (IAC) executive body and a random sampling of patients housed in general population (GP) and administrative segregation units. The results of the interviews conducted at FCC are summarized in the table below.

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

<i>Patient Interviews (not rated)</i>
1. Are you aware of the sick call process?
2. Do you know how to obtain a CDCR 7362 or sick call form?
3. Do you know how and where to submit a completed sick call form?
4. Is assistance available if you have difficulty completing the sick call form?
5. Are you aware of the health care appeal/grievance process?
6. Do you know how to obtain a CDCR 602 HC or health care grievance/appeal form?
7. Do you know how and where to submit a completed health care grievance/appeal form?
8. Is assistance available if you have difficulty completing the health care grievance/appeal form?
<i>Questions 9 through 21 are only applicable to ADA patients.</i>
9. Are you aware of your current disability/DPP status?
10. Are you receiving any type of accommodation based on your disability? (Like housing accommodation, medical appliance, etc.)
11. Are you aware of the process to request reasonable accommodation?
12. Do you know where to obtain a reasonable accommodation request form?
13. Did you receive reasonable accommodation in a timely manner?
14. Have you used the medical appliance repair program? If yes, how long did the repair take?
15. Were you provided interim accommodation until repair was completed?
16. Are you aware of the grievance/appeal process for a disability related issue?
17. Can you explain where to find help if you need assistance for obtaining or completing a form, (i.e., CDCR 602-HC Inmate/Parolee Health Care Appeal Form, CDCR 1824 Reasonable Modification or Accommodation Request Form, or similar forms)?
18. Have you submitted an ADA grievance/appeal? If yes, how long did the process take?
19. Do you know who your ADA coordinator is?
20. Do you have access to licensed health care staff to address any issues regarding your disability?
21. During the contact with medical staff, do they explain things to you in a way you understand and take time to answer any question you may have?

Comments:

During the onsite visit in December 2015, the audit team interviewed four IAC representatives, four GP patients and one ADA patient. There were only three CDCR patients housed in FCC’s restricted housing

unit at the time of the onsite visit. However, all three patients refused to be interviewed by the audit team as they were out on the yard at the time of the audit team's interview session with patient.

1. Regarding questions 1 through 4 – All interviewed patients were aware of the sick call process and had ready access to the forms, if needed. One patient claimed he had to wait three days to see a nurse after the sick call request was submitted. This claim could not be substantiated as clinical case and patient medical record review findings reflect nursing staff were seeing patients for a face-to-face evaluation in a timely manner.

Of the four GP patients interviewed, only two had utilized the sick call process at FCC. One patient claimed that two weeks prior to the audit team's onsite visit, he submitted a sick call request for a toe nail fungus issue. However, he was advised by the nurse who picked up sick call slips on that day, to withdraw his request for treatment as no treatment would be prescribed for a cosmetic defect. The CCHCS physician urged the patient next time to go through with the request and see a doctor to document the visit and to also prevent further complications with the medical issue. This concern was relayed to the facility's management staff during the audit exit meeting and it was recommended that if the patient requests to be seen by a doctor, the nursing staff should not ignore the request and refer the patient to the provider for a follow-up appointment.

Another interviewee had concerns with dysfunction of his right hand and wanted to ensure medical was taking action to address his medical issue. The patient claimed he was seen by a nurse practitioner for this issue approximately two weeks prior to the date of the patient's interview with the audit team. During that visit the nurse practitioner assessed the patient's hand and submitted a request for a referral to a specialist. At the time of the audit, the patient was awaiting appointment with an orthopedist. Following the onsite audit, the audit team reviewed the patient's chart to confirm a referral was made and found that in fact an order for a referral to an orthopedist was placed by the treating provider and is pending authorization. However, on January 12, 2016, the patient was transferred to Tallahatchie County Correctional Facility prior to seeing the specialist. Review of the Transfer Summary showed no documentation of a pending order for a specialty care appointment.

2. Regarding questions 5 through 8 – Of the eight patients interviewed, four were aware of the health care grievance/appeal process and some have even utilized the process in the past. The audit team explained the health care appeal process to the remaining four patients and informed them where the CDCR 602-HC forms can be located and submitted.
3. Questions 9 through 21 – At the time of the onsite audit, there was only one ADA patient housed at FCC. There were no negative responses or issues expressed by this patient.