CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date : January 27, 2015

To : Joseph Moss, Chief (A)
Contract Beds Unit
Division of Adult Institutions
California Department of Corrections and Rehabilitation

From :
Don Meier, Deputy Director
Field Operations
Corrections Services

Subject : **FINDINGS OF THE CONTRACT FACILITY HEALTH CARE MONITORING AUDIT AT NORTH FORK CORRECTIONAL FACILITY NOVEMBER 2014**

The Private Prison Compliance and Monitoring Unit (PPCMU) of Field Operations, Corrections Services (FOCS), California Correctional Health Care Services (CCHCS) staff completed an on-site audit of North Fork Correctional Facility (NFCF) between November 4 – 6, 2014. The facility is owned and run by Corrections Corporation of America (CCA) and is located in Sayre, Oklahoma. The purpose of this audit is to ensure that NFCF is consistent in meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006 and the *TCCF Remedial Plan.*

Attached you will find the report in which NFCF received an overall compliance rating of **90.3%.** This rating is an increase of 5.6% percentage points from the overall compliance rating of 84.7% achieved during the June 17-19, 2014 audit. The report contains an executive summary, an explanation of the methodology behind the audit, findings detailed by chapters of the *Health Care Monitoring Instrument,* and a corrective action plan (CAP) request in accordance with the TCCF Remedial Plan. Please ensure that CCA submits a CAP, as detailed in the attached report, to Susan Thomas, Health Program Specialist I, PPCMU, FOCS, via e-mail at susan.thomas@cdcr.ca.gov within 30 days of the date of this memorandum.

NFCF achieved an overall passing score; however, there were several deficient areas, some of which are repeat findings.

- Chemical Agent Exposure
- Chronic Care **(repeat finding)**
- Continuous Quality Improvement **(repeat finding)**
- Diagnostic Services **(repeat finding)**
- Medication Management

- Monitoring Logs **(repeat finding)**
- Patient Refusal of Health Care Treatment/No Show
- Staffing **(repeat finding)**

While CCA has made substantial improvements to numerous deficient areas including Continuous Quality Improvement and Grievance/Appeals, several repeat deficient findings remain. Systemic issues such as the LIP's failure to complete a follow-up visit within the specified timeframes for inmate-patients with clinically significant diagnostic test results, and health care staff documentation in the medical record and on monitoring logs continue to compromise the timeliness, accuracy, and quality of care provided to the California inmate-patient population. Therefore, demonstration of sustained improvement in the identified aforementioned areas is critical in order for CCA to meet the standards of safe access and quality of health care operations as required in the contract.

Should you have any questions or concerns, you may contact Donna Heisser, Health Program Manager II, PPCMU, FOCS, CCHCS, at (916) 691-4849 or via email at donna.heisser@cdcr.ca.gov.

Enclosures

cc: R. Steven Tharratt, M.D., M.P.V.M., F.A.C.P., Director, Health Care Operations, CCHCS
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Susan Thomas, Health Program Specialist I (HPS I), PPCMU, FOCS, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Contract Facility

Health Care Monitoring Audit

NORTH FORK CORRECTIONAL FACILITY

November 4 - 6, 2014

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INTRODUCTION

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

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

This report provides the findings associated with the audit conducted November 4 - 6, 2014 at North Fork Correctional Facility (NFCF) which is located in Sayre, Oklahoma. At the time of the audit, CDCR's Weekly Population Count, dated November 7, 2014, indicated a budgeted bed capacity of 8,988 out-of-state beds. The NFCF has a budgeted capacity of 2560 general population beds for CDCR inmate-patients of which 2508 are occupied. This facility has an American Correctional Association (ACA) Accreditation.

EXECUTIVE SUMMARY

On November 4-6, 2014, Field Operations staff conducted an onsite audit at NFCF. The audit team consisted of the following personnel:

Thomas Bzoskie, MD, Chief Medical Executive
Greg Hughes, Nurse Consultant Program Review
Irene Ogbeiwe, Nurse Consultant Program Review
Susan Thomas, Health Program Specialist I (HPS I)

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

The following summary table entitled Quantitative Compliance Ratings illustrates the overall compliance rating and how the rating was calculated. The overall rating represents the percentage of the total points awarded out of the total points possible. Points are awarded in three categories; Administration, Delivery, and Operations, which are broken down further into the individual chapters of the audit.

Based on the quantitative audit, NFCF achieved an overall compliance rating of **90.3%** with a rating of 83.1**%** in Administration, 90.8**%** in Delivery, and 95.0**%** in Operations**.** Table two on the following page provides a comparative overview of facility performance during the initial and follow-up audits, as well as a trend measurement to show improvement, decline, or sustainability. The overall compliance rating of 90.3% is an increase of 5.6 percentage points from the overall compliance rating of 84.7% achieved during the June 17-19, 2014 audit.

The completed quantitative audit, summary of qualitative findings, and CAP request are attached for your review.

Quantitative Compliance Ratings	Points Possible	Points Awarded	Score	CAP Required
Administration				
1. Administration	30.0	30.0	100.0%	No
2. Access to Healthcare Information	60.0	60.0	100.0%	No
6. Continuous Quality Improvement (CQI)	60.0	50.0	83.3%	Yes
13. Licensure and Training	160.0	160.0	100.0%	No
15. Monitoring Logs	150.0	117.0	78.0%	Yes
20. Staffing	150.0	90.0	60.0%	Yes
Administration Sub Score:	**610.0**	**507.0**	**83.1%**	
Delivery				
5. Chronic Care	90.0	60.0	66.7%	Yes
7. Diagnostic Services	120.0	81.5	67.9%	Yes
8. Medical Emergency Services/Drills	270.0	270.0	100.0%	No
9. Medical Emergency Equipment	560.0	560.0	100.0%	No
14. Medication Management	420.0	307.5	73.2%	Yes
17. Patient Refusal of Medical Treatment	40.0	30.0	75.0%	Yes
18. Sick Call	330.0	330.0	100.0%	No
19. Specialty/Hospital Services	330.0	321.4	97.4%	No
Delivery Sub-Score:	**2,160.0**	**1,960.4**	**90.8%**	
Operations				
3. ADA Compliance	60.0	60.0	100.0%	No
4. Chemical Agent Exposure	30.0	20.0	66.7%	Yes
10. Grievance/Appeal Procedure	50.0	50.0	100.0%	No
11. Infection Control	290.0	270.0	93.1%	No
12. Initial Intake Screening/Health Appraisal	240.0	223.4	93.1%	No
16. Observation Unit	90.0	90.0	100.0%	No
Operations Sub-Score:	**730.0**	**693.4**	**95.0%**	
21. Inmate Interviews (not rated)				
Final Score:	**3,500.0**	**3,160.8**	**90.3%**	

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

Table 2:

Quantitative Performance Comparison	Audit I 06/2014	Audit II 11/2014	Variance Increase/(Decrease)
1. Administration	100.0%	100.0%	0.0%
2. Access to Health Care Information	100.0%	100.0%	0.0%
3. ADA Compliance	100.0%	100.0%	0.0%
4. Chemical Agent Exposure	100.0%	66.7%	-33.3%
5. Chronic Care	82.2%	66.7%	-15.5%
6. Continuous Quality Imprvement (CQI)	66.7%	83.3%	16.6%
7. Diagnostic Services	45.8%	67.9%	22.1%
8. Medical Emergency Services/Drills	91.9%	100.0%	8.1%
9. Medical Emergency Equipment	85.7%	100.0%	14.3%
10. Grievance/Appeal Procedure	72.4%	100.0%	27.6%
11. Infection Control	96.6%	93.1%	-3.5%
12. Initial Intake Screening/Health Appraisal	86.1%	93.1%	7.0%
13. Licensure and Training	87.8%	100.0%	12.2%
14. Medication Management	93.8%	73.2%	-20.6%
15. Monitoring Logs	49.1%	78.0%	28.9%
16. Observation Unit	53.3%	100.0%	46.7%
17. Patient Refusal of Health Care Treatment/No Show	100.0%	75.0%	-25.0%
18. Sick Call	95.5%	100.0%	4.5%
19. Specialty/Hospital Services	88.4%	97.4%	9.0%
20. Staffing	60.0%	60.0%	0.0%
Overall Score:	84.7%	90.3%	5.6%

METHODOLOGY

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

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

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

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

- 85.0% for each chapter within the Final Audit Instrument.

Compliance and non-compliance are defined as follows:

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

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

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

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

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

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

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

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

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

CORRECTIVE ACTION PLAN REQUEST

The chart below reflects all quantitative analysis items where the institution was rated non-compliant, as well as any qualitative analysis items requiring a response from the institution. In accordance with the Delegation, the audit results for NFCF require the institution to develop a corrective action plan for the following specific items. The institution's response must be received no later than 30 days from the date of this report; specifically February 27, 2015**.**

Corrective Action Items – North Fork Correctional Facility, Sayre, OK	
Chapter 4, Question 4	Inmate-patients who refuse decontamination from chemical agents are not monitored by health care staff every 15 minutes for a minimum of 45 minutes.
Chapter 5, Question 2	The LIP is not providing health care education to inmate-patients regarding their chronic care condition during the last chronic care follow-up visit.
Chapter 6, Question 2	The facility CQI Committee Meeting minutes do not establish whether a quorum was met per the approved CQI Plan.
Chapter 7, Question 2	The LIP does not review, initial, and date inmate-patients' diagnostic reports within two days of receipt.
Chapter 7, Question 3	The inmate-patient is not seen by the LIP for a follow-up visit for clinically significant diagnostic test results within 14 days, or as clinically indicated, from the date the test results are reviewed by the LIP.
Chapter 7, Question 4	The inmate-patient is not given written notification of the diagnostic test results within two days of receipt.
Chapter 11, Question 11	The inmate-patient clinic area is not consistently being cleaned after each inmate-patient use.
Chapter 11, Question 12	Environmental cleaning of high touch surfaces are not being consistently documented in all medical clinics.
Chapter 14, Question 2	There is no documentation in the medical record to show that the LIP explained newly prescribed medications and their side-effects to the inmate-patients.
Chapter 14, Question 3	There is no documentation in the medical record that inmate-patients who did not show for or refused their prescribed medication 50% of the time or more during the audit period were referred to an LIP.
Chapter 14, Question 9	The LPN/RN does not directly observe an inmate-patient taking DOT medication.
Chapter 14, Question 10	Health care staff does not check every inmate-patient's mouth, hands and cup after administering DOT medications.
Chapter 15, Question 1	The *Sick Call Monitoring Log* did not document that the inmate-patients were seen within the specified timeframes set forth in the Sick Call policy.
Chapter 15, Question 4	The facility submits chronic care monitoring logs with incomplete data.

Chapter 15, Question 5	The *Initial Health Appraisal Monitoring Log* did not document that the inmate-patients received an initial health appraisal within 14 calendar days of arrival.
Chapter 16, Question 3	The facility does not have a functioning call system in the observation rooms.
Chapter 17, Question 4	If an inmate-patient does not appear for a scheduled medical appointment/treatment, the RN does not contact the LIP to determine if the inmate-patient needs to be rescheduled.
Chapter 20, Question 2	The facility does not have the contractually required management (Clinical Nursing Supervisor) staffing complement.
Chapter 20, Question 4	The facility does not have the contractually required Licensed Practical Nurse (LPN) staffing complement.
Qualitative Action Item 1	Related to findings for Question 4.1: The facility does not document custody consultation with health care staff prior to a controlled use of chemical agent.
Qualitative Action Item 2	Related to findings for Question 9.2: The emergency response bag check list does not list all items contained in the emergency response bags.
Qualitative Action Item 3	Related to findings for Question 9.2: Emergency response bags are not consistently organized in the same manner to ensure expedient access to medical supplies during an emergency response.
Qualitative Action Item 4	Related to findings for Question 9.2: Emergency response bags do not contain red hazardous waste bags.
Qualitative Action Item 5	Related to findings for Question 10.1: The inmate-patient handbook's Table of Contents does not list the correct page numbers for both *Programs* and *Health Care* in the Program and Services Section, or *Grievance Procedures* in the Inmate Rights Section.
Qualitative Action Item 6	Related to findings for Question 12.4: Inmate-patients who are referred for a follow-up medical, dental, or mental health appointment are not seen by the LIP within the specified timeframe.
Qualitative Action Item 7	Related to findings for Question 16.3: The facility does not have a functioning call system in all Observation Unit rooms.
Qualitative Action Item 8	Related to findings for Question 19.7: The LIP does not review the consultant's report and see the inmate-patient for a follow-up appointment within the specified timeframe. (≤ 3 days for emergent/urgent and ≤ 14 days for routine)

QUANTITATIVE FINDINGS - DETAILED BY CHAPTER

Chapter 1: Administration	Point Value	Points Awarded
1. Does all health care staff have access to the contractor's health care policies and procedures?	10.0	10.0
2. Does all health care staff have access to health care operational procedures?	10.0	10.0
3. Do health care staff know where and how to access the contractor's health care policies and procedures and health care operational procedures?	10.0	10.0
Final Scoring:	30.0	30.0
		100%

CHAPTER 1 COMMENTS

None.

Chapter 2: Access to Health Care Information	Point Value	Points Awarded
1. Does the treating physician have access to the inmate-patient's CCHCS Electronic Unit Health Record (eUHR)?	10.0	10.0
2. Are loose documents filed and scanned into the health record daily?	10.0	10.0
3. Does the facility have and maintain a Release of Information (ROI) log?	10.0	10.0
4. Does the ROI log contain all required information?	10.0	10.0
5. Are all written inmate-patient requests for health care information documented on a *Patient Access to Medical Record Form* or similar form?	10.0	10.0
6. Are all written inmate-patient requests for health care information filed into the Medico-Legal or Miscellaneous section of the health record?	10.0	10.0
7. Are all written requests for release of health care information from a third party authorized by a current *Authorization for ROI Form* or similar form?	10.0	N/A
8. Are all written requests for release of health care information from a third party filed in the Medico-Legal or Miscellaneous section of the health record?	10.0	N/A
Final Scoring:	80.0	60.0 (60.0)
		100%

CHAPTER 2 COMMENTS

1. Questions 7 & 8 – Not applicable. There were no third party requests for release of health care information during this audit review period.

Chapter 3: ADA Compliance	Point Value	Points Awarded
1. Is there a local operating procedure to track and monitor Disability Placement Program (DPP) inmate-patients and their accommodation(s) to ensure the needs of disabled inmate-patients are being addressed?	10.0	10.0
2. Is there a local operating procedure for tracking the provision of health care appliances for all DPP inmate-patients to ensure health care appliances are provided in a timely manner?	10.0	10.0
3. Is there a local operating procedure for tracking the repair of health care appliances for all DPP inmate-patients to ensure health care appliances are provided in a timely manner?	10.0	10.0

4. Is there a local operating procedure to provide an interim accommodation while an appliance is ordered, repaired, or in the process of being replaced?	10.0	10.0
5. Is there a local operating procedure explaining how the facility adds or removes an inmate-patient from the DPP list?	10.0	10.0
6. Is there a local operating procedure explaining how the facility ensures and documents the establishment of effective communication between health care staff and an inmate-patient during each clinical encounter?	10.0	10.0
Final Scoring:	60.0	60.0
		100%

CHAPTER 3 COMMENTS

None.

Chapter 4: Chemical Agent Exposure	**Point Value**	**Points Awarded**
1. Does custody staff consult with a Registered Nurse (RN) or Licensed Independent Practitioner (LIP) before using a controlled chemical agent on an inmate?	10.0	N/A
2. Was the inmate-patient offered decontamination by the facility staff?	10.0	10.0
3. Does facility staff provide directions on how to self-decontaminate if inmate-patients refuse decontamination by facility staff?	10.0	10.0
4. If the inmate-patient refused decontamination, did health care staff document that he was monitored every 15 minutes for a minimum of 45 minutes?	10.0	0.0
Final Scoring:	40.0	20.0 (30.0)
		66.7%

CHAPTER 4 COMMENTS

1. Question 1 – Not applicable. There were no incidents involving controlled use of a chemical agent during the audit review period.
2. Question 4 – Auditors reviewed 3 cases involving chemical agent exposure. None of the involved inmate-patients' medical records documented that the inmate-patients had been monitored every 15 minutes for a minimum of 45 minutes. This equates to 0.0% compliance.
3. NOTE: See discussion of qualitative action item #1 below for additional findings related to chemical agent exposure.

Chapter 5: Chronic Care	**Point Value**	**Points Awarded**
1. Was the inmate-patient's chronic care follow-up visit completed within the 90-day or less timeframe, or as ordered by the LIP?	30.0	30.0
2. Did the LIP provide health care education to inmate-patients regarding their chronic care condition during the last Chronic Care Clinic (CCC) follow-up visit?	30.0	0.0
3. If an inmate-patient did not show or refused their chronic care medication half of the time or more in a one-week period during the audited month was a referral made to a LIP?	30.0	30.0
4. If an inmate-patient did not show or refused their chronic care medication half of the time or more in a one-week period during the audited month did the LIP see the inmate-patient within seven days of the referral?	30.0	N/A
Final Scoring:	120.0	60.0 (90.0)
		66.7%

CHAPTER 5 COMMENTS

1. Question 2 – Auditors reviewed 15 relevant cases. None of the 15 involved inmate-patients' medical records documented that the LIP had provided health care education to the inmate-patients regarding their chronic care condition during the last Chronic Care Clinic follow-up visit. This equates to 0.0% compliance. *This is a substantial decline from the last audit's score of 93.3% compliance.*
2. Question 4 – Not applicable. There were no inmate-patients who failed to appear for, or refused their chronic care medication 50% of the time or more in a one-week period during the audit review period.

Chapter 6: Continuous Quality Improvement (CQI)	**Point Value**	**Points Awarded**
1. Does the facility have an approved CQI Plan?	10.0	10.0
2. Does the facility CQI Committee ensure a quorum is established per the approved CQI Plan?	10.0	0.0
3. Is there documentation to support the CQI Committee meets at least quarterly?	10.0	10.0
4. Does the documentation of the CQI monitoring activity include the *Aspects of Care Monitoring* form, or similar form?	10.0	10.0
5. Does the facility complete an analysis for each identified "opportunity for improvement" as listed on the *Aspects of Care Monitoring* form, or similar form?	10.0	10.0
6. Is there a documented action and follow-up plan for each identified "opportunity for improvement"?	10.0	10.0
Final Scoring:	60.0	50.0
		83.3%

CHAPTER 6 COMMENTS

1. Question 2 – The CQI Committee Meeting Minutes did not document that a quorum had been established, per the approved CQI Plan. This equates to 0.0% compliance. *This is a substantial decline from the last audit's score of 100% compliance.*

Chapter 7: Diagnostic Services	**Point Value**	**Points Awarded**
1. Was the diagnostic test provided to the inmate-patient within the timeframe specified by the LIP?	30.0	30.0
2. Does a LIP review, initial, and date an inmate-patient's diagnostic reports within two days of receipt?	30.0	22.9
3. Was the inmate-patient seen by the LIP for a follow-up visit for a clinically significant diagnostic test result within 14 days, or as clinically indicated, from the date the test results were reviewed by the LIP?	30.0	0.0
4. Was the inmate-patient given written notification of the diagnostic test results within two days of receipt?	30.0	28.6
Final Scoring:	120.0	81.5
		67.9%

CHAPTER 7 COMMENTS

1. Question 2 – Auditors reviewed 21 cases of inmate-patients who had received diagnostic tests within the review period. Sixteen inmate-patients' test results had been reviewed, initialed and dated by the LIP

within two days of receipt. This equates to 76.2% compliance. *This is an increase from the last audit's score of 38.9% compliance; however this remains an unresolved CAP item.*

2. Question 3 – Auditors reviewed 21 cases of inmate-patients who had received diagnostic tests within the review period. Three inmate-patients had clinically significant diagnostic test results. None of these inmate-patients had been seen by the LIP for a follow-up visit within 14 days, or as clinically indicated, from the date the test results had been reviewed by the LIP. This equates to 0.0% compliance. *The compliance rating remains unchanged from the previous audit.*
3. Question 4 – Auditors reviewed 21 relevant cases from within the review period. Twenty inmate-patients had received diagnostic test results within two days of the facility's receipt of the test results. This equates to 95.2% compliance. *This is an improvement from the previous score of 44.4% compliance in this area.*

Chapter 8: Medical Emergency Services/Drills	**Point Value**	**Points Awarded**
1. Does the facility have a current Medical Emergency Response procedure?	10.0	10.0
2. Does the facility's local operating procedure pertaining to medical emergencies/response contain instructions on how to communicate, respond, and transport inmate-patients during medical emergencies?	30.0	30.0
3. Does the facility's local operating procedure contain instructions on how to obtain Emergency Medical Services (EMS) transportation 24 hours a day, seven days a week?	30.0	30.0
4. When inmate-patients return from a community hospital emergency department, does an RN document their review of the inmate-patient's discharge plan?	30.0	30.0
5. When inmate-patients returns from a community hospital emergency department, does an RN document the completion of a face-to-face evaluation of the inmate-patient?	30.0	30.0
6. When an inmate-patient returns from a community hospital emergency department, does the inmate-patient receive a follow-up appointment with an LIP within five calendar days of discharge or sooner as clinically indicated from the day of discharge?	30.0	30.0
7. Is there documentation that the Emergency Response Review Committee has met at least once a month?	10.0	10.0
8. In the documentation of the Emergency Response Review Committee meetings, does the committee discuss and/or implement a quality improvement action after reviewing the results of an emergency medical response and/or emergency medical response drill?	10.0	10.0
9. Does the facility conduct quarterly emergency medical response (man-down) drills on each shift?	30.0	30.0
10. During emergency medical response and/or drills, is a Basic Life Support (BLS) certified staff member on-site within four minutes of the emergency medical alarm?	30.0	30.0
11. During emergency medical response and/or drills, is an Advanced Cardiac Life Support (ACLS) certified health care staff member providing treatment within eight minutes of the emergency medical alarm?	30.0	30.0
Final Scoring:	270.0	270.0
		100%

CHAPTER 8 COMMENTS

None.

Chapter 9: Medical Emergency Equipment	**Point Value**	**Points Awarded**
1. For each shift, do staff document that all Emergency Medical Response Bags in each clinic are secured with a seal?	30.0	30.0
2. Is there documentation, after each medical emergency, that all Emergency Medical Response Bags in each clinic are re-supplied and re-sealed?	30.0	30.0

3. Is there documentation, on each shift, that all Medical Emergency Crash Carts are secured with a seal?	50.0	50.0
4. Is there documentation, after each medical emergency, that all Medical Emergency Crash Carts are re-supplied and re-sealed?	30.0	30.0
5. Does the facility have a functional Defibrillator with Cardiac Monitor?	50.0	50.0
6. Is there documentation that the Defibrillator with Cardiac Monitor in each clinic is checked every shift for operational readiness?	30.0	30.0
7. Does the facility have a functional 12 Lead Electrocardiogram (EKG) machine with electrode pads?	50.0	50.0
8. Is there documentation that the 12 Lead EKG machine with electrode pads in each clinic is checked every shift for operational readiness?	30.0	30.0
9. Does the facility have functional Portable suction?	50.0	50.0
10. Is there documentation that the Portable suction in each clinic is checked every shift for operational readiness?	30.0	30.0
11. Does the facility have oxygen tanks?	50.0	50.0
12. Is there documentation that the oxygen tanks in each clinic is checked every shift for operational readiness (at least three-quarters full)?	30.0	30.0
13. Does the facility have a contract for routine oxygen tank maintenance service?	30.0	30.0
14. Is there documentation that the Automated External Defibrillator (AED) in each clinic is checked every shift for operational readiness?	30.0	30.0
15. Are first aid kits located in designated areas?	10.0	10.0
16. Do the first aid kits contain all required items?	10.0	10.0
17. Are spill kits located in the designated areas?	10.0	10.0
18. Do the spill kits contain all required items?	10.0	10.0
Final Scoring:	560.0	560.0
		100%

CHAPTER 9 COMMENTS

1. NOTE: See discussion of qualitative action items #2, 3 and 4 for additional findings related to *medical emergency equipment.*

Chapter 10: Grievance/Appeal Procedure	**Point Value**	**Points Awarded**
1. Does the inmate-patient handbook or similar document explain the grievance/appeal process?	10.0	10.0
2. Is CDCR Form 602 HC, *Patient-Inmate Health Care Appeal*, readily available to inmate-patients while housed in all housing units?	10.0	10.0
3. Are inmate-patients able to submit the CDCR-602 HC forms on a daily basis in secured/locked boxes in all housing units?	10.0	10.0
4. Are the First Level Health Care Appeals being processed within specified timeframes?	10.0	10.0
5. Does the Appeals Coordinator log all screened/rejected appeals?	10.0	10.0
Final Scoring:	50.0	50.0
		100%

CHAPTER 10 COMMENTS

1. NOTE: See discussion of qualitative action item #5 for additional findings related to first level health care appeals.

Chapter 11: Infection Control	Point Value	Points Awarded
1. Does the facility have an Infection Control Plan that meets CCHCS guidelines?	30.0	30.0
2. Does the facility have a Bloodborne Pathogen Exposure Control Plan?	30.0	30.0
3. Are packaged sterilized reusable instruments within the expiration date?	10.0	10.0
4. When autoclave sterilization is used, is there documentation showing weekly spore testing?	30.0	30.0
5. Are disposable instruments discarded after one use?	10.0	10.0
6. Are inmate-patients who come to the clinic with a potential communicable disease isolated from the rest of the inmate-patients in the clinic area?	10.0	10.0
7. Does the staff practice hand hygiene?	30.0	30.0
8. Does the facility have hand sanitizers which are maintained and available for staff use?	10.0	10.0
9. Is personal protective equipment (PPE) (i.e. gloves, masks, face shields, gowns, etc.) available for staff use?	10.0	10.0
10. Is healthcare staff following Universal Precaution measures during inmate-patient contact?	30.0	30.0
11. Is the inmate-patient clinic area cleaned after each inmate-patient use?	10.0	0.0
12. Is environmental cleaning of "high touch surfaces" completed within the medical clinic at least once a day?	10.0	0.0
13. Are biohazard materials placed in biohazard material labeled containers?	10.0	10.0
14. Are the central storage biohazard material containers emptied on a regularly scheduled basis?	10.0	10.0
15. Is the central storage area for biohazard materials labeled and locked?	10.0	10.0
16. Are sharps placed into a puncture resistant, leak-proof container that is closeable, locked, and labeled with the biohazard symbol?	10.0	10.0
17. Does the facility account for all sharps (needles, scalpels, etc.) by documenting the number at the end of each shift?	10.0	10.0
18. Does the facility have a process to reconcile the sharp count if needed?	10.0	10.0
19. Does the facility secure sharps?	10.0	10.0
Final Scoring:	290.0	270.0
		93.1%

CHAPTER 11 COMMENTS

1. Question 11 – The inmate-patient clinic areas are not consistently cleaned by medical staff after each inmate-patient use. This equates to 0.0% compliance. *The results indicate a significant decline from the previous audit results of 100% compliance.*
2. Question 12 – Environmental cleaning of high touch surfaces are not being consistently documented in all medical clinics. This equates to 0.0% compliance. *The compliance rating did not change from the previous audit and remains an unresolved CAP item.*

Chapter 12: Initial Intake Screening/ Health Appraisal	Point Value	Points Awarded
1. Did the inmate-patient receive an Initial Intake Screening upon arrival at the facility by licensed health care staff?	30.0	30.0
2. If an inmate-patient was referred to a LIP by nursing staff during the Initial Intake Screening, was the inmate-patient seen in the specified time frame? (Immediately, within 24 hours, or within 72 hours)	30.0	30.0
3. If the inmate-patient had an existing medication order upon arrival at the facility, was the inmate-patient seen by a LIP or had their medications ordered within 8 hours of arrival?	30.0	30.0
4. If the inmate-patient was referred for a follow-up medical, dental or mental health appointment, was the appointment completed within the time frame specified by the LIP?	30.0	20.0

5. Did the inmate-patient receive a complete Health Appraisal by the LIP ≤ 14 calendar days of arrival at the facility?	30.0	25.6
6. If the inmate-patient was enrolled in a Chronic Care Clinic at a previous facility, did the RN refer the patient to LIP or Primary Care Primary Care Physician (PCP) for CCC follow-up?	30.0	30.0
7. Did the inmate-patient receive a complete screening for the signs and symptoms of Tuberculosis (TB) upon arrival?	30.0	27.8
8. Did the inmate-patient receive a Tuberculin Skin Test (TS) evaluation upon arrival?	30.0	N/A
9. Does the initial intake screening take place in a manner that ensures inmate-patient confidentiality both visually and orally?	30.0	30.0
Final Scoring:	270.0	223.4 (240.0)
		93.1%

CHAPTER 12 COMMENTS

1. Question 4 – Auditors reviewed 27 cases involving inmate-patients who had received initial intake screenings during the review period. Six inmate-patients had been referred for follow-up medical, dental or mental health appointments. Four of these six inmate-patients were seen by the LIP within the specified timeframe. This equates to 66.7% compliance. *This is a significant decline from the previous rating of 100% compliance.*
2. Question 5 – Auditors reviewed 27 cases involving inmate-patients who had required a complete Initial Health Appraisal (IHA) by the LIP. Twenty-three of these received an IHA within the specified timeframe. This equates to 85.2% compliance. *This is a significant increase from the previous rating of 0.0% compliance.*
3. Question 7 – Auditors reviewed 27 cases involving inmate-patients who had required a screening for the signs and symptoms of TB. Twenty-five of these received the screening. This equates to 92.6% compliance. *This is a slight increase from the previous rating of 88.9% compliance.*
4. Question 8 – Not applicable. Due to a change in Department policy, inmate-patients are not required to receive a tuberculin (TB) skin test evaluation upon arrival. Inmate-patients receive a TB skin test at the CDCR Reception Center upon arrival to the CDCR, and thereafter receive a TB test annually.
5. NOTE: See discussion of qualitative action item #6 below for additional findings related to initial intake screening / health appraisal.

Chapter 13: Licensure and Training	**Point Value**	**Points Awarded**
1. Are copies of current licenses maintained for all health care staff?	30.0	30.0
2. Is there a centralized system for tracking expiration of license for all health care staff?	30.0	30.0
3. Are the ACLS certifications current for the Physician, Nurse Practitioner (NP), Physician Assistant (PA) and RN?	30.0	30.0
4. Are the BLS certifications current for the LPN/Custody Staff?	30.0	30.0
5. Is there a method in place to address expired certifications/licenses?	10.0	10.0
6. Is there a centralized system in place to track training provided to health care staff?	10.0	10.0
7. Is there a system in place to ensure that health care staff receives training for new or revised policies that are based on Inmate Medical Services Policy and Procedures IMSP & P requirements?	10.0	10.0
8. Did the CCA Management (onsite supervisors) receive training for new or revised policies that are based on IMSP & P requirements?	10.0	10.0
Final Scoring:	160.0	160.0
		100%

CHAPTER 13 COMMENTS

None.

Chapter 14: Medication Management	Point Value	Points Awarded
1. Was the medication administered to the inmate-patient as ordered by the LIP?	30.0	30.0
2. Did the prescribing LIP document that they explained the medication to the inmate-patient?	30.0	7.5
3. If a patient did not show or refused their prescribed medication 50% of the time or more during the audit period was a referral made to an LIP?	30.0	0.0
4. If a patient did not show or refused their prescribed medication 50% of the time or more during the audit period did the LIP see the patient within 7 days of the referral?	30.0	30.0
5. Does the same LPN/RN who prepares the inmate-patient medication also administer the medication?	30.0	30.0
6. Are inmate-patient medications administered on the same day that the medications are prepared?	30.0	30.0
7. Does the LPN/RN document the medication is administered on the Medication Administration Record (MAR) once the medication is given to the inmate-patient?	30.0	30.0
8. Are medication errors documented on the Incident Report-Medication Error Form?	30.0	30.0
9. Does the LPN/RN directly observe an inmate-patient taking DOT medication?	30.0	0.0
10. Does the LPN/RN check every inmate-patient's mouth, hands and cup after administering DOT medications?	30.0	0.0
11. Does the inmate-patient take all Keep on Person (KOP) medications to the designated LPN/RN prior to transfer?	30.0	30.0
12. Does the LPN/RN verify the KOP medications against the current pharmacy medication profile prior to transfer?	30.0	30.0
13. Does the transfer envelope contain a current pharmacy medication profile?	30.0	30.0
14. Does the transfer envelope contain a sufficient supply of prescription medications to cover the period of the inmate-patient transport?	30.0	30.0
Final Scoring:	420.0	307.5
		73.2%

CHAPTER 14 COMMENTS

1. Question 2 – Auditors reviewed 8 relevant cases from within the review period. Two medical records included documentation that the LIP had explained the medication to the inmate-patient. This equates to 25.0% compliance. *The compliance rating remains unchanged from the previous audit finding.*
2. Question 3 – According to health care staff interviewees, NFCF does not currently monitor for inmate-patients who miss 50% or more of their medications within a 7-day period.[1] Therefore any such inmate-patients are not being referred to the LIP. This equates to 0.0% compliance.
3. Question 9 – During the NCPR-Auditor's observation of two DOT medication administration lines, health care staff consistently allowed the inmate-patients to turn away from the nurse to drink/obtain water from the water fountain after they received their medication and cell lights were not required to be turned on. This equates to 0.0% compliance. *This is a significant decline from the previous finding of 100% compliance.*
4. Question 10 – Health care staff failed to check inmate-patient's mouth after administration of DOT medications. This equates to 0.0% compliance.

[1] Inmate Medical Services Policy & Procedure, Vol. IV, Chapter 11(C)(4)

Chapter 15: Monitoring Log	Point Value	Points Awarded
1. Are inmate-patients seen within timeframes set forth in the sick call policy?	30.0	28.4
2. Are inmate-patients seen within the timeframes set forth in the specialty care policy?	30.0	30.0
3. Are inmate-patients seen within the timeframes set forth in the emergency/hospital services policy?	30.0	30.0
4. Are inmate-patients seen within timeframes as it relates to chronic care policy?	30.0	0.0
5. Are inmate-patients seen within timeframes set forth in the initial intake screening/health appraisal policy?	30.0	28.6
Final Scoring:	150.0	117.0
		78.0%

CHAPTER 15 COMMENTS

1. Question 1 – Auditors reviewed 368 cases involving inmate-patients requesting sick call appointments during the review period. Of these, 348 were seen within the specified time frame. This equates to 94.6% compliance. *This is an improvement from the previous finding of 49.1% compliance.*

Routine		Urgent		Emergent		Totals	
#	# within timeframe	#	# within timeframe	#	# within timeframe	#	# within timeframe
289	273	30	28	49	47	**368**	**348**

2. Question 4 – The NFCF Chronic Care Monitoring log was submitted incomplete; specifically, with missing dates. Based on this information it could not be ascertained whether inmate-patients had been seen by the LIP within the specified timeframe. This equates to 0.0% compliance. *The compliance rating remains unchanged from the previous audit*.
3. Question 5 – Auditors reviewed 215 cases involving inmate-patients requiring an Initial Health Appraisal. Of these, 205 had been seen for the IHA within the specified time frame. This equates to 95.3% compliance. *This is a significant improvement from the previous finding of 26.3% compliance*

Chapter 16: Observation Unit	Point Value	Points Awarded
1. Are inmate-patients checked by the nursing staff every eight hours or more as ordered by an LIP?	30.0	30.0
2. Did the LIP document daily face-to-face encounters with all inmate-patients housed in the Observation Unit?	30.0	30.0
3. Is there a functioning call system in all Observation Unit rooms?	30.0	30.0
Final Scoring:	90.0	90.0
		100%

CHAPTER 16 COMMENTS

1. NOTE: See discussion in qualitative action item #7 for additional findings related to observation unit.

Chapter 17: Patient Refusal of Health Care Treatment/No Show	Point Value	Points Awarded
1. If an inmate-patient refuses a health care appointment/treatment, did an RN/LIP complete the CDCR Form 7225, *Refusal of Examination and/or Treatment* Form?	10.0	10.0
2. If an inmate-patient refuses a health care appointment/treatment, did an RN/LIP document their discussion of risk and benefits of refusing the appointment/treatment in the inmate-patient's Progress Notes section of the Electronic Medical Record?	10.0	10.0
3. If an inmate-patient did not show for their medical appointment, did the RN/LIP contact the housing unit supervisor to have the inmate-patient escorted to medical to speak with health care staff?	10.0	10.0
4. If an inmate-patient was a no show for a medical appointment/treatment, did the RN contact the LIP to determine if/when the inmate-patient should be rescheduled?	10.0	0.0
Final Scoring:	40.0	30.0
		75.0%

CHAPTER 17 COMMENTS

1. Question 4 – Auditors reviewed 6 medical records. Of these, only 1 case was identified involving an inmate-patient refusing a medical appointment. This medical record did not contain documentation that the RN had contacted the LIP to determine a need for the inmate-patient to be rescheduled. This equates to 0.0% compliance.

Chapter 18: Sick Call	Point Value	Points Awarded
1. Does the inmate-patient handbook or similar document explain the sick call process?	10.0	10.0
2. Is an RN reviewing all sick call request forms within one day of receipt?	30.0	30.0
3. Are inmate-patients seen and evaluated face-to-face by an RN/LIP if the sick call request form indicates an emergent health care need?	30.0	30.0
4. Are inmate-patients seen and evaluated by an RN/LIP within the next business day if the sick call request indicated a non-emergent health care need?	30.0	30.0
5. Does an RN/LIP follow the Patient Care Protocol to address an inmate-patient's chief complaint, and is the chief complaint documented in the Progress Note on the sick call request form?	30.0	30.0
6. Is the Subjective-Objective-Assessment-Plan-Education (S.O.A.P.E) section of the Patient Care Protocol/Progress Note completed by an LPN/RN?	30.0	30.0
7. If an inmate-patient was referred for follow-up to the LIP by the RN, was the inmate-patient seen within the specified timeframe?	30.0	30.0
8. If an inmate-patient was referred for follow-up by the LIP, was the inmate-patient seen within the ordered timeframe?	30.0	30.0
9. Are all inmate-patients referred to an LIP by an RN if they presented to sick call three or more times in a month for the same complaint?	30.0	30.0
10. Do the sick call visit locations provide for inmate-patient confidentiality both visually and orally in General Population (GP), Administrative Segregation (Ad Seg), and Lockdown?	30.0	30.0
11. Does nursing staff conduct daily rounds in Administrative Segregation Housing Units?	30.0	30.0
12. Are the sick call request forms readily available to inmate-patients in all housing units?	10.0	10.0
13. Are inmate-patients able to submit sick call request forms on a daily basis in secured/locked boxes in all housing units?	10.0	10.0
Final Scoring:	330.0	330.0
		100%

CHAPTER 18 COMMENTS

None.

Chapter 19: Specialty/Hospital Services	Point Value	Points Awarded
1. Are LIP requests for urgent specialty services approved or denied within 72 hours of being requested?	30.0	30.0
2. Are LIP requests for routine specialty services approved or denied within seven days of being requested?	30.0	30.0
3. Are LIPs evaluating an inmate-patient every 30 days or as specified until the routine specialty appointment occurs?	30.0	30.0
4. Are inmate-patients seen by a specialist within the timeframe specified by an LIP? (Emergent=immediately, Urgent < 14 days or Routine < 90 days)	30.0	30.0
5. Upon return from a specialty consult appointment, does an RN/LIP complete a face-to-face evaluation prior to the inmate-patient returning to their assigned housing unit?	30.0	30.0
6. When and inmate-patient returns from a specialty consult appointment, does an RN notify an LIP of any immediate medication orders or follow-up instructions provided by the specialty consultant?	30.0	30.0
7. Does an LIP review the consultant's report and see the inmate-patient for a follow-up appointment within the specified timeframe? (≤ 3 days for emergent/urgent and ≤ 14 days for routine)	30.0	21.4
8. Does all pertinent health care information accompany the inmate-patient to their specialty consult appointment?	30.0	30.0
9. When an inmate-patient is discharged from a community hospital, does an RN document their review of the inmate-patient's discharge plan?	30.0	30.0
10. When an inmate-patient is discharged from a community hospital, does the RN document their face to face evaluation of the inmate-patient prior to the inmate-patient being re-housed?	30.0	30.0
11. When an inmate-patient is discharged from a community hospital, does the inmate-patient receive a follow-up appointment with an LIP within five calendar days from the day discharged or sooner as clinically indicated?	30.0	30.0
Final Scoring:	330.0	321.4
		97.4%

CHAPTER 19 COMMENTS

1. Question 7 – Auditors reviewed 7 cases involving an inmate-patient who had returned from a specialty consult appointment. Of these, 5 records included documentation that the LIP had reviewed the consultant's report and saw the inmate-patient for a follow-up appointment within the specified timeframe. This equates to 71.4% compliance. *This is a decline from the previous finding of 100% compliance.*

Chapter 20: Staffing	Point Value	Points Awarded
1. Does the facility have the required LIP staffing complement?	30.0	30.0
2. Does the facility have the required management staffing complement?	30.0	0.0
3. Does the facility have the required RN staffing complement?	30.0	30.0
4. Does the facility have the required LPNS staffing complement?	30.0	0.0

5. Does the facility have the required Certified Medical Assistant (CMA) staffing complement?	30.0	30.0
Final Scoring:	150.0	90.0
		60.0%

CHAPTER 20 COMMENTS

1. Question 2 – Out of 2 clinical nursing supervisors (CNS) contractually required, only 1 CNS was employed by NFCF during the audit. As the minimum required staffing in this classification has not been achieved, this contractual requirement has not been satisfied. This equates to 0.0% compliance.
2. Question 4 – Out of 11.61 LPN required by the contract, only 10.61 LPN staff were employed by NFCF during the audit. As the minimum required staffing in this classification has not been achieved, this contractual requirement has not been satisfied. This equates to 0.0% compliance.

QUALITATIVE FINDINGS

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

The audit team conducted the qualitative analysis primarily via interview of key institution personnel and through review of the electronic medical record. At NFCF the personnel interviewed included the following:

Martin Frink - Warden
Susan Montford – Regional Director, Health Services (RDHS)
William Crane, Physician, Regional Medical Director
Robert Ringrose – Physician
Rachel Scobee – Nurse Practitioner
Patricia Siemionko – Nurse Practitioner
Lakeisha Hodge – Quality Assurance Manager (QAM)
Deborah McGee, Grievance Coordinator
Jennifer Robertson, ADA Coordinator (A)
Erica Sollis – Health Services Administrator (HSA)
Shirley May – RN, Clinical Nursing Supervisor (CNS)
Elizabeth White, Certified Medication Assistant (CMA)
Catherine Mears – Consults / Medical Records Supervisor

The following narrative represents a summary of the information gleaned through interview of the above-listed personnel, as well as conclusions and inferences drawn from correlating observations and data collected during other portions of the audit. The findings are loosely categorized into two themes: *Personnel,* which focus on the collaborative/cooperative relationship between essential offices and departments within the institution; and *Operations*, which focuses on operational efficiencies, inefficiencies, best practices, and challenges observed during the audit.

SUMMARY OF QUALITATIVE FINDINGS

The clinical areas where examinations occur include two (2) clinics and one examination room: one clinic in the main medical area, one in the expansion clinic where patients can be seen and telemedicine services are provided, and an examination room in the administrative segregation unit. The nurse-auditor also noted that although the facility did not have a functioning call system in all observation unit rooms, they do have a procedure in place to address the medical needs of inmate-patients while in the observation rooms. The *CCA Policy 13-63, Observation Beds*, requires "A correctional officer to be within sight or sound at all times" when an inmate-patient is placed in an observation room. CCHCS recommends that CCA modify their policy to reflect what they are actually doing, which is posting a correctional officer in the observation unit, when an inmate-patient is housed in the observation room.

The nurse-auditors observed the medication administration, sick call and infection control processes. The physician-auditor observed the facility physicians and nurse practitioners assessing inmate-patients

during sick call, chronic care and telemedicine appointments. The physician-auditor also reviewed documentation completed by each provider in the electronic medical records (EMR) for numerous inmate-patients. The HPS I-auditor interviewed the custody staff within each housing unit to assess their knowledge of sick call and grievance appeal procedures, and verified that an adequate supply of sick call and grievance appeal forms were available. The audit team further interviewed several clinical staff, custody staff, and inmate-patients regarding the daily operations of the facility.

Findings of these observations and interviews are detailed in the sections below.

The First Aid and Spill Kits in all housing units and other key locations were inspected by the HPS I-auditor to ensure they contained the required items. Out of the 30 first aid/spill kits examined, one box in the maintenance area was not sealed. However, the box did contain all the required supplies. Upon return to the main medical clinic, the nursing supervisor instructed one of the health care staff to immediately go to the maintenance area and reseal the box.

Operations:

Health Services Administrator (HSA): The auditors interviewed the HSA in order to ascertain her knowledge of the daily operations of the medical clinic, emergency response and drills, grievance appeal and sick call processes. The HSA demonstrated a solid understanding of all operational activities and processes in the medical clinic as well as the deficiencies in medical services and what operational improvements were needed. The auditors discussed the need for the HSA's continued attention to correcting the deficiencies and making the necessary operational improvements. The HSA voiced her intention of continuing to address all identified deficiencies.

BEST PRACTICE: During the facility tour to check first aid and spill kits, the HPS I-auditor observed that the HSA had created medical binders containing CCA's sick call forms 13-80A3 (English and Spanish), *602 HC Grievance/Appeal* forms, and KOP Medication Renewal Request forms, and had placed them in all 21 housing units. The binders were clearly marked and easy to identify as containing health care forms. HPS I-auditor verified there was an adequate supply of the sick call forms available in all housing units. During the previous audit, some of the housing units did not have a sufficient supply of sick call forms. This was a CAP item from the prior audit, which the audit team found had been superbly corrected.

During the previous audit, auditors had observed a large backlog of unanswered first level appeals. However, during the current audit, the team verified that NFCF's appeals were up to date and there were no remaining backlog of grievance/appeals. The HSA now appears to be addressing and completing the first level health care appeals consistently within the specified timeframes. The HSA documents all first level health care appeals received on the *First Level Health Care Appeal Monitoring Log* and submits the log to the PPCMU monthly. The previous CAP regarding this practice appears to have been fully resolved at this time.

Quality Assurance Manager (QAM): The HPS I-auditor conducted a brief interview with the QAM to assess the availability of information to inmate-patients regarding the sick call and grievance/appeal processes. The QAM provided the HPS I-auditor a copy of the facility inmate-patient handbook, titled *North Fork Correctional Facility, Inmate Handbook* (revised August 26, 2014). The QAM informed the HPS I-auditor that the handbook is provided to all new arrivals. The handbook clearly explains the sick call process, and states that the health care grievance/appeal procedures are the same as those for non-health care appeals. The HPS I-auditor interviewed both the HSA and the facility Grievance Coordinator.

Both stated inmate-patients are not required to complete the CDCR Form 22 prior to submission of their 602 or 602-HC appeal forms.

The CDCR Form 22, *Inmate/Parolee Request for Interview, Item or Service,* is not required prior to submitting a health care appeal (602-HC) or custody appeal (602). However, the paragraph regarding the use of the Form 22 in the handbook is located in the grievance section of the inmate-patient handbook, giving the impression that a Form 22 is required prior to submitting a 602-HC or 602. It was the team's recommendation to move the paragraph out of the grievance section and further clarify that although a Form 22 can be used to resolve many grievances, it is not required prior to submitting a 602-HC or 602.

Upon review of the handbook, the HPS I-auditor found that the table of contents incorrectly listed the page numbers for both "Programs" and "Health Care" in the Program and Services section and "Grievance Procedures" in the Inmate Rights section. The HPS I auditor advised the facility HSA to correct the page numbers in the table of contents.

ADA Coordinator: The auditor met with the acting ADA Coordinator since the facility ADA Coordinator was out of office. It should be noted that the ADA coordinator was unavailable for interview during the previous audit as well. The acting ADA coordinator could not answer any of the questions related to the duties and responsibilities associated with the ADA coordinator position. The standard answer received from the acting Coordinator was, "if I have any questions regarding the ADA process, I will contact the facility HSA". The inability to speak to the assigned individual on two separate occasions casts a shadow of concern on the facilities ability to coordinate and enforce the applicable standards. During the next scheduled audit, NFCF administration must ensure that the assigned ADA Coordinator is made available to the team to be interviewed.

NFCF Health Care Staff: The facility maintains a log of all private citizen requests for health care information. The Medical Records Supervisor is responsible to ensure requestors name, inmate-patient's name and CDCR number, and the additional required information is contained on the log. The auditors found the log contains all the required information.

The facility has a full complement of Licensed Independent Providers (LIP). The facility had one vacancy each in the Licensed Practical Nurse (LPN) and Registered Nurse (RN) classifications at the time of the audit; however, interviews for both positions were scheduled to be held November 7, 2014. At the time of the previous audit, some RNs had not been ACLS certified. This deficiency has since been corrected. All staff licenses, BLS and ACLS certifications were up to date at the time of the current audit.

The NCPR-auditor interviewed main clinic RN staff, including a discussion of protocols for inmate-patients exposed to chemical agents. The RNs reported custody staff does consult with an RN/LIP before a controlled use of a chemical agent; however, the RNs were unable to describe a process for documenting the consult (Qualitative Action Item #1). During chart review, the NCPR-Auditor identified 3 inmate-patients who had refused decontamination after chemical agent exposure. There was no documentation those inmate-patients had been monitored every 15 minutes for a minimum of 45 minutes after exposure.[2] The boxes on the Emergency Anatomical Forms had been inconsistently checked indicating whether the inmate-patient had accepted or refused decontamination. Specifically, three inmate-patients' records contained a CCA Form 13-34A2, *Facility Emergency Anatomical Form* with the boxes checked documenting the inmate-patient had been decontaminated *and* had refused

[2]Inmate Medical Services Policy & Procedure, Vol. IV, Chapter 17.1(F)

decontamination. The section of the form that documents the time when an inmate-patient is brought into the medical clinic and when the inmate-patient is released back to custody displays incorrect data. The timeframe documented on the form between the time the inmate-patient arrived in the medical clinic and when he was released back to custody did not afford health care staff enough time to complete an examination to complete the Emergency Anatomical Form. The NCPR discussed the need to correctly document the times on the 13-34A2 form with the HSA and RDHS, they stated additional training on proper completion of the 13-34A2 form would be provided to staff.

The NCPR-auditors observed all medication administration lines. During the AM and PM Direct Observation Therapy (DOT) pill lines the NCPR-auditors observed the facility nurses allowing the inmate-patients to turn away from the nurse to drink/obtain water from the water fountain after receiving their medications. Nurses also failed to check the inmate-patients' mouths, hands, and cups after administering the DOT medications. During pill pass in Administrative Segregation Unit (ASU), medication administration took place at cell front, and the nurse did not require inmate-patients to turn on the interior cell lights, which made it difficult to observe the inmate-patients. The NCPR-auditor discussed her observations with the Clinic Charge Nurse. The security officer escorting the medication nurse in ASU should require the inmate-patient to turn on the light in his cell for both safety and security of staff, as well as to more positively confirm ingestion of the medications. The Clinical Nursing Supervisor stated she would follow up with her medication nurses and the ASU officers to ensure DOT medication protocols are followed.

The NCPR-auditor interviewed medication nurses regarding the local processes for inmate-patients who refuse their NA/DOT medications. Per the medication nurses, if an inmate-patient shows a pattern of refusals or "no-shows," the nurse will notify the provider if it is an essential medication. Per policy[3], a licensed health care staff "shall perform a weekly review of the MARs and refer, in writing via a CDCR Form 128-C, any patient who has missed 3 consecutive days of medications, or fifty percent (50%) of any medication in one week either by refusal, no-show, or shows a pattern of unexplained missed medications, to the prescriber for medication follow-up counseling." Despite the medication nurses' assertion that the first watch RN reviews the MARs for missed NA/DOT medications, and if the inmate-patient missed 3 consecutive doses, the inmate-patient is referred to either the RN or an LIP, the facility has not been following this procedure in practice. Providers are not being notified of all inmate-patients who refuse or miss 3 consecutive doses of medication. The NCPR-auditor discussed this issue with the CNS during the audit and it was also discussed during the exit conference. The CNS indicated that NFCF will revert to the previous practice of having the evening nurse review inmate-patient refusals and "no-shows" on a weekly basis.

NFCF nurses are not documenting on the MAR the inmate-patient medication refusals or "no shows." Policy[4] requires the licensed health care staff "assigned to the clinic shall document each medication no-show/refusal on the MAR by circling and initialing in red the date and time slot where the medication would have been recorded had it been given. If the patient refuses medication the nurse shall attempt to determine why the patient is refusing the medication and document the reason for each medication refused on the back of the MAR." Currently, NFCF nurses do not ask the inmate-patient for the reason for the refusal and do not document the reason on the MAR. If the inmate-patient does not arrive to receive medication, the nurse is required to contact the housing unit and determine if there are any barriers to the inmate-patient coming to the pill line. According to NFCF nursing staff, NFCF medication

[3] IMSP&P Vol 4 Chapter 11 Procedure C 4
[4] IMSP&P Vol 4 Chapter 11 Procedure C 3

nurses do not initiate contact with the housing officer, nor do they make any notation in the MAR of this contact or any barriers identified.

During the NCPR-auditor's review of the EMR, there was no documentation in the chronic care medical records that the LIP had provided education regarding the inmate-patients' chronic care condition(s) to the inmate-patients. The chronic care forms further lacked a complete list of inmate-patient's medications.

The facility continues to be deficient in diagnostic services. Medical records reviewed by the NCPR-auditor continued to lack documentation that the LIP had reviewed the diagnostic report within 2 days of receipt. The records reviewed further indicated that abnormal lab tests had no documentation of LIP follow-up within 14 days. Per *IMSP&P, Vol. 4 Chapter 10 Procedure III, Section A.16, "The PCP shall review, initial, and date all diagnostic reports received including radiology. The PCP shall review laboratory results within two business days of the date test was received."* The audit team discussed the systemic issue of lack of chart documentation with the RDHS and HSA during the audit and during the exit conference. The RDHS and HSA stated they understood the need for consistent and complete documentation and will continue to work to resolve these deficiencies with additional staff training. It is noted that lack of documentation has been a continuing systemic issue for this facility, for which training has been provided in the past without improvement. The PPCMU audit team recommends that in addition to training, the institution strongly consider corrective action for individuals who fail to improve performance.

During the NCPR-auditor's inspection of the emergency response bags the following deficiencies were found:

- The bags contained items that are not on the checklist (oxygen, nasal cannula and mask),
- Multiple bags are not organized in the same manner which can cause a delay in medical treatment; consistency allows for expedient care by ensuring the responder the ability to immediately locate the needed emergency item(s).
- The bags do not contain red hazardous waste disposal bags.

During the exit conference, the NCPR-auditor advised the facility executives and managers to correct the above-identified deficiencies with the emergency response bags. The HSA reported the checklists would be revised to include the items which were not previously listed on the log including a red hazardous waste disposal bag, which she would ensure was placed in each bag. The HSA stated that she understood the advantage of having all emergency response bags organized in the same manner, based upon the audit teams findings, the HSA assured all concerned parties that the health care management team would ensure the bags had a complete checklist, as well as a organized standard layout for each emergency response bag.

The facility staff conducted an emergency response drill during the audit. At the conclusion of the emergency response drill, the physician- and NCPR-auditors discussed with the HSA and responding health care staff, their observations and suggestions for improvement. The NCPR-auditor highlighted the need to check for a possible second ligature, as well as to continue to check the inmate-patient's pulse while the inmate-patient is in transport to meet with EMS.

The audit team observed the RNs and LIP during their clinical encounters with inmate-patients in the main clinic and expansion clinic. These areas were found to be appropriately equipped. The NCPR-auditors observed staff cleaning the exam table, patient's chair and other multi-use equipment after

each inmate-patient/RN encounter. However, while the physician-auditor observed clinical encounters between inmate-patients and one of the LIPs, the exam table, patient's chair or multi-use equipment were not cleaned after each inmate-patient/LIP encounter. Additionally, there was no documentation that the inmate-patient examination room in the Administrative Segregation Unit was being cleaned on a daily basis, and no log documenting cleaning practices for that room.

The NCPR-auditor's electronic medical record (EMR) review revealed documentation deficiencies in the following areas: chemical agent; chronic care; initial intake screening; medication management; observation unit; patient refusal of medical treatment/no show; and sick call. Sick call forms did not include the acuity of the referral to the LIP and did not consistently document the inmate-patient's pain level. The audit team again advised the RMD, RDHS, and HSA of the importance of documenting inmate-patient encounters. The RDHS and HSA stated they would provide additional training to staff regarding documentation on health care forms. As stated above, further training should be accompanied with corrective action for specific individuals who fail to improve.

NCPR-auditors found it difficult to identify specialty referral orders in the medical record. All specialty referral orders found were documented as "ASAP" rather than routine, urgent or emergent. The NCPR-auditor's review of the medical record found follow-up of specialty services is not being completed within the required timeframe. The physician-auditor found that facility utilization review of services recommended by the specialist is not readily apparent in the medical record. The physician-auditor discussed with the RMD, RDHS and HSA the need to review recommended services from the specialty consults to determine necessity. The RMD agreed to ensure recommended services from specialty consultants are thoroughly reviewed.

The physician-auditor interviewed NFCF, medical staff, custody, and four inmate-patients and reviewed various documents including medical records, policies and past provider reviews.

During the physician-auditor's interviews with the four inmate-patients, they were unable to identify who their Licensed Independent Provider (LIP) was. Two inmate-patients were being transferred out of the facility; however they provided positive comments about the medical staff.

During observation of LIP staff during the audit, the physician-auditor found access to medical care, process and delivery to inmate-patients to be appropriate and compatible with community standard. The physician-auditor identified no significant departures from standards of practice. However, during the exit conference, the following findings were discussed:

- The facility should have a primary care model and adequate permanent provider staff,
- The facility would benefit from having "Morning Huddles" occurring in a regular, organized fashion,
- Asthma assessments did not have/utilize an Asthma Assessment tool i.e., "ACAT, Asthma Control Assessment Test", and
- Completion and more in-depth documentation in the Subjective, Objective, Assessment, Plan and Education Sections of the Chronic Care Forms.

The facility currently has one full-time permanent physician, one full-time registry physician, and two mid level providers, who are employed through a registry. One of the registry providers provides telemedicine services. The full time permanent physician is on call 24 hours/day, 7 days per week; The registry staff do not provide on call services.

The physician-auditor provided the RMD current copies of CCHCS Chronic Care Guidelines on Asthma, COPD, Anticoagulation, Diabetes, Hepatitis C, Hyperlipidemia and Hypertension for dissemination to the LIPs at the facility. Regular "Morning Huddles" would provide the opportunity to discuss unusual medical cases, provide for additional training, allow LIPs to bring up questions or issues involving inmate-patient health care, and allow custody to provide feedback as well.

The Chronic Care forms utilized by NFCF contained minimal documentation of the subjective history. The template progress notes have an area for free-form documentation in the Subjective, Objective, Assessment and Plan (SOAP) areas that is inconsistently utilized and often left blank by providers. The Assessment areas do not facilitate an "At Goal" or "Not at Goal" assessment. The physician-auditor discussed changes/additions to the forms with the RMD. During the exit conference the CCA CMO stated that the chronic care forms were currently being revised and requested that the RMD forward any suggestions provided by the physician-auditor to him for consideration.

During the exit conference, the audit team advised the facility staff to offer influenza vaccinations to the entire inmate-patient population. Health care staff is in the process of offering the vaccinations to all inmate-patients at the facility and will have completed the process by January 30, 2015.

In closing, NFCF staff was open to discussion and fully cooperative during the audit. It is evident that the NFCF health care staff is committed to correct the deficiencies identified in the June 2014, audit, as 30 of the 42 corrective action items from the June 2014, audit have been satisfactorily resolved. The remaining items will remain unresolved and continue to be subject to monitoring in future audits. It is imperative that the facility continue working to resolve the outstanding corrective action items from the previous and current audits and maintain a minimum compliance rating of at least 85.0%. NFCF is encouraged to maintain an open line of communication with PPCMU and other facilities with whom CDCR contracts out-of-state beds, in order to determine best practices for the resolution of all remaining CAP items.

STAFFING UTILIZATION

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

A review of the health care staff positions for the week of the audit, November 3-7, 2014, revealed one Clinical Nursing Supervisor and LPN vacancy during this audit period. The following table is a summary of the staffing and findings of the review.

North Fork, OK/CDCR Pop: 2,560, Total Pop: 2,508

Primary Care	Original Contract FTE	Current FTE	Variance
Senior Physician	0.0	0.0	0.0
Physician	1.0	2.0	1.0
ARNP/PA	2.0	2.0	0.0
Physician (contract)	0.5	0.0	(0.5)
ARNP/PA (contract)	0.0	0.0	0.0
Total Primary Care	**3.5**	**4.0**	**0.5**
CCA Management			
Deputy Director/ Senior Health Services Administrator	0.0	0.0	0.0
Health Services Administrator	1.0	**1.0**	0.0
Clinical Supervisor	2.0	**1.0**	1.0
Total CCA Management	**3.0**	**2.0**	**1.0**
Nursing Services			
Staff RN (7 day)	10.0	10.0	0.0
Staff RN (5 day)	1.0	1.0	0.0
RN-CQI	[1.0]	1.0	1.0
Coordinator, Infectious Disease	[0.0]		[0.0]
RN Total	**11.0**	**12.0**	**0.0**
LPN's			
Staff LPN/LVN (5 day)	1.0	1.0	0.0
Staff LPN/LVN (7 day)	7.0	9.61	2.61
Pharmacy Tech/LPN	[3.0]	0.0	[3.0]
LPN Health Information Specialist	[1.0]	1.0	[1.0]
Phlebotomist	[0.0]	0.0	[0.0]
Certified Medication Aide (CMA)	[0.0]	2.0	2.0
LPN Total	**8.0**	**7.0**	**1.0**
Total Nursing	**19.0**	**18.0**	**1.0**

INMATE INTERVIEWS

The intent of this portion of the audit is to elicit substantive responses from a designated number of the inmate-patients, by utilizing each question as a springboard for discussion, with appropriate follow up to identify any areas where barriers to health care access may potentially exist. A random sampling of inmate-patients in their housing units was utilized to obtain a pool of inmate-patients to interview to determine their knowledge of the Sick Call and Grievance/Appeal process. The results of these interviews are summarized in the chart below.

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

Chapter 21: Inmate Interviews (not rated)
1. Are the inmate-patients aware of the sick call process?
2. Does the inmate-patient know where to get a Sick Call request form?
3. Does the inmate-patient know where to place the completed Sick Call request form?
4. Is there assistance available if you have difficulty in completing the Sick Call form?
5. Are inmate-patients aware of the grievance/appeal process?
6. Does the inmate-patient know where the CDCR-620 HC form can be found?
7. Does the inmate-patient know where and how to submit the CDCR-602 HC form?
8. Is assistance available if you have difficulty completing the CDCR 602-HC form?
9. Are you aware of your current disability/ADA status?
10. Are you receiving any type of accommodation based on your disability? (Housing Accommodation, Medical Appliance)
11. Are you aware of the process to request reasonable accommodation?
12. Do you know where to obtain a request for reasonable accommodation form?
13. Did you receive reasonable accommodation in a timely manner? If no, were interim accommodations provided?
14. Have you used the medical appliance repair program?
15. If yes, how long did the repair take?
16. If yes, were you provided an interim accommodation?
17. Are you aware of the grievance/appeal process for a disability related issue?
18. Can you explain where to find help if you need assistance obtaining or completing a form (i.e. CDCR 602-HC Inmate/Parolee Health Care Appeal Form, CDCR 1824 Reasonable Modification or Request for Reasonable Accommodation Form)
19. Have you submitted an ADA Grievance/Appeal?
20. If yes, how long did the process take?
21. Do you know who your ADA Coordinator is?
22. Do you have access to license health care staff to address any issues regarding your disability?
23. During contact with medical staff do they explain things to you in a way you understand?

COMMENTS

The CCHCS PPCMU HPS I auditor requested to interview 10 randomly-selected inmate-patients regarding ADA compliance, sick call and appeals. The HPS I auditor interviewed six inmate-patients; and four inmate-patient refused to be interviewed. The inmate-patients who refused to be interviewed stated they had previously been interviewed and were not interested in being interviewed again. The following comments are provided as a summary of their responses to the above standardized questions:

1. Questions 1 – 4: Of the six inmate-patients interviewed, all were familiar with the sick call process and knew where to access and submit the sick call request forms. They all reported satisfaction with the health care they receive at NFCF. One inmate-patient expressed a desire to have an influenza vaccination. The HPS I-auditor reviewed the inmate-patient's medical record and found documentation that he received the influenza vaccination on 12/08/14. No other issues or concerns were expressed by the inmate-patients.
2. Questions 5 – 8: Of the six inmate-patients interviewed, all were familiar with the appeal process and knew how to access and submit the grievance/appeal forms. When asked by the HPS I-auditor if they had submitted any health care appeals in the past 4 months, two reported they had and had received a timely first level response to their appeal. One inmate-patient reported he was required to submit a Form 22 and attach the response to his 602 when submitting it for response. The HPS I-auditor asked if he was required to submit the Form 22 prior to submitting his health care appeal. The inmate-patient reported he was required to submit the Form 22 to his custody related 602 form, not his health care 602-HC form. No additional issues or concerns were expressed by the inmate-patients.
3. Questions 9 – 23: All six inmate-patients interviewed had qualifying disabilities for inclusion in the Disability Placement Program (DPP). Three of the inmates knew the name of the ADA coordinator. Those three inmate-patients stated they occasionally meet with the ADA coordinator if they have questions. The other three inmates reported they had never met the ADA coordinator.