CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Contract Facility

Health Care Monitoring Audit

TALLAHATCHIE COUNTY CORRECTIONAL FACILITY

October 21-23, 2014

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DATE OF REPORT

December 5, 2014

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 contracted facilities, 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 facilities 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 on October 21 through 23, 2014, at Tallahatchie County Correctional Facility (TCCF) which is located in Tutwiler, Mississippi. At the time of the audit, CDCR's Weekly Population Count, dated October 17, 2014, indicated a budgeted bed capacity of 8,988 out-of-state beds. The TCCF has a design capacity of 2,682 general population beds, of which 2,640 are occupied with CDCR inmates. This facility has an American Correctional Association Accreditation.

EXECUTIVE SUMMARY

From October 21 through 23, 2014, Field Operations staff conducted an onsite audit at TCCF. The audit team consisted of the following personnel:

Ralph Delgado, Physician Advisor
Gary White, Nurse Consultant Program Review
Christopher Troughton, Health Program Specialist 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, TCCF achieved an overall compliance rating of **93.5%** with a rating of 89.0% in Administration, 96.8% in Delivery, and 88.0% 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 93.5% is a decrease of 3.6% from the overall compliance rating of 97.1% achieved during the June 3-4, 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	80.0	75.0	93.8%	No
6. Continuous Quality Improvement (CQI)	50.0	40.0	80.0%	Yes
13. Licensure and Training	160.0	160.0	100.0%	No
15. Monitoring Logs	150.0	97.1	64.7%	Yes
20. Staffing	150.0	150.0	100.0%	No
Administration Sub Score:	**620.0**	**552.1**	**89.0%**	
Delivery				
5. Chronic Care	60.0	53.6	89.3%	No
7. Diagnostic Services	120.0	99.0	82.5%	Yes
8. Medical Emergency Services/Drills	270.0	255.0	94.4%	No
9. Medical Emergency Equipment	560.0	560.0	100.0%	No
14. Medication Management	340.0	340.0	100.0%	No
17. Patient Refusal of Medical Treatment	20.0	20.0	100.0%	No
18. Sick Call	330.0	310.6	94.1%	No
19. Specialty/Hospital Services	300.0	298.5	99.5%	No
Delivery Sub-Score:	**2,000.0**	**1,936.7**	**96.8%**	
Operations				
3. ADA Compliance	60.0	60.0	100.0%	No
4. Chemical Agent Exposure	10.0	10.0	100.0%	No
10. Grievance/Appeal Procedure	50.0	50.0	100.0%	No
11. Infection Control	290.0	250.0	86.2%	No
12. Initial Intake Screening/Health Appraisal	210.0	165.0	78.6%	Yes
16. Observation Unit	90.0	90.0	100.0%	No
Operations Sub-Score:	**710.0**	**625.0**	**88.0%**	
21. Inmate Interviews (not rated)				
Final Score:	**3,330.0**	**3,113.8**	**93.5%**	

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).

Quantitative Performance Comparison	Audit I 06/2014	Audit II 10/2014	Variance Increase/(Decrease
1. Administration	100.0%	100.0%	0.0%
2. Access to Health Care Information	100.0%	93.8%	-6.2%
3. ADA Compliance	100.0%	100.0%	0.0%
4. Chemical Agent Exposure	100.0%	100.0%	0.0%
5. Chronic Care	100.0%	89.3%	-10.7%
6. Continuous Quality Imprvement (CQI)	100.0%	80.0%	-20.0%
7. Diagnostic Services	80.4%	82.5%	2.1%
8. Medical Emergency Services/Drills	100.0%	94.4%	-5.6%
9. Medical Emergency Equipment	100.0%	100.0%	0.0%
10. Grievance/Appeal Procedure	100.0%	100.0%	0.0%
11. Infection Control	100.0%	86.2%	-13.8%
12. Initial Intake Screening/Health Appraisal	100.0%	78.6%	-21.4%
13. Licensure and Training	99.1%	100.0%	0.9%
14. Medication Management	91.4%	100.0%	8.6%
15. Monitoring Logs	76.9%	64.7%	-12.2%
16. Observation Unit	100.0%	100.0%	0.0%
17. Patient Refusal of Health Care Treatment/ No Show	100.0%	100.0%	0.0%
18. Sick Call	98.4%	94.1%	-4.3%
19. Specialty/Hospital Services	98.0%	99.5%	1.5%
20. Staffing	100.0%	100.0%	0.0%
Overall Score:	97.1%	93.5%	-3.6%

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% for each chapter within the 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 *Final Audit 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 TCCF 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 **January 5, 2015.**

Corrective Action Items – Tallahatchie County Correctional Facility, Tutwiler, MS	
Chapter 6, Question 5	In the CQI Meeting Minutes, the facility did not complete an analysis for each identified "opportunity for improvement" as listed on the *Aspects of Care* Monitoring form, or similar form.
Chapter 7, Question 2	The Licensed Independent Provider (LIP) on a consistent basis is not reviewing, initialing and dating all inmate-patient diagnostic reports within the specified timeframe. This CAP item remains open from the previous audit.
Chapter 7, Question 4	Inmate-patients are not consistently receiving written notification of diagnostic test within the specified timeframe. This CAP item remains open from the previous audit.
Chapter 12, Question 2	Inmate-patients who are referred to a LIP by nursing staff during the Initial Intake Screening are not being seen within specified timeframes.
Chapter 12, Question 3	On a consistent basis medical staff neither reordered current prescription medications within 8 hours of inmate-patients' arrival at the facility, nor were they seen by a PCP within 24 hours.
Chapter 15, Question 1	The Sick Call Monitoring Log did not include documentation that the inmate-patients were consistently seen within the specified timeframes set forth in the Sick Call policy.
Chapter 15, Question 4	The Chronic Care Monitoring Log did not include documentation that the inmate-patients were consistently seen within the specified timeframes as set forth in the Chronic Care policy. This CAP item remains open from the previous audit.
*Qualitative Action Item 1 Chapter 2, Question 1	TCCF mid level providers did not submit the necessary paperwork in order to gain access to the Electronic Unit Health Record (eUHR).
*Qualitative Action Item 2 Chapter 5, Question 2	The physician does not consistently provide health care education to inmate-patients regarding their chronic care condition during the Chronic Care Clinic follow up visit.
*Qualitative Action Item 3 Chapter 7, Question 1	LIP does not provide diagnostic test results consistently to the inmate-patients within the specified timeframe.
*Qualitative Action Item 4 Chapter 8, Question 4	The RN does not document on a consistent basis that they reviewed the inmate-patient's discharge plan upon the inmate-patients' return to the facility from the community hospital emergency department.
*Qualitative Action Item 5 Chapter 11, Question 7	Medical staff do not practice proper hand hygiene.
*Qualitative Action Item 6 Chapter 11, Question 8	TCCF does not have hand sanitizer available for staff use.

*Qualitative Action Item 7 Chapter 18, Question 6	The S.O.A.P.E note in the Patient Care Protocol/Progress Note is not being completed by medical staff.
*Qualitative Action Item 8 Chapter 18, Question 8	When inmate-patients are referred for a follow-up appointment by the LIP, they are not seen within the specified timeframe.
*Qualitative Action Item 9	Medical providers are not knowledgeable on *Title XV.*

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

QUANTITATIVE FINDINGS - DETAILED BY CHAPTER

Chapter 1: Administration	Point Value	Points Awarded
1. Do all health care staff have access to the contractor's health care policies and procedures?	10.0	10.0
2. Do 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	5.0
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	10.0
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	10.0
Final Scoring:	80.0	75.0
		93.8%

CHAPTER 2 COMMENTS

1. Question 1 – Out of four providers requiring eUHR access, two providers had access at the time of the onsite audit. This equates to 50.0% compliance.

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	N/A
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	N/A
Final Scoring:	40.0	10.0 (10.0)
		100%

CHAPTER 4 COMMENTS

1. Question 1 - Not applicable. There was no controlled use of a chemical agent during the audit review period. However, during the onsite audit the audit team observed one instance where a controlled use of a chemical agent was used; custody staff consulted medical staff before incident. Both inmate-patients were decontaminated and one inmate-patient was brought to medical for observation due to medical issues identified in his medical chart.
2. Questions 3 – 4 – Not applicable. During the audit review period there were no inmate-patients that refused decontamination. Therefore, these questions could not be evaluated.

Chapter 5: Chronic Care	**Point Value**	**Points Awarded**
1. Was the inmate-patient's chronic care follow-up visit completed within the 90-day or less 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	23.6
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	N/A

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	53.6 (60.0)
		89.3%

CHAPTER 5 COMMENTS

1. Question 2 – Out of 14 medical records reviewed, 11 included documentation that the LIP had provided health care education to the inmate-patients regarding their chronic care condition during their last Chronic Care Clinic follow-up visit. This equated to 78.6% compliance. The previous compliance rating was 100%. *The results indicate a significant decline in compliance.*
2. Questions 3 - 4 – Not applicable. There were no inmate-patients, who refused chronic care medications during this 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	10.0
3. Is there documentation to support the CQI Committee meets at least quarterly?	10.0	10.0
4. Does the documentation of the CQI monitoring activity include the *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	0.0
6. Is there a documented action and follow-up plan for each identified "opportunity for improvement"?	10.0	N/A
Final Scoring:	60.0	40.0 (50.0)
		80.0%

CHAPTER 6 COMMENTS

1. Question 5 – While onsite the audit team interviewed the CQI nurse, who was unable to provide any documentation showing that an analysis was completed for each "opportunity for improvement" identified in the June 2014 CQI meeting minutes. This equates to 0.0% compliance.
2. Question 6 – Not Applicable. This question automatically fails as the result of question 6.5. Under the double fail rule, the points for this question have therefore been removed from the total available points, and the question rendered non-applicable.

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	25.5
2. Does an LIP review, initial, and date an inmate-patient's diagnostic reports within two days of receipt?	30.0	22.5
3. Was the inmate-patient seen by 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	30.0

4. Was the inmate-patient given written notification of the diagnostic test results within two days of receipt?	30.0	21.0
Final Scoring:	120.0	99.0
		82.5%

CHAPTER 7 COMMENTS

1. Question 1 – Out of 20 inmate-patients, 17 received diagnostic tests within the timeframe specified by the LIP. This equates to 85.0% compliance. The previous compliance rating was 100%. *The results indicate a significant decline in compliance.*
2. Question 2 – Out of 20 inmate-patients, 15 inmate-patient records were reviewed, initialed and dated by the LIP within two days of receipt. This equates to 75.0% compliance. The results indicate a slight increase from the previous audit of 73.7% compliance; *however this remains an unresolved CAP item.*
3. Question 4 – Out of 20 inmate-patients, 14 received diagnostic test results within two days of receipt. This equates to 70.0% compliance. The results indicate an increase from the previous audit of 57.9% compliance; *however this remains an unresolved CAP item*.

Chapter 8: Medical Emergency Services/Drill	**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	15.0
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	255.0
		94.4%

CHAPTER 8 COMMENTS

1. Question 4 – During the audit review period out of 14 inmate-patients who returned from a community hospital emergency visit, seven inmate-patients' discharge plans were reviewed by the facility RN upon their return to the facility. This equates to 50.0% compliance. *This is a significant decline from the previous audit of 100% compliance.*

Chapter 9: Medical Emergency Equipment	**Point Value**	**Points Awarded**
1. For each shift, do staff document that all Emergency Medical Response Bags in each clinic are secured with a seal?	30.0	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

None.

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. Are CDCR Forms 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

None.

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	0.0
8. Does the facility have hand sanitizers which are maintained and available for staff use?	10.0	0.0
9. Is personal protective equipment (PPE) (i.e. gloves, masks, face shields, gowns, etc.) available for staff use?	10.0	10.0
10. Are 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	10.0
12. Is environmental cleaning of "high touch surfaces" completed within the medical clinic at least once a day?	10.0	10.0
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	250.0
		86.2%

CHAPTER 11 COMMENTS

1. Question 7 – The facility medical staff were not practicing proper hand hygiene. This equates to 0.0% compliance.
2. Question 8 – The facility does not have hand sanitizers available for staff use. This equates to 0.0% compliance.

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	0.0
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	15.0
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	30.0
5. Did the inmate-patient receive a complete Health Appraisal by the LIP ≤ 14 calendar days of arrival at the facility?	30.0	N/A
6. If the inmate-patient was enrolled in a Chronic Care Clinic at a previous facility, did the RN refer the patient to a LIP or 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	30.0
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	165.0 (210.0)
		78.6%

CHAPTER 12 COMMENTS

1. Question 2 – Out of the 10 records reviewed for initial intake screening, only one inmate-patient was referred to the LIP by nursing staff and was not seen in within the specified timeframe. This equates to 0.0% compliance. *This is a significant decline from the previous audit of 100% compliance.*
2. Question 3 – Out of two inmate-patients who had an existing medication order, only one inmate-patient was seen by the LIP and had his medications ordered within 8 hours of arrival. This equates to 50.0% compliance. *This is a significant decline from the previous audit of 100% compliance.*
3. Question 5 – Not applicable. All inmate-patients, who arrived at this facility during this audit review period received Health Appraisals at La Palma Correctional Facility, this question does not apply since CCA policy 13-40(a1) states, "California patient inmates/residents transferring from one CCA facility to another CCA facility are not required to receive a full health appraisal if there is documented evidence that the patient inmate/resident has received a health appraisal at the previous CCA facility."
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.

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 (on-site 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	30.0
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	N/A
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	N/A
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?	10.0	10.0
9. Does the LPN/RN directly observe an inmate-patient taking DOT medication?	30.0	30.0
10. Does the LPN/RN check every inmate-patient's mouth, hands and cup after administering DOT medications?	30.0	30.0
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:	400.0	340.0 (340.0)
		100%

CHAPTER 14 COMMENTS

1. Questions 3 and 4 – Not applicable. No inmate-patients refused their prescribed medication 50% of the time or more during this audit review period.

Chapter 15: Monitoring Log	**Point Value**	**Points Awarded**
1. Are inmate-patients seen within timeframes set forth in the sick call policy?	30.0	3.0
2. Are inmate-patients seen within the timeframes set forth in the specialty care policy?	30.0	29.2
3. Are inmate-patients seen within the timeframes set forth in the emergency/hospital services policy?	30.0	29.3
4. Are inmate-patients seen within timeframes as it relates to chronic care policy?	30.0	5.6
5. Are inmate-patients seen within timeframes set forth in the initial intake screening/health appraisal policy?	30.0	30.0
Final Scoring:	150.0	97.1
		64.7%

CHAPTER 15 COMMENTS

1. Question 1 – Of the 272 inmate-patients requesting sick call appointments, 27 were seen within the specified timeframes. This equates to 10.0% compliance. *This is a substantial decline from last audit's score of 85.7% compliance.*

Routine		**Urgent**		**Emergent**		**Totals**	
#	# within timeframe	#	# within timeframe	#	# within timeframe	#	# within timeframe
210	2	47	14	15	11	**272**	**27**

2. Question 2 – Of the 75 inmate-patients referred for a specialty care appointment, 73 were seen within the specified timeframe. This equates to 97.3% compliance. *This is an improvement from the previous audit. The previous compliance rating was 80.1%.*

Routine		**Urgent**		**Emergent**		**Totals**	
#	# within timeframe	#	# within timeframe	#	# within timeframe	#	# within timeframe
72	72	3	3	0	0	**75**	**73**

3. Question 3 – Of the 40 inmate-patients sent to the emergency/hospital services, 39 inmate-patients were seen within the specified timeframe by the LIP. This equates to 97.7% compliance. *This is an improvement from last audit's score of 73.3% compliance.*

4. Questions 4 – Of the 135 inmate-patients referred to chronic care clinic, 25 inmate-patients were seen within the specified timeframe. This equates to 18.5% compliance. *This is a significant decline from last audit's score of 68.6% compliance; therefore this remains an unresolved CAP item.*

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

None.

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	N/A
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	N/A
Final Scoring:	40.0	20.0 (20.0)
		100%

CHAPTER 17 COMMENTS

1. Question 3 - 4 – Not applicable. There were no inmate-patient "no-shows" during this audit review period.

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	28.5

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	29.0
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	25.0
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	26.7
8. If an inmate-patient was referred for follow-up by the LIP, was the inmate-patient seen within the ordered timeframe?	30.0	21.4
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	310.6
		94.1%

CHAPTER 18 COMMENTS

1. Question 4 – Out of 20 inmate-patients submitting a sick call request with a non-emergent health care need, 19 received a face-to-face evaluation within the specified timeframe. This equates to 95.0% compliance.
2. Question 5 –Out of 30 inmate-patient charts reviewed, 29 charts showed documentation that the RN/LIP followed the Patient Care Protocol to address the inmate-patients chief complaint. This equates to 96.7% compliance.
3. Question 6 – Out of 30 inmate-patients' S.O.A.P.E. notes reviewed, 25 were completed by an LPN/RN. This equates to 83.3% compliance. *This is a decline from the previous audit score of 96.5% compliance.*
4. Question 7 –Out of nine inmate-patients referred to a LIP by an RN, eight received a follow-up appointment with a LIP in a timely manner. This equates to 88.9% compliance. *This is a decline from the previous audit score of 94.2% compliance.*
5. Question 8 – Out of seven inmate-patients, five received a follow-up in the ordered timeframe. This equates to 71.4% compliance. *This is a significant decline from the previous audit score 91.2% compliance.*

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	N/A
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	28.5

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	30.0
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	298.5 (300.0)
		99.5%

CHAPTER 19 COMMENTS

1. Question 3 – Not applicable. There was no requirement for the LIP to evaluate the inmate-patients prior to their specialty care appointment as all inmate-patient specialty care appointments were completed before the 30 day timeframe during this audit period. Therefore this question could not be evaluated.
2. Question 5 – Out of 20 inmate-patients, 19 received a face-to-face evaluation from an RN prior to returning to their assigned housing unit. This equates to 95.0% 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	30.0
3. Does the facility have the required RN staffing complement?	30.0	30.0
5. Does the facility have the required LPN staffing complement?	30.0	30.0
6. Does the facility have the required Certified Medical Assistant (CMA) staffing complement?	30.0	30.0
Final Scoring:	150.0	150.0
		100%

CHAPTER 20 COMMENTS

None.

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. At TCCF the personnel interviewed included the following:

Fred Figueroa – Warden
William Crane – Regional Medical Director
Shadzad Pour – Physician
Daisy Thomas – Physician
Shellie Burks – Nurse Practitioner
Dawn Peery – Family Nurse Practitioner
Stephanie Gurley – Health Services Administrator
Calvin Stewart – Clinic Nursing Supervisor
Dorothy Strong – Clinic Nursing Supervisor/ADA Coordinator
Delores Marshall – Registered Nurse/Continuous Quality Improvement
Lennie Henson – Registered Nurse/Infection Control
Rhonda Lawson – Health Information Specialist
Kina Love – Medical Records/Data Entry Clerk

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

Personnel:

Upon the arrival of the audit team at TCCF, they were greeted by several of the facility health care staff and subsequently escorted to a conference room where an entrance conference was conducted; the audit team outlined the audit process and discussed the Corrective Action Plan (CAP) submitted by the facility addressing the issues identified during the previous audit. The audit team advised the facility staff of the requirement to submit proof of practice documents to the team for review to support closing the previously documented CAP deficiencies, as no proof of practice documentation accompanied the CAP. Since the facility could not produce such documents, the auditors advised the medical staff that the identified deficiencies would remain non-compliant until such time as the proof of practice documents are received.

At the conclusion of the entrance conference, the audit team proceeded in conducting the onsite audit of the facility. The physician and nurse auditors had not been to TCCF previously and required a tour of the facility, which was accommodated by the Health Services Administrator and the Clinical Nurse Supervisor. Based on their observation during the facility tour the physician and nurse auditors stated that the facility appeared to be well maintained and esthetically pleasing; all hallways were freshly cleaned and waxed and the grounds were well manicured.

Following the tour the nurse auditor and physician auditor began their onsite audit, where the nurse auditor observed medication pass, nursing sick call processes and infection control processes. The physician auditor observed the physicians and nurse practitioners assessing the inmate-patients during sick call and chronic care appointments as well as conducting a review of the documentation completed by each provider in the Electronic Medical Records (EMR) of several inmate-patients.

The HPS I-auditor was escorted by the Health Information Specialist to each housing unit where the auditor interviewed the custody staff to assess their knowledge of sick call and grievance appeal procedures and verified that an adequate supply of sick call and grievance appeals forms were available in all housing units. The auditor also interviewed medical staff and inmate-patient in the main medical building.

During the audit, the auditors observed the interaction between health care and custody staff to be professional, friendly and efficient, with open communication between all staff. While at the facility, the auditors observed a controlled use of a chemical agent which revealed custody staff consulting with medical staff before the use of chemical agent; it was determined that one of the inmate-patients had a pre-existing medical condition and medical staff would need to be onsite when the chemical agent was utilized. After the controlled use of chemical agent both inmate-patients were decontaminated and escorted to main medical. The inmate-patient that required medical attention remained in the medical clinic and per Inmate Medical Services Policies and Procedures (IMSP&P), observed by medical staff every 15 minutes for a 45 minute period. The other inmate-patient was cleared by medical and escorted to Administrative Segregation. The audit team observed custody and medical staff working collaboratively to ensure processes were completed within policy guidelines.

Operations:

The audit team interviewed several clinical staff, custody staff, and inmate-patients regarding the daily operations of the facility. Below is a summary of those interviews:

Health Service Administrator (HSA): The auditors interviewed the HSA several times during the onsite audit in order to ascertain the HSA's knowledge of the daily operations of the medical clinic, emergency response and drills, grievance appeals and sick call processes. The HSA demonstrated a solid understanding of all operational activities and processes in the medical clinic.

During the facility tour, the auditors observed that the HSA had implemented the recommendation made by the HPS I-auditor during the previous audit and created Medical binders with Sick call (English and Spanish) and *602 HC Grievance/Appeal* forms and placed them in all housing units. While in the housing units the HPS I-auditor requested custody staff show them the various medical forms; some of the newly hired custody staff could not identify the requested forms. Consequently, during the exit conference, the HPS I-auditor informed the HSA and warden of this issue, the warden affirmed that the custody staff would be trained on the sick call and grievance appeal process. The warden ensured all

concerned parties they would familiarize all custody with the pertinent forms routinely requested for use by inmate-patients.

ADA Coordinator: The ADA Coordinator was out of office at the time of the onsite audit; however was available via telephone for a telephonic interview. The HSA assumed the responsibilities of the ADA Coordinator in her absence. The HPS I-auditor interviewed the ADA coordinator regarding the process for tracking and monitoring Disability Placement Program (DPP) inmate-patients. It was learned during the interview that since the prior audit, the ADA coordinator has created DPP binders and placed them in each of the housing units for custody staff's reference. These binders include the inmate-patients names, CDCR numbers, DPP classifications, housing restrictions and details on the type of accommodation provided to these inmate-patients.

The ADA coordinator stated that she conducts bi-weekly checks on all DPP inmate-patients to make sure their needs are being met. While onsite the HPS I-auditor conducted DPP inmate-patient interviews, which confirmed that the ADA Coordinator was performing the duties as stated. However, the ADA Coordinator was not documenting in the EMR that effective communication was established during DPP inmate-patient encounters. The HPS I-auditor advised the ADA coordinator to document all DPP inmate-patient encounters by documenting that effective communication was utilized during each encounter. The ADA coordinator was receptive to the recommendation and agreed to document all DPP inmate-patient encounters. This requirement will be continually monitored to ensure compliance during subsequent audits.

While being escorted throughout the facility the HPS I-auditor requested custody staff identify the DPP inmate-patients housed in their units. The majority of the custody staff could not identify the DPP inmate-patients. This issue was brought to the warden's attention during the exit conference; the warden assured the auditors that all custody staff would be adequately trained per the requirements stated under Section IV Field Operations, section I-institution procedures, item 3. Special identification, in the *Armstrong Remedial Plan:* "Each institution/facility (DPP designated institution, nondesingated institution, and reception center), shall ensure custody staff in housing units where an inmate with impairments that impact placement resides, maintain a copy of the identification card/picture for that inmate with the inmate roster, to alert unit staff of the special needs of the inmate during count, emergency evacuation, verbal announcements, etc. Special needs may include personal notification for hearing impaired inmate or assistance provided to vision impaired inmate in responding to ducats or emergency evacuations. These procedures shall also be incorporated into unit staff's post orders."

During the previous audit, the ADA coordinator had voiced some concerns to the HPS-1 auditor relating to two DPP inmate-patients. The HPS I-auditor readdressed these concerns during the audit and was informed that all issues have been corrected. While the HPS I-auditor conducted DPP inmate-patient interviews, the concerns that were addressed by the ADA coordinator were confirmed by the inmate-patients, the inmate-patients also confirmed that the issues had been remedied.

Grievances/Appeals Coordinator: One of the Clinical Nurse Supervisors acts as the Appeals Coordinator and is responsible for processing and completing all first level Health Care appeals. During the interview the Appeals Coordinator exhibited a thorough understanding of the grievance/appeals process when interviewed. The Appeals coordinator maintains a log of all first level health care appeals. Review of the

log maintained by the facility Appeals Coordinator confirmed that all but one first level healthcare appeal was processed in a timely manner. However, upon return from the audit, the HPS I-auditor consulted with PPCMUs second level appeals coordinator, who revealed several deficiencies within the first level appeals log when compared with second level appeals log. The discrepancies are as noted below:

1. TCCF does not date stamp the first level health care appeals upon receipt. Therefore, the date the appeal was received cannot be verified; the date documented on the 1st level appeals log is currently considered as the date the appeal was received.
2. Appeals Coordinator does not consistently document the date of completion on the *602 HC Grievance/Appeal forms* when the appeal processing is completed and mailed/delivered to the inmate-patient. This makes it difficult to verify the actual date of completion of first level appeals process.
3. The tracking numbers assigned to first level health care appeals does not consistently match with the tracking numbers documented on the first level health care appeals log.
   This conflicting information raises the question whether the appeals coordinator is responding to health care appeals within the 30 day timeframe.
4. The tracking number and dates on several of the second level health care appeals received at CCHCS does not match the tracking number and dates documented on the first level heath care appeals log.

Even though TCCF received a passing score for the questions related to Grievance/Appeal in the Quantitative section of the report, they will need to place a higher level of cognizance when processing 1st level health care appeals. It is the recommendation of the audit team that the HSA review all 1ST level health care appeals prior to being delivered to the inmate-patient, by making sure that all information is accurately captured in the 1st level health care appeals log.

TCCF Health Care Staff: The Main Medical Facility is staffed twenty-four hours, seven days a week, mainly focusing on inmate processing, transfer of inmates, and providing general and emergency medical services.

The CCHCS physician-auditor conducted an interview with the facility Supervising Physician, Physician Assistant, Nurse Practitioners and the HSA to discuss the key elements of the intake and flow of new inmate-patient arrivals, staffing issues, chronic care, sick call, emergency response and formulary restrictions and overrides. The physician-auditor also discussed with the medical providers, where he highlighted areas of excellence and areas that require improvement.

The physician-auditor met with all TCCF providers starting with the supervising physician. The supervising physician provides oversight of the newly hired Nurse Practitioner (NP); he meets with her on a daily basis and reviews her documentation in the charts for completeness and accuracy. The supervising physician seems to be very open to discussion and explains the appropriate delivery of medical care when the NP seeks his guidance. During the onsite audit the physician-auditor reviewed the supervising physician's clinical notes and observed that his notes were very brief and to the point; however the physician was observed to provide appropriate medical care to the inmate-patients during his clinical encounters. The physician-auditor addressed the issue with brief documentation with the

supervising physician and the Regional Medical Director; the supervising physician agreed to make his clinical notes more detailed in the future.

The physician-auditor also met with the other physician assigned to "P" Medical. The facility physician was observed by the physician auditor demonstrating her commitment to the inmate-patients in her yard by providing a constitutional level of health care to the inmate-patients that she oversees. The physician routinely signs off on diagnostic test results and meets with the inmate-patient to discuss the results.

The physician-auditor also met with the newly hired NP, who had only been treating the inmate-patient population for three weeks at the time of the audit. The physician-auditor raised concern that the NP had a limited ability for treating chronic care inmate-patients as her specialization was in emergency room and outpatient urgent care settings. The physician-auditor addressed this with the Regional Medical director, who stated that the supervising physician will closely monitor NP's Chronic Care evaluations. The physician-auditor reviewed several clinical notes from the NP which showed that the NP lacked a description of symptoms without labels or diagnosis being assigned. An example for this was a case of an inmate-patient with abdominal pain where the NP did not give a differential diagnosis for the inmate-patient's condition. The physician-auditor discussed this with the supervising physician and he agreed to meet with the NP and educate her on the appropriate clinical documentation.

During the exit conference the physician-auditor summarized his findings, several areas were identified that required immediate attention. The Regional Medical Director, supervising physician and the HSA will be working collaboratively to ensure that these issues are addressed. Below are the concerns brought to light by the physician-auditor at TCCF:

1. None of the providers are knowledgeable on *Title XV* requirements.
2. All providers review diagnostic reports on a daily basis, even when they are out of office; however, there is no process in place to review, find errors or omissions, or documenting that the reviews are completed in specified time frames. This is a Quantitative CAP item that the HSA will be working on to rectify.
3. There is no process in place to assure that a follow up visit is scheduled within 14 days if a request for services is denied. Currently the scheduler notifies the LIP that the request was denied, but there is no system in place to follow CDCR guidelines. This is a TCCF internal process, in which the HSA devising a plan of action.
4. The providers raised concern about missed lab orders. Often, when an order for a laboratory study is ordered and the specimen is not collected, there is no system in place to notify the provider that the blood draw was not completed. This is an internal process, in which the HSA is devising a plan of action with medical staff to communicate better with the medical providers.
5. Currently, there is a problem with timely uploading of diagnostic test results from "Bioreference Labs" into the EMR. The existing practice is that a laboratory person faxes the results to each provider weekly. This practice does not meet current IMSP&P requirement which states that the diagnostic test results are to be reviewed by the LIP within two business days of receipt of results. A system needs to be implemented to meet this

guideline; or the facility's IT department has to devise a process to integrate outside results into the EMR system. CCA is currently working with Bioreference Labs and the TCCF IT department to devise a plan of action for receiving laboratory results in a timely manner.

The physician and nurse auditors met with the Continuous Quality Improvement (CQI) nurse to review the Quarterly CQI meeting minutes, review and discuss the CAP from previous audit. There was some confusion during the interview in regards to the documentation needed for the June 2014 audit CAP. The CQI nurse could not produce any proof of practice documents requested by the auditors, resulting in the identified items remaining open until proof of practice documents are submitted. During the interview with the CQI nurse, the HSA was present. When the auditors asked questions to the CQI nurse, the HSA constantly interrupted the CQI nurse and answered auditor's questions on the nurse's behalf. During the interview when the auditors asked specific questions to the CQI nurse, the CQI nurse's responses were observed to be slower and more methodical at times the HSA would get frustrated and rebuke the CQI nurse. An example for this rude behavior was when the CQI nurse had difficulty locating information in the EMR for the auditors, the HSA remarked, "Marshall don't act like you haven't worked in the EMR before,". The HSA immediately grabbed the mouse from the nurse and located the requested information promptly. The auditors found this to be highly unprofessional and concluded the interview with the CQI nurse shortly thereafter.

The auditors recommend that the CQI nurse function independently in her new position in order for her to fully comprehend her role and responsibilities as the CQI nurse. Since the HSA had been previously handling the responsibilities of CQI, and the audit team recommends that HSA relinquish her CQI duties and allow the current CQI nurse to assume all functions related to the position.

During a post audit telephone conversation, the Regional Nursing Advisor and HPS I-auditor discussed the findings of the audit. During this conversation a dialogue was held about the auditor's observations of the HSA and CQI interaction and the above recommendations were reiterated to the Regional Nursing Director, who stated that she would have a discussion with the HSA to remedy the situation.

The nurse-auditor interviewed the Infection Control nurse (ICN). The nurse-auditor discussed with the ICN the lack of availability of hand sanitizer in the medical clinics and the nursing staff's lack of practicing hand hygiene per industry standards. The ICN stated that they did have wipes that nursing staff use after each clinical encounter. The nurse-auditor stated that this was an inappropriate method of hand hygiene since the wipes are not meant for hand sanitation and is only to be used for cleaning the high touch surface areas. The nurse-auditor also brought to the attention of the ICN that the wipes packaging was labeled as hazardous and clearly states that the product was harmful to humans and could cause skin irritation. The ICN stated they don't have hand sanitizers in the medical clinic because she was unable to find any alcohol free hand sanitizer. The auditors researched hand sanitizers and found several different hand sanitizers without alcohol and provided this information to the HSA during the exit conference. The HSA stated that she would place an order for the hand sanitizers immediately.

The nurse-auditor observed the nursing staff triaging inmate-patients during sick call clinic. All nursing staff were knowledgeable of the sick call process. All nurses utilized the EMR to document their face-to-face encounters with inmate-patients. When an inmate-patient required a higher level of care the nurses referred the inmate-patients to the physician.

While onsite the nurse-auditor also observed the RNs conducting medication pill pass in both the Main Medical Clinic and in "P" unit medical. All nursing staff followed all the medication distribution pass protocols. The nurse-auditor requested to see the Medication Administration Record (MAR) log for the inmate-patients who were being seen at the pill call window. The facility RN compared the inmate-patients' names and CDCR numbers to their MAR profile, the nurse-auditor did not find any discrepancies when observing medication pill pass. Main medical has a refrigerator that is used to store all medications that require refrigeration. The nurse-auditor checked the refrigerator temperature to ensure that the nursing staff is checking and logging the refrigerator temperature on a daily basis.

Emergency Response: The audit team observed a mock medical emergency drill that was staged in the Administrative Segregation unit, involving an inmate-patient with a bed sheet around his neck who was discovered in his smoke filled cell. A custody officer discovered the inmate-patient and called a Code 1 emergency in the Administrative Unit via institutional radio. Medical staff and custody staff arrived within one minute of the initial notification. Custody cut the inmate-patient down and medical staff assumed control of the incident by rolling the inmate-patient onto the back board and placing a C-collar around his neck. Medical staff conducted Cardio Pulmonary Resuscitation (CPR) and applied AED shocks when medically necessary. The inmate-patient was transported to Main Medical where CPR was continued until EMS arrived on scene.

Following the drill a debriefing was conducted, where deficiencies and compliance were identified. Some of the key deficiencies that were identified are as follows:

1. Custody staff cut the noose from the inmate-patient's neck but did not make two cuts when cutting the noose off. They also left the noose around the inmate-patients neck. Custody staff will be retrained on the proper method of cutting a noose off a hanging inmate-patient. During the drill, medical staff removed the noose from the inmate-patient's neck before placing the C-collar around his neck.
2. Custody staff did not remove the inmate-patient from the smoke filled room. In the event this was a real emergency, all involved participants would have been placed in harm's way and the ability to provide patient care would have been hampered.
3. The Emergency Medical Response Drill Response Drill Checklist/Review notated that medical staff used 1.5 mg of Lidocaine when treating the inmate-patient. The physician-auditor made the recommendation that the facility should use Atropine in lieu of using Lidocaine.

STAFFING UTILIZATION

Prior to the onsite audit at TCCF, 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, October 21-23, 2014, revealed no vacant positions. The following table is a summary of the staffing and findings of the review.

Tallahatchie, MS/CDCR Total Population: 2,682

Primary Care	Original Contract FTE	Current Required FTE	Variance
Senior Physician	1.0	1.0	-
Physician	1.0	1.0	-
ARNP/PA	2.0	2.0	-
ARNP/PA (contract)	0.0	0.0	-
Total Primary Care	**4.0**	**4.0**	**-**
CCA Management			
Deputy Director/ Senior Health Services Administrator	1.0	1.0	-
Health Services Administrator	1.0	1.0	-
Clinical Supervisor	2.0	2.0	-
Total CCA Management	**4.0**	**4.0**	**-**
Nursing Services			
Staff RN (7 day)	12.0	12.0	-
Staff RN (5day)	1.0	1.0	-
RN-CQI	1.0	1.0	-
Coordinator, Infectious Disease	1.0	1.0	-
RN Total	**15.0**	**15.0**	**-**
LPN's			
Staff LPN/LVN (5 day)	6.0	6.0	
Staff LPN/LVN (7 day)	8.0	8.0	
Pharmacy Tech/LPN	2.0	2.0	-
LPN Health Information Specialist	1.0	1.0	-
Phlebotomist	1.0	1.0	-
CMA	2.0	2.0	-
LPN Total	**20.0**	**20.0**	**-**
Total Nursing	**35.0**	**35.0**	**-**

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. The Disability & Effective Communication Roster was utilized to obtain a pool of inmates to interview to determine if their accommodations were being met as it relates to their DPP disability as well as their knowledge of 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

CCHCS staff requested to interview 13 inmate-patients during this onsite audit. The following comments are provided as a summary of their responses to the standardized questions:

1. Questions 1 – 4: The auditor interviewed 13 inmate-patients on the sick call process. All inmate-patients knew where to locate the sick call request forms and how to submit them, and were knowledgeable of the process.

2. Questions 5 – 8: The auditor interviewed 13 inmate-patients on the Grievance/Appeal process. All inmate-patients knew where to locate the Grievance/Appeal request forms and how to submit them. All inmate-patients were knowledgeable of the process.

3. Questions 9 – 23: The auditor interviewed 13 DPP inmate-patients. While conducting the interviews, for two of the DPP inmate-patients, the auditor utilized the language interpreter to translate the questions. 11 inmate-patients knew the process to request reasonable accommodation. The other two inmate-patients arrived at TCCF two weeks prior to the onsite audit and had not yet received orientation from the ADA coordinator. The HPS I-auditor informed the two inmate-patients that the ADA coordinator was on leave but in the interim the HSA was their point of contact. The HPS I- auditor informed the HSA that these two inmate-patients had not had a face-to-face with the ADA coordinator, she stated that she would bring these two inmate-patients to medical as soon as possible.