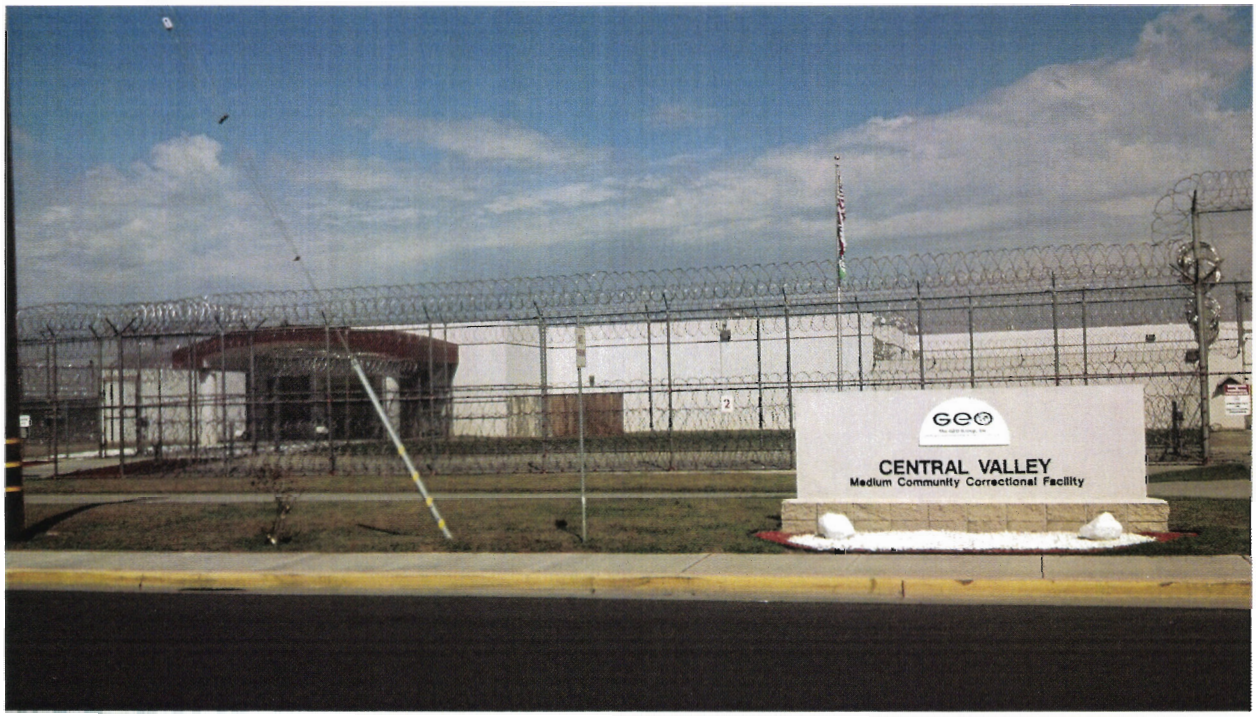
CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Contract Facility

Health Care Monitoring Audit



Central Valley

Modified Community Correctional Facility

January 26 - 27, 2015

TABLE OF CONTENTS

DATE OF REPORT

March 10, 2015

INTRODUCTION

As a result of an increasing inmate population and a limited capacity to house inmates, the California Department of Corrections and Rehabilitation (CDCR), entered into contractual agreements with private prison vendors. 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 which includes medical records, monitoring reports, staffing rosters, Disability Placement Program (DPP) list, and other relevant health care documents. An onsite assessment is completed by conducting various 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 from January 26 through 27, 2015, at Central Valley Modified Community Correctional Facility (CVMCCF), which is located in McFarland, California. At the time of the audit, CDCR's *Weekly Population Count*, dated January 30, 2015, indicated that CVMCCF had a design capacity of 700 beds, of which 673 were occupied with CDCR inmates.

EXECUTIVE SUMMARY

From January 26 through 27, 2015, Field Operations staff conducted an onsite audit at CVMCCF. The audit team consisted of the following personnel:

Patricia Matranga, Registered Nurse
Steven Moulios, DO, Regional Physician Advisor
Susan Thomas, Health Program Specialist I (HPS I)
Vera Lastovskiy, HPS I

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

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.

CVMCCF achieved an overall compliance rating of **89.6%,** based on the quantitative audit; with a rating of 90.8% in Administration, 85.7% in Delivery, and 96.9% in Operations. Table 2 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 89.6% is an increase of 3.3 percentage points from the overall compliance rating of 86.3% achieved during the July, 2014 audit. The completed quantitative audit, summary of qualitative findings, and CAP request are attached for your review.

Table 1

Quantitative Compliance Ratings	Points Possible	Points Awarded	Score	CAP Required
Administration				
1. Administration	180.0	180.0	100.0%	No
2. Access to Health Care Information	80.0	80.0	100.0%	No
6. Continuous Quality Improvement (CQI)	10.0	0.0	0.0%	Yes
13. Licensure and Training	160.0	160.0	100.0%	No
15. Monitoring Logs	120.0	71.1	59.3%	Yes
20. Staffing	90.0	90.0	100.0%	No
Administration Sub Score:	**640.0**	**581.1**	**90.8%**	
Delivery				
5. Chronic Care	60.0	44.5	74.2%	Yes
7. Diagnostic Services	120.0	98.9	82.4%	Yes
8. Medical Emergency Services/Drills	170.0	130.0	76.5%	Yes
9. Medical Emergency Equipment	290.0	260.0	89.7%	No
14. Medication Management	220.0	166.0	75.5%	Yes
17. Patient Refusal of Medical Treatment	20.0	20.0	100.0%	No
18. Sick Call	260.0	236.0	90.8%	No
19. Specialty/Hospital Services	150.0	150.0	100.0%	No
Delivery Sub-Score:	**1,290.0**	**1,105.4**	**85.7%**	
Operations				
3. ADA Compliance	60.0	60.0	100.0%	No
4. Chemical Agent Exposure	N/A	N/A	N/A	N/A
10. Grievance/Appeal Procedure	50.0	50.0	100.0%	No
11. Infection Control	160.0	150.0	93.8%	No
12. Initial Intake Screening/Health Appraisal	300.0	292.5	97.5%	No
16. Observation Unit	N/A	N/A	N/A	N/A
Operations Sub-Score:	**570.0**	**552.5**	**96.9%**	
21. Inmate Interviews (not rated)				
Final Score:	**2,500.0**	**2,239.0**	**89.6%**	

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 07/2014	Audit II 01/2015	Variance Increase/(Decrease)
1. Administration	100.0%	100.0%	0.0%
2. Access to Health Care Information	75.0%	100.0%	25.0%
3. ADA Compliance	100.0%	100.0%	0.0%
4. Chemical Agent Exposure	N/A	N/A	N/A
5. Chronic Care	93.3%	74.2%	-19.1%
6. Continuous Quality Imprvement (CQI)	0.0%	0.0%	0.0%
7. Diagnostic Services	84.8%	82.4%	-2.4%
8. Medical Emergency Services/Drills	92.9%	76.5%	-16.4%
9. Medical Emergency Equipment	87.2%	89.7%	2.5%
10. Grievance/Appeal Procedure	100.0%	100.0%	0.0%
11. Infection Control	98.4%	93.8%	4.6%
12. Initial Intake Screening/Health Appraisal	100.0%	97.5%	-2.5%
13. Licensure and Training	100.0%	100.0%	0.0%
14. Medication Management	77.1%	75.5%	-1.6%
15. Monitoring Logs	0.0%	59.3%	59.3%
16. Observation Unit	N/A	N/A	N/A
17. Patient Refusal of Health Care Treatment/No Show	63.4%	100.0%	36.6%
18. Sick Call	94.3%	90.8%	-3.5%
19. Specialty/Hospital Services	77.8%	100.0%	22.2%
20. Staffing	100.0%	100.0%	0.0%
Overall Score:	86.3%	89.6%	3.3%

METHODOLOGY

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

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

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

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

- 85% for each chapter within the final audit instrument.

Compliance and non-compliance are defined as follows:

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

The methodology utilized by the audit team for determining compliance with each standard measure in the audit is described in detail in the *Instruction Guide for the Contracted Facilities Health Care 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 facility demonstrates compliance of less than 100% are assigned partial compliance scores by the method shown above.

Chapter scores are calculated by dividing the total points assessed in each chapter by the total points possible for that chapter, and multiplying by 100 to yield an overall percentage. For example, a chapter with 10 questions may have a total of 180.0 possible points. If during an audit a facility earns 140.0 of those points, the chapter score will be calculated as follows: 140.0 ÷ 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 facility. As with individual chapter scores, the compliance percentage for each operational area is calculated by dividing the total points earned by the total points available in that area, and multiplying by 100 to yield a percentage. The final overall quantitative score is calculated by the same method.

Scoring for Non-Applicable Questions and Double-Failures:
For questions that are not applicable to the facility being audited, or where a single deviation from policy would result in multiple question failures, the weighted values of such questions are subtracted from the applicable points for the component.

CORRECTIVE ACTION PLAN REQUEST

The chart below reflects all quantitative analysis items where the facility was rated non-compliant, as well as any qualitative analysis items requiring a response from the facility. The audit results for CVMCCF require the facility to develop a CAP for the following specific items. The facility's response must be received no later than 30 days from the date of this report; specifically **April 10, 2015.**

Corrective Action Items – Central Valley Modified Community Correctional Facility, McFarland, CA	
Chapter 5, Question 1	Chronic care follow-up visits are not consistently completed within the 90-day or less timeframe, or as ordered by the Primary Care Provider (PCP).
Chapter 5, Question 2	The physician does not consistently document health care education regarding the inmate-patients chronic care condition during the Chronic Care Clinic.
Chapter 6, Question 1	The facility does not have an approved Continuous Quality Improvement (CQI) plan.
Chapter 7, Question 2	The PCP does not consistently review, initial and date all inmate-patient diagnostic reports within the specified timeframe.
Chapter 7, Question 3	The PCP does not see the inmate-patient for a follow-up visit for clinically significant diagnostic test result consistently within the specified timeframe.
Chapter 7, Question 4	Inmate-patients do not receive written notification of diagnostic tests consistently within the specified timeframe.
Chapter 8, Question 7	The facility does not have an established Emergency Response Review Committee (ERRC).
Chapter 8, Question 11	The PCP does not participate in the quarterly emergency medical drills, the minutes do not have documentation that the PCP responds to the emergency drill within eight minutes of the emergency medical alarm.
Chapter 14, Question 2	The PCP does not consistently document the inmate-patient education for newly prescribed medications.
Chapter 14, Question 9	The registered nurse (RN) does not consistently check the inmate-patient's mouth, hands and cup after administering Directly Observed Therapy (DOT) medications.
Chapter 15, Question 1	Inmate-patients are not consistently being seen within the timeframes set forth in the sick call policy.
Chapter 15, Question 2	Inmate-patients are not consistently being seen within the timeframes set forth in the specialty care policy.
*Qualitative Action Item 1 (Chapter 9, Question 1)	Emergency response bags are not being inspected on each shift to ensure the seal is secure.
*Qualitative Action Item 2 (Chapter 11, Question 6)	The inmate-patient clinic area (chair) used during the inmate-patient examination is not cleaned after each inmate-patient use.

*Qualitative Action Item 3 (Chapter 12, Question 12)	Inmate-patients are not consistently receiving orientation regarding the procedures for accessing health care at the initial intake screening.
*Qualitative Action Item 4 (Chapter 18, Question 2)	The RN is not reviewing sick call request forms on the same day of receipt.
*Qualitative Action Item 5 (Chapter 18, Question 5)	The RN is not consistently performing a face-to-face evaluation within the next business day if the health care request slip indicated a non-emergent health care need.
*Qualitative Action Item 6 (Chapter 18, Question 6)	The RN is not consistently completing S.O.A.P.E notes on the CDCR Form 7362, Health Care Services Request and/or CDCR Form 7230, Interdisciplinary Progress Notes or a similar MCCF form.
*Qualitative Action Item 7 (Chapter 18, Question 7)	The inmate-patient is not being seen within the specified timeframes when referred to the HUB or MCCF PCP by the MCCF RN.
Qualitative Action Item 8	A peer review of the PCP is not conducted annually.1
Qualitative Action Item 9	The PCP is not knowledgeable on Title XV.

*Qualitative action items 1 through 7 are failed questions from passing (85% or higher) quantitative chapters.

[1] Inmate Medical Services Policy & Procedure, Vol. III, Chapter 4(II)(B)

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
4. Does the facility have a written policy and/or procedure related to the maintenance/management of the Unit Health Records (UHR)?	10.0	10.0
5. Does the facility have a written policy that addresses the requirements for the release of medical information?	10.0	10.0
6. Does the facility have a written policy and/or procedure related to the Chemical Agent/Use of Force process?	10.0	10.0
7. Does the Chemical Agent/Use of Force policy and/or procedure contain a decontamination process?	10.0	10.0
8. Does the facility have a written policy and/or procedure related to Chronic Care?	10.0	10.0
9. Does the facility have a written policy and/or procedure related to Health Screening?	10.0	10.0
10. Does the facility have a written policy and/or procedure related to the History and Physical (H&P) examination?	10.0	10.0
11. Does the facility have a written policy and/or procedure related medication management?	10.0	10.0
12. Does the facility have a written policy and/or procedure related to the Sick Call Process?	10.0	10.0
13. Does the facility have a written policy and/or procedure related specialty services?	10.0	10.0
14. Does the facility have a written policy and/or procedure related ADA?	10.0	10.0
15. Does the facility have an Infection Control Plan?	10.0	10.0
16. Does the facility have a written policy and/or procedure related to Bloodborne Pathogen Exposure?	10.0	10.0
17. Does the facility have a written policy and/or procedure related to licensure and training?	10.0	10.0
18. Does the facility have a written policy and/or procedure related to Emergency services?	10.0	10.0
Final Scoring:	180.0	180.0
		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 copied and forwarded weekly to the Hub to be scanned into the eUHR?	10.0	10.0
3. Does the facility have and maintain a Release of Information (ROI) log?	10.0	10.0
4. Does the ROI log contain all required information?	10.0	10.0
5. Are all inmate-patient's written requests for Release of Health Care Information documented on the CDCR 7385 Authorization for Release of Information form or similar form?	10.0	10.0

6. Are all written requests from inmate-patients documented on a ROI log?	10.0	10.0
7. Are all inmate-patient's written requests for health care information filed in the MCCF's shadow file and in the Medico-Legal or miscellaneous section of the eUHR?	10.0	10.0
8. Are all inmate-patients written requests for release of health care information noted in a progress note in the MCCF's shadow file and in the eUHR?	10.0	10.0
9. Are all written requests for release of health care information from Third Parties accompanied by a valid CDCR 7385 Authorization for Release of Information form or similar form?	10.0	N/A
10. Are all written requests from Third Parties documented on a ROI log?	10.0	N/A
11. Are all written requests of release of information from Third Parties filed in the MCCF's shadow file and in the Medico-Legal or miscellaneous section of the eUHR?	10.0	N/A
Final Scoring:	110.0	80.0 (80.0)
		100%

CHAPTER 2 COMMENTS

1. Questions 9 through 11 – Not applicable. The facility has not had any third party requests for health care information during the 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. In the event of Chemical Agent exposure, if an inmate-patient refuses decontamination, did the facility staff document that he/she was given direction on how to self-decontaminate?	10.0	N/A
2. In the event of Chemical Agent exposure, if an inmate-patient refuses decontamination, did the health care staff monitor the inmate-patient every 15 minutes for a minimum of 45 minutes?	10.0	N/A

Final Scoring:	20.0	N/A
		N/A

CHAPTER 4 COMMENTS

1. Questions 1 through 2 – Not applicable. There were no inmate-patients exposed to a chemical agent during the audit review period; therefore, these questions were not 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 PCP?	30.0	27.0
2. Did the PCP provide health care education to inmate-patients regarding their chronic care condition during the last Chronic Care Clinic (CCC) follow-up visit?	30.0	17.5
3. If an inmate-patient refuses CCC services, is a Refusal of Treatment form completed?	30.0	N/A
4. If an inmate-patient refuses CCC services, is the inmate-patient referred to the PCP?	30.0	N/A
Final Scoring:	120.0	44.5 (60.0)
		74.2%

CHAPTER 5 COMMENTS

1. Question 1 – Of the ten shadow medical files reviewed, nine included documentation that the chronic care follow-up visit had been completed within the 90-day or less timeframe, or as ordered by the PCP. This equates to 90.0% compliance. This is an improvement from the previous score of 85.7% compliance in this area.
2. Question 2 – Of the twelve shadow medical files reviewed, seven included documentation that the PCP provided health care education to inmate-patients regarding their chronic care condition during the last chronic care clinic follow-up visit. This equates to 58.3% compliance. This is a significant decline from the previous audit rating of 100% compliance.
3. Questions 3 through 4 – Not applicable. During the audit review period, there were no documented instances of inmate-patients refusing their chronic care appointments.

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

Final Scoring:	60.0	0.0 (10.0)
		0.0%

CHAPTER 6 COMMENTS

1. Question 1 – The facility does not have an approved CQI plan. This equates to 0.0% compliance. This remains an unresolved CAP item from the previous audit.
2. Questions 2 through 6 – These questions automatically fail as the result of the failure described in question 6.1. Under the double-failure rule, the points for this question have therefore been removed from the total available points, and the questions 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 PCP?	30.0	30.0
2. Does the PCP review, initial, and date an inmate-patient's diagnostic reports within two days of receipt?	30.0	21.8
3. Was the inmate-patient seen by the PCP for a follow-up visit for a clinically significant diagnostic test result within 14 days, or as clinically indicated, from the date the test results were reviewed by the PCP?	30.0	22.5
4. Was the inmate-patient given written notification of the diagnostic test results within two days of receipt?	30.0	24.6
Final Scoring:	120.0	98.9
		82.4%

CHAPTER 7 COMMENTS

1. Question 2 - Of the eleven shadow medical files reviewed wherein the shadow medical files contained inmate-patient diagnostic reports, eight included documentation that the PCP had reviewed, initialed, and dated the inmate-patient's diagnostic reports within the required timeframe. This equates to 72.7% compliance. This is a slight decline from the previous audit rating of 75.0% compliance. This remains an unresolved CAP item from the previous audit.
2. Question 3 - Of the eight shadow medical files reviewed wherein the shadow medical files contained clinically significant diagnostic reports; six had been seen by the PCP for a follow-up visit within the required timeframe, or as clinically indicated, from the time the test results had been reviewed by the PCP. This equates to 75.0% compliance. The compliance rating remains unchanged from the previous audit. This remains an unresolved CAP item from the previous audit.
3. Question 4 - Of the eleven shadow medical files reviewed containing diagnostic test results, nine inmate-patients received written notification of their diagnostic test results within 2 days of receipt. This equates to 81.8% compliance. This is a slight decline from the previous audit rating of 88.9% compliance. This remains an unresolved CAP item from the previous audit.

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	30.0	30.0

during medical emergencies?		
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	N/A
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	N/A
6. When an inmate-patient returns from a community hospital emergency department, does the inmate-patient receive a follow-up appointment with a PCP within five calendar days of discharge or sooner as clinically indicated from the day of discharge?	30.0	N/A
7. Is there documentation that the Emergency Response Review Committee has met at least once a month?	10.0	0.0
8. In the documentation of the Emergency Response Review Committee meetings, does the committee discuss and/or implement a quality improvement action after reviewing the results of an emergency medical response and/or emergency medical response drill?	10.0	N/A
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	0.0
Final Scoring:	270.0	130.0 (170.0)
		76.5%

CHAPTER 8 COMMENTS

1. Questions 4 through 6 – Not applicable. There were no inmate-patients sent out to a community hospital or emergency room during this audit review period.
2. Question 7 – This facility does not have an established Emergency Medical Response Review Committee and is not holding meetings as required. This equates to 0.0% compliance. The compliance rating remains unchanged from the previous audit. This remains an unresolved CAP item from the previous audit.
3. Question 8 – Not applicable. This question automatically fails as the result of the failure described in question 7 delineated immediately above. Under the double-failure rule, the points for this question have therefore been removed from the total available points, and the question rendered non-applicable
4. Questions 11 – The facility PCP is the only ACLS certified staff member at the facility. The PCP is not participating in the emergency response drills. The facility quarterly emergency response drill minutes do not specify if the PCP participated in the drills. The PCP did not participate in the drill performed during the onsite audit. This equates to 0.0% compliance.

Chapter 9: Medical Emergency Equipment	**Point Value**	**Points Awarded**
1. For each shift, do staff document that all Emergency Medical Response Bags in each clinic are secured with a seal?	30.0	0.0
2. Is there documentation, after each medical emergency, that all Emergency Medical Response Bags in each clinic are re-supplied and re-sealed?	30.0	N/A
3. Does the facility have functional Portable suction?	50.0	50.0

4. Is there documentation that the Portable suction in each clinic is checked every shift for operational readiness?	30.0	30.0
5. Does the facility have oxygen tanks?	50.0	50.0
6. Is there documentation that the oxygen tanks in each clinic is checked every shift for operational readiness (at least three-quarters full)?	30.0	30.0
7. Does the facility have a contract for routine oxygen tank maintenance service?	30.0	30.0
8. Is there documentation that the Automated External Defibrillator (AED) in each clinic is checked every shift for operational readiness?	30.0	30.0
9. Are first aid kits located in designated areas?	10.0	10.0
10. Do the first aid kits contain all required items?	10.0	10.0
11. Are spill kits located in the designated areas?	10.0	10.0
12. Do the spill kits contain all required items?	10.0	10.0
Final Scoring:	320.0	260.0 (290.0)
		89.7%

CHAPTER 9 COMMENTS

1. Question 1 – The facility is not documenting that the Emergency Medical Response Bag seal inspections in the clinic on every shift. This equates to 0.0% compliance. The compliance rating remains unchanged from the previous audit. This remains an unresolved CAP item from the previous audit.
2. Question 2 – Not applicable. There were no medical emergencies during this audit review period.

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 the 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. Are disposable instruments discarded after one use?	10.0	10.0
2. Are inmate-patients who come to the clinic with a potential communicable disease isolated from the rest of the inmate-patients in the clinic area?	10.0	10.0
3. Does the staff practice hand hygiene?	30.0	30.0
4. Is personal protective equipment (PPE) (i.e. gloves, masks, face shields, gowns) available for staff use?	10.0	10.0

5. Does the facility have hand sanitizers which are maintained and available for staff use?	10.0	10.0
6. Is the inmate-patient clinic area cleaned after each inmate-patient use?	10.0	0.0
7. Is environmental cleaning of "high touch surfaces" completed within the medical clinic at least once a day?	10.0	10.0
8. Are biohazard materials placed in biohazard material labeled containers?	10.0	10.0
9. Are biohazard material containers picked up from the central storage location on a regularly scheduled basis?	10.0	10.0
10. Is central storage area for biohazard material labeled and locked?	10.0	10.0
11. Are sharps placed into a puncture resistant, leak-proof container that is closeable, locked, and labeled with the biohazard symbol?	10.0	10.0
12. Does the facility account for all sharps (needles, scalpels, etc.) by documenting the number at the end of each shift?	10.0	10.0
13. Does the facility have a process to reconcile the sharp count if needed?	10.0	10.0
14. Does the facility secure sharps?	10.0	10.0
Final Scoring:	160.0	150.0 (160.0)
		93.8%

CHAPTER 11 COMMENTS

1. Question 6 – The chair used during inmate-patient encounters is not cleaned after each inmate-patient 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. Did the inmate-patient receive a complete H&P exam by a PCP ≤ 14 calendar days of arrival at the facility?	30.0	30.0
3. If an inmate-patient was referred to a PCP by nursing staff during the Initial Intake Screening, was the inmate-patient seen in the specified time frame? (Immediately, within 24 hours, or within 72 hours)	30.0	N/A
4. Was the inmate-patient who presented with an urgent medical, dental or mental health symptoms upon arrival given an immediate referral to appropriate health care professionals for emergency care, prescription management, or modality authorization?	30.0	N/A
5. If an inmate-patient presents with medical, dental, or mental health symptoms upon arrival does the nurse contact the Hub?	30.0	N/A
6. If an inmate-patient was referred for a follow-up medical, dental or mental health appointment, was the appointment completed?	30.0	N/A
7. Does the MCCF RN compare the medication profile received from the sending facility/institution with the medications the inmate-patient arrived with?	30.0	30.0
8. Did the nurse identify current prescription medication orders and have the medication re-ordered within 8 hours of arrival or was the inmate-patient seen by a PCP within 24 hours of arrival?	30.0	30.0
9. Does the MCCF RN consult with the Hub RN and/or specialty services schedulers to ensure the inmate-patient does or does not have any pending medical appointment?	30.0	30.0
10. Did the MCCF RN sign and date the CDCR 7371, Health Care Transfer Information form?	30.0	30.0
11. Did the PCP document the health appraisal/H&P on the intake H&P form, CDCR 196B?	30.0	30.0
12. At the initial intake screening, did all inmate-patients receive orientation regarding the procedures for accessing health care?	30.0	22.5
13. Did the inmate-patient receive a complete screening for the signs and symptoms of Tuberculosis (TB) upon arrival?	30.0	30.0

14. Did the inmate-patient receive a Tuberculin Skin Test (TST) evaluation upon arrival?	30.0	N/A
15. Does the initial intake screening take place in a manner that ensures inmate-patient confidentiality both visually and orally?	30.0	30.0
Final Scoring:	450.0	292.5 (300.0)
		97.5%

CHAPTER 12 COMMENTS

1. Question 3 – Not applicable. During the audit review period, no inmate-patients were referred to the PCP by nursing staff following the Initial Intake Screening.
2. Questions 4 through 5 – Not applicable. During this audit review period there were no inmate-patients presenting with urgent medical, dental or mental health symptoms..
3. Question 6 – Not applicable. During the review period there were no inmate-patients screened at intake with symptoms requiring referral for physician follow-up.
4. Question 12 – Out of four shadow medical files reviewed, three files contained documentation that the inmate-patient received orientation regarding the procedures for accessing health care at the initial intake screening. This equates to 75.0% compliance. The results indicate a significant decline from the previous audit rating of 100% compliance.
5. Question 14 – Not applicable. Due to a change in departmental policy, inmate-patients are not required to receive a tuberculin (TB) skin test evaluation upon arrival. Inmate-patients receive a TB skin test at the CDCR Reception Center upon arrival to the CDCR, and receive a TB test annually thereafter.

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), and/or Physician Assistant (PA)?	30.0	30.0
4. Are the BLS certifications current for the RN/Custody Staff?	30.0	30.0
5. Is there a method in place to address expired certifications/licenses?	10.0	10.0
6. Is there a centralized system in place to track training provided to health care staff?	10.0	10.0
7. Is there a system in place to ensure that health care staff receives training for new or revised policies that are based on Inmate Medical Services Policy and Procedures IMSP & P requirements?	10.0	10.0
8. Is annual training provided to medical staff?	10.0	10.0
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 PCP?	30.0	30.0
2. Did the prescribing PCP document that they explained the new medication to the inmate-patient?	30.0	6.0
3. Was a referral made to the PCP for a discussion for those inmate-patients who did not show for three consecutive days for medication administration or showed a pattern of missed doses?	30.0	N/A
4. Does the RN document the medication is administered on the Medication Administration Record (MAR) once the medication is given to the inmate-patient?	30.0	30.0
5. Are inmate-patient's no shows documented on the MAR?	10.0	N/A
6. Are inmate-patient's refusals for medication administration documented on the MAR?	10.0	10.0
7. Are medication errors documented on the Incident Report-Medication Error Form?	10.0	N/A
8. Does the RN directly observe an inmate-patient taking DOT medication?	30.0	30.0
9. Does the RN check every inmate-patient's mouth, hands and cup after administering DOT medications?	30.0	0.0
10. Does the inmate-patient take all Keep on Person (KOP) medications to the designated RN prior to transfer?	30.0	30.0
11. Does the RN verify the KOP medications against the current pharmacy medication profile prior to transfer?	30.0	30.0
Final Scoring:	270.0	166.0 (220.0)
		75.5%

CHAPTER 14 COMMENTS

1. Question 2 – Of the five shadow medical files reviewed, one included documentation showing that the PCP had provided patient education for the new medication. This equates to 20.0% compliance. The results indicate a significant decline from the previous audit rating of 62.5% compliance. This remains an unresolved CAP item.

2. Question 3 – Not applicable. There were no inmate-patients who had missed three consecutive doses or showed a pattern of missed doses of medications during the audit review period.

3. Question 5 – Not applicable. The nurse-auditor's review of shadow medical files and medication administration records revealed there were no inmate-patients who had not shown for pill call during this audit review period.

4. Question 7 – Not applicable. The nurse-auditor's review of shadow medical files and medication administration records revealed there were no medication errors during this audit review period.

5. Question 9 – The facility RN who administers DOT medications, does not consistently follow DOT medication protocols by checking to ensure the inmate-patients swallowed their medications. This equates to 0.0% compliance. This is a significant decline from the previous audit rating of 100% compliance.

Chapter 15: Monitoring Logs	Point Value	Points Awarded
1. Are inmate-patients seen within timeframes set forth in the sick call policy?	30.0	11.1
2. Are inmate-patients seen within the timeframes set forth in the specialty care policy?	30.0	0.0

3. Are inmate-patients seen within the timeframes set forth in the emergency/hospital services policy?	30.0	N/A
4. Are inmate-patients seen within timeframes as it relates to chronic care policy?	30.0	30.0
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	71.1 (120.0)
		59.3%

CHAPTER 15 COMMENTS

1. Question 1 – The auditors reviewed the sick call documents from the previous quarter and found incomplete documentation, specifically missing dates. Based on the availability only 43 of 116 inmate-patients were seen by the PCP within the specified timeframes. This equates to 37.1% compliance. This is an improvement from the previous rating of 0.0% compliance in this area; however this item remains as an unresolved CAP item from the previous audit.

Routine		Urgent		Emergent		Totals	
#	# within timeframe	#	# within timeframe	#	# within timeframe	#	# within timeframe
112	42	4	1	0	0	116	43

3. Question 2 – The specialty services monitoring log is not maintained, however, during the chart review, the RN-auditor identified one inmate-patient who was referred to the Hub for specialty services. Due to the inmate-patient not being identified on the monitoring log, the facility is non-compliant. This equates to 0.0% compliance. This remains an unresolved CAP item from the previous audit.

4. Question 3 – Not applicable. The facility did not refer any inmate-patients to a community emergency department or community hospital during the audit review period.

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 PCP?	10.0	N/A
2. Did the PCP document daily face-to-face encounters with all inmate-patients housed in the Observation Unit?	10.0	N/A
3. Is there a functioning call system in all Observation Unit rooms?	10.0	N/A
Final Scoring:	30.0	N/A
		N/A

CHAPTER 16 COMMENTS

1. Questions 1 through 3 – Not applicable. The facility does not have an 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/PCP 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/PCP document their discussion of risk and benefits of refusing the appointment/treatment in the inmate-patient's Medical Record?	10.0	10.0

3. If an inmate-patient did not show for their medical appointment, did the RN/PCP contact the housing unit supervisor to have the inmate-patient escorted to medical to speak with health care staff?	10.0	N/A
4. If an inmate-patient was a no show for a medical appointment/treatment, did the RN contact the PCP to determine if/when the inmate-patient should be rescheduled?	10.0	N/A
5. If an inmate-patient did not show for their medical treatment appointment, did the RN document the reason why the inmate-patient did not show up for their medical treatment?	10.0	N/A
Final Scoring:	50.0	20.0 (20.0)
		100%

CHAPTER 17 COMMENTS

1. Questions 3 through 5 – Not applicable. All inmate-patients presented to their medical appointments during the 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	25.0
3. If the sick call request reflected inmate-patients symptoms, was it reviewed by an RN within one business day?	30.0	30.0
4. Are inmate-patients seen and evaluated face-to-face by an RN/PCP if the sick call request form indicates an emergent health care need?	30.0	30.0
5. Did the inmate-patient have a Face-to-Face (FTF) evaluation within the next business day if the health care request slip review indicates a non-emergent health care need?	30.0	24.5
6. Was the S.O.A.P.E note on the CDCR Form 7362, Health Care Service Request and/or CDCR Form 7230, Interdisciplinary Progress Notes or a CCF similar form completed?	30.0	22.5
7. If an inmate-patient was referred to the Hub or MCCF PCP by the MCCF RN, was the inmate-patient seen within the specified timeframe?	30.0	24.0
8. If an inmate-patient presented to sick call three or more times in a one month period for the same complaint, was the inmate-patient referred to the PCP?	30.0	N/A
9. Does the RN maintain accurate and confidential medical records/shadow files?	10.0	10.0
10. Does the RN administrator ensure compliance with the inmate co-payment requirement?	10.0	10.0
11. If the MCCF RN/PCP determined the inmate-patient's request for medical services are beyond the level available at the facility, does the RN contact the medical Hub institution immediately?	30.0	N/A
12. If the MCCF RN/PCP determines the inmate-patient's request for medical services are beyond the level available at the facility, does the RN schedule a sick call appointment with the Hub for the inmate-patient and process the appropriate paperwork?	30.0	N/A
13. If the MCCF RN/PCP determines the inmates request for medical services are beyond the level available at the facility, does the RN obtain approval/authorization for the Hub CME or designee?	30.0	N/A
14. If the MCCF RN/PCP determines the inmate-patients request for medical services are beyond the level available at the facility, does the RN notify the appropriate MCCF staff to coordinate transportation?	30.0	N/A
15. Do the sick call visit locations provide for inmate-patient confidentiality both visually and orally in all housing units?	30.0	30.0
16. Are the sick call request forms readily available to inmate-patients in all housing units?	10.0	10.0

17. Are inmate-patients able to submit sick call request forms on a daily basis in secured/locked boxes in all housing units?	10.0	10.0
Final Scoring:	410.0	236.0 (260.0)
		90.8%

CHAPTER 18 COMMENTS

1. Question 2 – Of the 12 sick call requests reviewed, 10 requests were reviewed by an RN on the day of receipt. This equates to 83.3% compliance. This is a significant decline from the previous audit rating of 100% compliance.
2. Question 5 – Of the 12 sick call requests reviewed, 11 sick call requests indicated a non-emergent health care need. Of those 11, only 9 included documentation that the inmate-patient had a face-to-face (FTF) evaluation within the next business day. This equates to 81.8% compliance. This is a slight decline from the previous audit rating of 88.9% compliance.
3. Question 6 – Of the twelve sick call requests reviewed, nine shadow medical files included the S.O.A.P.E note on the CDCR Form 7362, *Health Care Service Request*, CDCR Form 7230, *Interdisciplinary Progress Notes*, or a similar MCCF form. This equates to 75.0% compliance. This is an improvement from the previous rating of 50.0% compliance in this area; however remains an unresolved CAP item.
4. Question 7 – Of five inmate-patients who were referred to the Hub or MCCF PCP by the MCCF RN, four were seen within the specified timeframe. This equates to 80.0% compliance. This is a significant decline from the previous audit rating of 100% compliance.
5. Question 8 – Not applicable. A review of twelve shadow medical files revealed no inmate-patients had presented to sick call three or more times in a one month period for the same complaint, during this audit review period.
6. Questions 11 through 14 – Not applicable. During the audit review period, no inmate-patient sick call request was beyond the level at the facility.

Chapter 19: Specialty/Hospital Services	**Point Value**	**Points Awarded**
1. Does pertinent information from the eUHR accompany the inmate-patient to the consultation appointment?	30.0	30.0
2. Does the MCCF RN follow utilization review procedures by seeking advance approval from the CME or designee at the Hub institution for any non-emergent care outside the facility?	30.0	30.0
3. Was the inmate-patient seen by the specialist within the timeframe specified by the PCP?	30.0	30.0
4. Did the RN complete a FTF evaluation upon the inmate-patient's return from a specialty consultation appointment?	30.0	30.0
5. When inmate-patient returns from a specialty consult appointment, does an RN notify the PCP of any immediate medication orders or follow-up instructions provided by the specialty consultant?	30.0	N/A
6. Does a PCP review the consultant's report and see the inmate-patient for a follow-up appointment within the specified timeframe? (≤ 3 days for emergent/urgent and ≤ 14 days for routine)	30.0	30.0
Final Scoring:	180.0	150.0 (150.0)
		100.0%

CHAPTER 19 COMMENTS

1. Question 5 – Not applicable. There was only one specialty service provided during the audit period. There were no immediate medication orders or follow-up instructions when inmate-patient returned to the MCCF from the specialty consult appointment.

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

CHAPTER 20 COMMENTS

None.

QUALITATIVE FINDINGS

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

The audit team conducted the qualitative analysis primarily via interview of key facility personnel. At CVMCCF the personnel interviewed included the following:

Mark Bowen – Warden
Cheng-Tsung Yeh - Medical Doctor/Primary Care Provider
Alexander Calvo – Compliance Administrator
Demetria Daniels – Registered Nurse (RN)/ Health Services Administrator (HSA)
Satvir Kaur – Registered Nurse

The following narrative represents a summary of the information obtained 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 categories: *Personnel,* which focus on the collaborative/cooperative relationship between essential offices and departments within the facility; and *Operations*, which focuses on operational efficiencies, inefficiencies, best practices, and challenges observed during the audit.

SUMMARY OF QUALITATIVE FINDINGS

Personnel:

Subsequent to the prior audit in July 2014, there has been a change in nurse staffing at CVMCCF. None of the nursing staff has attended training at the Hub institution on CCHCS IMSP&P. CVMCCF's failure in provisioning adequate training to the facility's new and existing medical staff has resulted in the facility's poor performance in key areas, such as chronic care, medical emergency services/drills, and medication management all which has adversely affected the overall score of this audit.

Operations:

The audit team interviewed several clinical and custody staff during the daily operations of the facility. Below is a summary of those interviews and additional findings.

CVMCCF Health Care Staff:

In general, CVMCCF's physician demonstrated an inadequate working knowledge of IMSP&P; California Code of Regulations, Title 15; and GEO's local and corporate policies and procedures. The facility physician stated he was not aware of the CCHCS Clinical Guidelines nor could he identify where to locate them. The facility physician was unaware of the Title 15 Guidelines on medical necessity. Upon returning from the audit, the physician auditor provided the guidelines to the facility. The facility physician reported he has never called the CDCR Hub seeking answers to medical questions, he

considers the HSA to be his mentor. The facility physician expressed his concern regarding sharing space with Dental services as there is not enough space in the clinic to provide medical services in a confidential manner.

While onsite the physician-auditor reviewed inmate-patient shadow medical files to gauge the adequacy of medical services being provided to the inmate-patients. The physician-auditor determined that the medical charts were well organized and easy to follow; however, the following deficiencies were noted:

- Lab results were not consistently signed (History & Physical, and EKG),
- Documentation of physical exams was unacceptable; physician's notes did not document examination of inmate-patient's chief complaint and,
- There was no Problem List in shadow medical file.

The physician auditor discussed these deficiencies with the facility physician who stated he would improve in these areas.

The nurse-auditor observed the facility RN conducting sick call appointments and direct observation therapy (DOT) medication pill pass. The facility RN appeared to be conducting the sick call appointments according to IMSP&P guidelines. The facility RN also did not check the hands and mouth on a consistent basis of inmate-patients during the DOT medication pill pass.

The nurse-auditor's inspection of the emergency medical response (EMR) bag revealed that the bag contained all of the required items; however documentation shows that the EMR bag seal is only checked once each day. The HSA stated that the seal on the EMR bag is checked at the beginning of each shift, however when the nurse-auditor showed the HSA the documentation; only one check per day was reflected on the log.

The hub facility provides training to MCCF health care staff regarding the IMSP&P and the best practices used by CCHCS health care staff. During the HPS I-auditor's interview with the HSA, it was discovered that the HSA has just recently communicated with the hub facility to arrange training for all CVMCCF medical staff. The HSA has contacted the hub facility to set up training for the CVMCCF medical staff during March 2015.

The HPS I-auditor, the HSA and Compliance Administrator discussed the deficiencies of the facility's Sick Call, Specialty Care, and Chronic Care monitoring logs from the previous quarter. The Sick Call log was missing dates the inmate-patient was seen by the PCP after having been referred by an RN. The Specialty Services log was missing the name of an inmate-patient who was identified by the nurse-auditor as having been referred for specialty services during the audit review period. The Chronic Care log was missing the inmate-patient's next scheduled chronic care appointment. The HPS I-auditor re-emphasized the requirement to accurately complete and submit the logs in a timely manner. The HSA and Compliance Administrator stated they now understood how to properly maintain the monitoring logs.

Emergency Medical Response Drill:

The audit team observed an Emergency Medical Response (EMR) drill. The drill scenario involved an inmate-patient in cardiac arrest in one of the vocational classrooms. The facility staff who discovered the inmate-patient failed to check for a pulse or begin CPR until 1-1/2 minutes after calling in the code.

Health care staff arrived on-scene within 3 minutes of the call, however the portable oxygen was not brought to the scene. Use of chest compressions, Ambu Bag, oxygen and AED were not clearly demonstrated. CPR was discontinued for more than a minute as the inmate-patient was transferred to a gurney.

Following the drill, a debriefing was conducted and the key deficiencies above were identified and discussed with facility health care staff.

Due to the failure of staff to assess and begin CPR immediately upon finding the inmate-patient and the discontinuance of CPR during the transference of the inmate to the gurney, the victim would have a very low chance of survival.

Review of the Performance Improvement Meeting agenda and the meeting minutes do not show documentation that the emergency response drills are discussed. There is no documentation of the adequacy or deficiencies observed during the emergency response drills or any recommendations for improvement. The quarterly emergency response drill minutes do not clearly identify the responding medical staff as nursing or PCP. The minutes should reflect the title of each responding staff member. It is imperative that the facility create both an EMRRC and CQI Plan in order to address the deficiencies observed during the emergency drill performed at the time of the onsite audit; including a plan for improvement. One of the responsibilities of the EMRRC would be to evaluate the following: compliance with existing policies and procedures, response time, medical and custody response, and appropriateness of medical care and documentation as per CCHCS requirements. Forming an EMRRC is essential in monitoring the proficiencies of all staff's awareness and preparedness. Additionally, the facility physician should be required to attend emergency medical drills.

Prior CAP Resolution:

Although a number of CAP items from the previous audit of July 2014 were found to be resolved, a large number of items were not, the facility will take responsibility in resolving these items. The facility's advancement toward resolution of the previous audit's CAP items is summarized below:

1. *Medical records had not been sent to the hub for uploading into the eUHR.* The facility provided training to health care staff and had them sign a document stating they had received the training. The current process is the facility forwards the originals to the hub facility on a daily basis. There was no backlog of medical records at the time of the current audit. The facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and the issue resolved.

2. *The facility does not have the inmate-patient complete a CDCR 7385 Authorization for Release of Information (ROI) Form when requesting copies of their medical records.* The facility provided training to health care staff and had them sign a document stating they had received the training. The HPS I-auditor reviewed the ROI Log from the current audit and confirmed that all inmate-patients who requested records had signed a CDCR 7385, Authorization for Release of Information Form, and that the forms were scanned into the inmate-patient's eUHR. The facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and the issue resolved.

3. *The facility does not have an approved Continuous Quality Improvement (CQI) Plan.* The facility began holding monthly Performance Improvement Committee Meetings in August 2014, and provided the meeting agenda and minutes for August and October 2014, and January 23, 2015. However, the facility is still required to have a CQI Plan and hold meetings. This corrective item is unresolved and will continue to be monitored during subsequent audits.

4. *The PCP does not review, initial, and date inmate-patient's diagnostic reports within 2 days of receipt.* The facility provided training and had the PCP sign a document that he was informed of the requirement for the PCP to review, initial and date diagnostic reports within two business days of the facility's receipt. During shadow medical file reviews, the RN-auditor found the PCP is still not reviewing, initialing, nor dating the diagnostic reports consistently within two days of receipt. This corrective item is unresolved and will continue to be the subject of monitoring during subsequent audits.

5. *The PCP does not see the inmate-patient for a follow-up visit within the specified timeframe following review of the test results for a clinically significant diagnostic test result.* The facility provided training and sent a document signed by the PCP that he was informed of the requirement to follow-up on clinically significant diagnostic test results and see the inmate-patient within 14 days or as clinically indicated if the diagnostic test results meet the "High Risk" criteria. During chart reviews, the nurse-auditor found the PCP is still not following up on clinically significant diagnostic test results consistently within 14 days or as clinically indicated. This corrective item is unresolved and will continue to be monitored during subsequent audits.

6. *The inmate-patients do not receive written notification of their diagnostic test results within the specified timeframe.* The facility provided documented training to the health care staff regarding the requirement that the inmate-patients receive a copy of their diagnostic test results within two business days of the date the facility receives the diagnostic results. During shadow medical file reviews, the nurse-auditor found the inmate patients have not are not provided written notification of their diagnostic test results consistently within two days of receipt. This corrective item is unresolved and will continue to be monitored during subsequent audits.

7. *The facility inmate-patient handbook does not explain the healthcare grievance/appeal process.* The facility made revisions to the handbook and the Compliance Coordinator provided the revisions to the CCHCS HSP I for review. The copy of the Inmate Patient Orientation Handbook section regarding submission of the 602-HC forms provided by the Compliance Administrator clearly explains the healthcare grievance/appeal process. The corrective action is considered to have been effective and the issue resolved.

8. *The PCP is required to document that they explained newly prescribed medication to the inmate-patient.* The facility provided training documents indicating the PCP was informed of the requirement to provide inmate-patients education regarding newly prescribed medication. During chart reviews, the nurse-auditor found the PCP does not consistently document the inmate-patient with education regarding newly prescribed medication. This corrective item is unresolved and will continue to be monitored during subsequent audits.

9. *The facility RN does not ensure that prescribed Keep on-Person (KOP) medications are placed in the transfer envelope with the exception of nitroglycerin and rescue inhalers for inmates transferring out*

of the MCCF. The facility provided documented training on the requirement for the RN to confirm and place all prescribed KOP medication in the Transfer Envelope of inmate-patients who are transferring out of the facility. During chart reviews, the nurse-auditor found KOP medications were given to the RN and placed in the Transfer Envelope prior to the inmate-patient transferring out of the MCCF. The corrective action is considered to have been effective and the issue resolved.

10. *The Sick Call Monitoring Log is not accurate and does not document whether inmate-patients were seen within the specified timeframes set forth in the sick call policy.* The facility provided documented training of the requirement to complete the Sick Call log correctly. However, during the HPS I-auditor's review of the monitoring log for the current audit period, the log was missing required information. The HPS I met with the HSA and Compliance Administrator during the audit to discuss the log requirements and provided additional training. This corrective item remains unresolved and will continue to be monitored during subsequent audits.

11. *The facility Chronic Care Monitoring Log is incomplete, contains inaccurate dates, and does not document whether the inmate-patient was seen within the specified timeframes set forth in the chronic care policy.* The facility provided training and had health care staff sign documentation that they understand the requirement to complete the Chronic Care Log correctly. However, while the Chronic Care log indicated the inmate-patients were seen within the specified timeframes, the next appointment date was not documented on the log. This corrective item remains unresolved and will continue to be monitored during subsequent audits.

12. *The facility Specialty Care Monitoring Log is not completed and does not document whether the inmate-patient was seen within the specified timeframes set forth in the specialty care policy.* The facility provided documented to health care staff s on the requirements to complete the Specialty Care Log. However, during the HPS I-auditor's review of the monitoring log for the current audit period, the log did not identify the one inmate-patient's name referred for specialty services during the audit review period. The HSA and Compliance Administrator he would ensure all future inmate-patients referred for specialty services are added to the log. This corrective item remains unresolved and will continue to be monitored during subsequent audits.

13. *The facility Initial Intake Screening Log is incomplete, contains inaccurate dates, and does not document whether the inmate-patient was seen within the specified timeframes set forth in the initial intake screening/health appraisal policy.* The facility provided documented to health care staff on the requirement to complete the Initial Intake Screening Log correctly. The review of the initial intake screening monitoring log for the current audit period shows the log is completed correctly. The corrective action is considered to have been effective and the issue is resolved.

14. *The facility RN/PCP does not complete the CDCR Form 7225, Refusal of Examination and/or Treatment form, or similar form if the inmate-patient refuses a health care appointment/treatment.* The facility provided the PCP and RNs training on the completion of the CDCR Form 7225. During the current audit, the nurse-auditor's review of inmate-patient shadow medical files confirmed the facility is completing the CDCR 7225 form. The facility has improved in this area and achieved 100% compliance. The corrective action is considered to have been effective and the issue resolved.

15. *The eUHR does not contain documentation that the RN/PCP contacts the housing unit supervisor to have the inmate-patient escorted to medical to speak with health care staff if the inmate-patient*

fails to show for their medical appointment. The facility provided training to the PCP and RNs on the requirement to have the inmate-patient refusing an appointment or treatment brought to the clinic. During the current audit, there were no inmate-patients identified who refused the medical appointments. This CAP item will remain open and monitored during future audits to determine compliance.

16. *The eUHR review indicated that when an inmate-patient fails to show up for their medical appointment, the RN does not document the reason for the no-show in the inmate-patient's shadow medical file.* The facility provided training, on the requirement to have the RN staff document in the shadow medical file the reason for the inmate-patient no show or refusal of treatment. During the current audit, there were no inmate-patients identified who did not show for their medical appointment or treatment. This CAP item will remain open and monitored during future audits to determine compliance.

17. *The eUHR does not contain documentation that the RN completes a face-to-face evaluation upon the inmate-patient's return from a specialty consult appointment.* The facility provided training to RNs on the requirement to complete a face-to-face evaluation of inmate-patients returning from a specialty consult appointment. During the current audit, the nurse auditor's review of inmate-patient shadow medical files confirmed that for the one specialty consult during this audit period, the RN completed a face-to-face evaluation when the inmate-patient returned to the MCCF. The facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.

18. *The UHR does not contain documentation that the RN notifies the PCP of any immediate medication orders or follow-up instructions provided by the specialty consultant when an inmate-patient returns from a specialty consult appointment.* The facility provided training to the RNs on the requirement to have the RN notify the PCP of any immediate medication orders or follow-up instructions provided by the specialty consultant when an inmate-patient returned from a specialty consultation appointment. During the current audit, there was only one specialty service provided during the audit period. The inmate-patient did not have any immediate medication orders or follow-up instructions when he returned to the MCCF from the specialty consult appointment. This CAP item will remain open and monitored during future audits to determine compliance.

19. *The facility did not ensure that all health care staff had access to the CDCR electronic Unit Health Record (eUHR), specifically the facility physician.* The PCP has received access to the CDCR eUHR. The physician auditor observed the PCP accessing the eUHR. The facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and the issue resolved.

20. *The facility is required to document that the Emergency Medical Response Bag is secured with a seal on every shift.* The facility purchased a larger Emergency Response Bag and has begun to use an Emergency Response Bag Monthly Inventory Checklist. During the current audit, the nurse-auditor found that the Emergency Response Bag Seal Check log indicates the seal was checked only once a day, rather than on per shift. It is recommended the HSA review the log on a daily basis to confirm the RN documents the Emergency Response Bag Seal is intact on each shift. This corrective item is unresolved and will continue to be the subject of monitoring during subsequent audits.

21. *The facility is required to have Personal Protective Equipment (PPE), including gloves, masks, face shields, and gowns available for staff use.* The facility was missing the gowns for PPE during the previous audit. The facility provided an invoice for the purchase of the PPE gowns. During the current audit, the nurse-auditor confirmed there were PPE gowns available for all staff. The corrective action is considered to have been effective and the issue resolved.

22. *The RN/PCP are required to document Subjective, Objective, Assessment, Plan and Education (S.O.A.P.E.) Note on the CDCR Form 7362, Health Care Service Request and/or CDCR Form 7230, Interdisciplinary Progress Notes or a similar form.* The facility provided documented training on the requirement to document each health care encounter using the S.O.A.P.E. format on a Health Care Services Request Form (CDCR Form 7362) and/or an Interdisciplinary progress Notes Form (CDCR 7230) or a Geo similar form. The facility scored a 75.0% compliance rating during this audit period. This is an improvement from the previous score of 50.0% compliance in this area. However, this corrective item is unresolved and will continue to be monitored during subsequent audits.

New CAP Issues:

New quantitative and qualitative CAP items are fully discussed in the relevant section(s) of this report. There are two new qualitative CAP items that require further detail:

1. *A peer review of the facility PCP is not conducted annually. Per the Contract Scope of Work* between the Geo Group Inc. and CDCR under Staff Selection/Training & Credentialing Section, the *Contractor is also required to complete an initial written peer review after 30 days of employment, and then annually.*[2] Also, Per CCHCS IMSP&P Clinical Mentoring-Proctoring Program Phase VI: *Ongoing mentoring-proctoring activities by supervising clinicians, including annual performance appraisals.*[3] This is a qualitative CAP item.

2. *The PCP is not knowledgeable on Title XV.* The PCP should familiarize himself with the California Code of Regulations, Title XV regarding medical necessity as it applies to the treatment of CDCR inmate-patients.[4] This is a qualitative CAP item.

Conclusion:

The audit revealed that CVMCCF is struggling to provide health care meeting IMSP&P standards as it relates to; chronic care; diagnostic services and medication management. Poor performance scores in numerous components areas is a direct result of the lack of standards to achieve substantial compliance, including the lack of staff training, no established CQI Plan, absent monthly CQI and EMMRC meetings and inaccurate completion of the facility's monitoring logs for CDCR inmate-patients that are housed at this facility.

The audit team reiterated their recommendation from the previous audit to management, that the facility form an EMRRC and to establish a quorum for the committee. The EMMRC will be responsible

[2] Scope of Work, Central Valley Modified Community Correctional Facility/CDCR Contract pg 17, para. b
[3] IMSP&P Vol. 3, Chapter 4B Section I A
[4] California Code of Regulations, Title XV, Article 8, 3350(b)(1)

for conducting monthly meetings to review facility's emergency response procedures and the staff's responses to medical emergencies and drills. The committee shall document and maintain minutes for all meetings held, the names of all attendees, and formulate CAPs for deficiencies identified in the response procedures.

The audit team also reiterated to CVMCCF management that the need for the development and implementation of an approved CQI process/plan and a formal EMRRC is of the utmost importance for the facility to meet the compliance standards set forth by CDCR to ensure adequate health care to California inmate-patients. The quality improvements would enable the facility to identify and correct health care deficiencies and help the facility in attaining an overall improvement in their delivery of health care to the CDCR inmate-patient population.

CVMCCF staff were receptive to these recommendations, seemed willing to accept the feedback as presented by the CCHCS audit team and acknowledged their need to adhere to contractual obligations in providing adequate patient-inmate care.

STAFFING UTILIZATION

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

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

CVMCCF is currently staffed with two physicians who are providing a total of 20 hours of coverage, 5 days per week. The facility currently has six registered nurses (RN) providing coverage at the facility 24 hours/7 days a week. In addition, the HSA works Monday through Friday. CVMCCF is within current contractual guidelines to provide on-site physician and nursing coverage.

INMATE-PATIENT INTERVIEWS

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

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

Chapter 21: Inmate Interviews (not rated)

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

COMMENTS

1. Questions 1 through 4 - Eight inmate-patients were interviewed regarding the sick call process. All inmate-patients reported they were aware of the sick call process, knew where to obtain the sick call form, and where to place the form when completed. All inmate-patients reported they knew where to obtain help completing forms if needed. One inmate-patient stated he sometimes had trouble obtaining a sick call form, another reported that diabetic strips are sometimes not available, and a third inmate stated he had to wait two weeks to be seen for a common cold. Several inmates expressed concern over what they believed to be mold in the shower areas. The audit team discussed this issue with the Warden and Compliance Administrator who reported the facility is currently cleaning the showers on a daily basis with a bleach solution and is in the process of replacing the shower panels. Upon return to the office, the HPS-I auditor discussed the inmate-patient's concerns regarding the possible mold with the Chief Deputy Administrator at the Contract Beds Unit. The Chief Deputy Administrator stated he had toured the showers at the facility and believed the inmates were mistaking mildew and soap scum for mold, but also

reiterated the facility has begun a daily cleaning of the showers with a bleach solution and is in the process of replacing the shower panels.

2. Questions 5 through 8 - Eight inmate-patients were interviewed regarding the grievance/appeal process. Two of the inmate-patients were unaware of the health care grievance/appeal process and the auditors explained the process to the inmate-patients, informed them of where they could obtain the 602-HC form, and where to place the form once completed. The other six inmate-patients were aware of the grievance/appeal process; however one inmate-patient stated he felt inmate-patients were dissuaded from submitting appeals. The six inmate-patients knew where to obtain the grievance/appeal form, and where to place the grievance/appeal form when completed. All inmate-patients stated they felt satisfied with the health care they received at the MCCF.

3. Questions 9 through 23 - CVMCCF has one inmate-patient on the DPP list. The inmate-patient reported he is hearing impaired and wears a vest and hearing aid. The auditor achieved effective communication by speaking loudly and slowly. The DPP inmate-patient reported it took more than a month for his hearing aid to be repaired. He submitted a CDCR 7362, *Health Care Services Request Form* on December 4, 2014 and was not scheduled to be seen for repair in the Audiology Specialty Clinic at the hub until January 23, 2015 at which time the hearing aid was repaired. The HPS I-auditor spoke with the HSA advising that the hearing aid should have been sent to the hub facility for repair as soon as the inmate-patient submitted the CDCR 7362 Form and she should log the send-out on the Health Care Appliance Repair Log. She was advised she should contact the hub facility and speak to the Specialty Services clerk if she has any questions regarding the sending out of health care appliances for repair. During the interview the inmate-patient was also wearing his hearing vest which was faded and no longer yellow in color. He reported he had been requesting a new vest for quite a while but had not yet received one. The HSA reported she had instructed the inmate-patient to request a new vest each time he had gone to the hub for services, but that the inmate-patient always arrived back without a new vest.

   Upon return from the audit, the HPS I-auditor contacted the hub facility regarding the replacement of the hearing vest for the inmate-patient. The hub advised the inmate-patient is required to be seen at the hub to determine if he continues to require a hearing vest. The inmate-patient was given an appointment for February 18, 2015. The HPS I auditor followed up with the HSA on February 19, 2015, and was informed the inmate-patient had received a new hearing vest. Overall, the DPP inmate patient states he is satisfied with the health care he receives.