March 10, 2015

Wanda Wilson, Warden
McFarland Female Community Reentry Facility
120 Taylor Avenue
McFarland, CA, 93250

Dear Warden Wilson,

The staff from Private Prison Compliance and Monitoring Unit (PPCMU), Field Operations, Corrections Services, California Correctional Health Care Services (CCHCS) completed an onsite health care monitoring audit at McFarland Female Community Reentry Facility (FCRF) on February 9 through 10, 2015. The purpose of this audit is to ensure that FCRF is meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006 and the *Tallahatchie County Correctional Facility (TCCF) Remedial Plan.*

Attached you will find the audit report in which FCRF received an overall compliance rating of **79.6%.** The report contains an executive summary, an explanation of the methodology behind the audit, findings detailed by chapters of the *Contract Facility Health Care Monitoring Audit Instrument,* and a corrective action plan (CAP) request in accordance with the *TCCF Remedial Plan*. Please submit a CAP, as detailed in the attached report, to Kala Srinivasan, Health Program Specialist I (HPS I), PPCMU, Field Operations, Corrections Services, CCHCS, via e-mail at Kala.Srinivasan@cdcr.ca.gov within 30 days of the date of this letter.

The audit findings reveal that FCRF is struggling to provide adequate health care to CDCR inmate-patients housed at this facility. The access and quality of medical care provided to the CDCR inmate-patient population at FCRF is undesirable and not meeting Inmate Medical Services Policies and Procedures (IMSP&P) standards of care. This creates a grave concern for the well being of the inmate-patient population housed at this facility. Numerous deficiencies were identified in the following program components and require facility's immediate attention and resolution:

- Administration (Policies and Procedures)
- Access to Health Care Information
- Continuous Quality Improvement Plan
- Diagnostic Services
- Medical Emergency Services/Drills
- Medical Emergency Equipment
- Medication Management
- Infection Control

- Infection Control
- Monitoring Logs

The inefficient performance of the medical staff identified in various health care areas and poor documentation practices pose a great risk to the mortality and well being of the inmate-patient population housed at this facility. The deficient program areas listed above can be brought to compliance by the facility's strict adherence to the established policies and procedures outlined in the contract, in addition to meeting IMSP&P guidelines. The FCRF is encouraged to work diligently in order to improve the quality of medical services provided to the CDCR inmate population and to expediently resolve the concerns and deficiencies identified in the attached report.

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

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

Enclosure

cc: Richard Kirkland, Chief Deputy Receiver, CCHCS
Diana Toche, Undersecretary, Health Care Services, California Department of Corrections and Rehabilitation (CDCR)
R. Steven Tharratt, M.D., M.P.V.M., F.A.C.P., Director, Health Care Operations, CCHCS
John Dovey, Director, Corrections Services, CCHCS
Kelly Harrington, Director (A), Division of Adult Institutions (DAI), CDCR
Steven F. Ritter, D.O., Deputy Director, Medical Services, CCHCS
Roscoe L. Barrow, Chief Counsel, CCHCS
Ricki Barnett, M.D., Deputy Medical Executive, Utilization Management, CCHCS
Cheryl Schutt, R.N., B.S.N., CCHP, Statewide Chief Nurse Executive, Nursing Services, CCHCS

Jay Virbel, Associate Director, Female Offender Programs and Services/Special Housing, DAI, CDCR
Steven Moulios, D.O., Physician Advisor, Central Region, Utilization Management, CCHCS
Robin Harrington, Correctional Administrator, Female Offender Program and Services, CDCR
Ada Rivera, M.D., Chief Medical Officer, Geo Group, Inc.
Catherine Murdoch, Correctional Administrator (A), Field Operations, Corrections Services CCHCS
Patricia Matranga, R.N., Nursing Services, CCHCS
Donna Heisser, Health Program Manager II, PPCMU, Field Operations, Corrections Services, CCHCS
Kala Srinivasan, HPS I, PPCMU, Field Operations, Corrections Services, CCHCS
Vera Lastovskiy, HPS I, PPCMU, Field Operations, Corrections Services, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Contract Facility

Health Care Monitoring Audit

McFarland Female Community Reentry Facility

February 9-10, 2015

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INTRODUCTION

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

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

This report provides the findings associated with the audit conducted from February 9 through 10, 2015, at McFarland Female Community Reentry Facility (FCRF) which is located in McFarland, California. At the time of the audit, CDCR's *Weekly Population Count*, dated February 6, 2015, indicated that FCRF had a design capacity of 300 beds, of which 228 were occupied with CDCR inmates.

EXECUTIVE SUMMARY

From February 9 through 10, 2015, Field Operations audit team conducted an onsite audit at FCRF. The audit team consisted of the following personnel:

K. Srinivasan, Health Program Specialist I (HPS I)
S. Moulios, Medical Doctor, Regional Physician Advisor
P. Matranga, Nurse Consultant Program Review
V. 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.

Table 1 on the following page illustrates the overall compliance rating achieved during this audit, as well as how the ratings are calculated. The overall rating represents the percentage of the total points awarded out of the total points possible. Points are awarded in three categories; Administration, Delivery, and Operations, which are broken down further into the individual chapters of the audit.

Based on the quantitative portion of this audit, FCRF achieved an **overall compliance rating of 79.6%** with a rating of 79.6% in Administration, 80.5% in Delivery, and 77.3% in Operations**.**

The completed quantitative audit, summary of qualitative findings, and Corrective Action Plan (CAP) request are attached for your review.

Table 1.

Quantitative Compliance Ratings	Points Possible	Points Awarded	Score	CAP Required
Administration				
1. Administration	180.0	150.0	83.3%	Yes
2. Access to Health Care Information	70.0	50.0	71.4%	Yes
6. Continuous Quality Improvement (CQI)	50.0	40.0	80.0%	Yes
13. Licensure and Training	160.0	150.0	93.8%	Yes
15. Monitoring Logs	150.0	77.4	51.6%	Yes
20. Staffing	90.0	90.0	100.0%	No
Administration Sub Score:	**700.0**	**557.4**	**79.6%**	
Delivery				
5. Chronic Care	120.0	115.0	95.8%	Yes
7. Diagnostic Services	120.0	81.4	67.8%	Yes
8. Medical Emergency Services/Drills	200.0	121.0	60.5%	Yes
9. Medical Emergency Equipment	260.0	210.0	80.8%	Yes
14. Medication Management	220.0	128.6	58.5%	Yes
17. Patient Refusal of Medical Treatment	50.0	47.5	95.0%	Yes
18. Sick Call	380.0	380.0	100.0%	No
19. Specialty/Hospital Services	90.0	75.0	83.3%	Yes
Delivery Sub-Score:	**1,440.0**	**1,158.5**	**80.5%**	
Operations				
3. ADA Compliance	60.0	30.0	50.0%	Yes
4. Chemical Agent Exposure	N/A	N/A	N/A	N/A
10. Grievance/Appeal Procedure	50.0	40.0	80.0%	Yes
11. Infection Control	160.0	105.0	65.6%	Yes
12. Initial Intake Screening/Health Appraisal	300.0	265.7	88.6%	Yes
16. Observation Unit	N/A	N/A	N/A	N/A
Operations Sub-Score:	**570.0**	**440.7**	**77.3%**	
21. Inmate Interviews (not rated)				
Final Score:	**2,710.0**	**2,156.6**	**79.6%**	

NOTE: For specific information regarding any non-compliance findings indicated in the chart above, please refer to the CAP request (located on page 7 of this report), or to the detailed quantitative findings (located on page 10).

METHODOLOGY

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

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

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

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

- 85% for each chapter within the audit instrument.

Compliance and non-compliance are defined as follows:

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

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

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

Point Value	Weighting Criteria
50.0	Failing to meet the requirement poses *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 20 ratable chapters of the *Contract Facility Health Care Monitoring Audit* have been categorized into three major operational areas: **administration, delivery**, and **operations**. These overall operational areas are sub-totaled, and sub-scored, on the Qualitative Analysis Findings section of the final report. This is provided for the informational benefit of the facility. As with individual chapter scores, the compliance percentage for each operational area is calculated by dividing the total points earned by the total points available in that area, and multiplying by 100 to yield a percentage. The final overall quantitative score is calculated by the same method.

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

CORRECTIVE ACTION PLAN REQUEST

The chart below reflects all quantitative analysis items where the facility was rated non-compliant, as well as any qualitative analysis items requiring a response from the facility. The audit results for FCRF 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 – McFarland Female Community Reentry Facility	
Chapter 1, Question 5	The facility does not have a written policy that addresses the requirements for the release of medical information.
Chapter 1, Question 13	The facility does not have a written policy and/or procedure related to specialty services.
Chapter 1, Question 17	The facility does not have a written policy and/or procedure related to licensure and training.
Chapter 2, Question 1	The Nurse Practitioner (NP) could not demonstrate her ability to access the Electronic Unit Health Record.
Chapter 2, Question 4	The facility's Release of Information (ROI) log does not contain all the required information.
Chapter 3, Question 4	The facility does not have a local operating procedure (LOP) that explains provision of interim accommodation to a Disability Placement Program (DPP) inmate-patient while an appliance is ordered, repaired, or in the process of being replaced.
Chapter 3, Question 5	The facility does not have a LOP defining a process for adding to or removing an inmate-patient from a DPP list.
Chapter 3, Question 6	The facility does not have a LOP defining the requirement to establish and document effective communication between health care staff and inmate-patient during each clinical encounter.
Chapter 6, Question 5	The Continuous Quality Improvement committee does 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 PCP does not consistently review, initial, and date all inmate-patient diagnostic test reports within the specified timeframe.
Chapter 7, Question 4	The inmate-patients do not consistently receive written notification of the diagnostic test results within two days of receipt.
Chapter 8, Question 4	The facility's nursing staff does not consistently document the review of the inmate-patient's discharge plan upon inmate-patient's return to the facility from the community hospital emergency department.
Chapter 8, Question 5	The facility's nursing staff does not consistently document the face-to-face evaluation of inmate-patients upon their return to the facility from the community hospital emergency department.
Chapter 8, Question 7	The facility does not hold monthly Emergency Response Review Committee meetings.

Chapter 8, Question 9	The facility does not conduct quarterly emergency medical response drills on each shift.
Chapter 9, Question 3	The facility does not have a portable suction device.
Chapter 10, Question 1	The inmate orientation manual/handbook does not explain the health care grievance/appeal process in detail.
Chapter 11, Question 2	The inmate-patients who come to the clinic with a potential communicable disease are not isolated from the rest of the inmate-patients in the clinic area.
Chapter 11, Question 3	The facility's nursing staff does not consistently practice proper hand hygiene.
Chapter 11, Question 6	The inmate-patient clinic area is not being cleaned after each inmate-patient use.
Chapter 11, Question 10	The central storage area for biohazard materials is not labeled.
Chapter 14, Question 1	The nursing staff does not consistently administer medications to inmate-patients as ordered by the PCP.
Chapter 14, Question 2	The PCP does not consistently document that they explained the medication to the inmate-patient.
Chapter 14, Question 4	The nursing staff does not document on the Medication Administration Record (MAR), after the medication is administered to the inmate-patient.
Chapter 14, Question 5	The nursing staff does not consistently document on the MAR when the inmate-patient is a no show for medication administration.
Chapter 15, Question 1	Inmate-patients are not consistently seen within the specified timeframes as set forth in the sick call policy.
Chapter 15, Question 2	Inmate-patients are not consistently seen within the specified timeframes as set forth in the specialty care policy.
Chapter 15, Question 3	Inmate-patients are not consistently seen within the specified timeframes as set forth in the emergency/hospital services policy.
Chapter 15, Question 4	Inmate-patients are not consistently seen within the specified timeframes as set forth in the chronic care policy.
Chapter 15, Question 5	Inmate-patients are not consistently seen within the specified timeframes as set forth in the initial intake screening policy.
Chapter 19, Question 3	The inmate-patients are not consistently seen by the specialist within the timeframe specified by the PCP.
Qualitative Action Item #1	Not all of the facility's custody staff and vocational instructors have current Basic Life Support (BLS) certifications.
*Qualitative Action Item #2 (Chapter 5, Question 1)	The inmate-patient's chronic care follow-up visits are not consistently completed within the 90-day or less timeframe, or as ordered by the treating PCP.

*Qualitative Action Item #3 (Chapter 12, Question 11)	The treating PCP is not documenting the inmate-patient health appraisals/history and physical examinations on the CDCR 196-B, *Intake History and Physical* form.
*Qualitative Action Item #4 (Chapter 13, Question 7)	The facility does not have a system in place to ensure health care staff receives training for new or revised policies based on *Inmate Medical Services Policies and Procedures* requirements.
*Qualitative Action Item #5 (Chapter 17, Question 5)	The nursing staff does not consistently document the reason for the inmate-patient's no-show to their medical treatment /appointment.

*Qualitative action items #2 through #5 are questions that failed within Quantitative chapters receiving an overall passing score (85% or higher).

QUANTITATIVE FINDINGS - DETAILED BY CHAPTER

Chapter 1: Administration	Point Value	Points Awarded
1. Does all health care staff have access to the contractor's health care policies and procedures?	10.0	10.0
2. Does all health care staff have access to health care operational procedures?	10.0	10.0
3. Do health care staff know where and how to access the contractor's health care policies and procedures and health care operational procedures?	10.0	10.0
4. Does the facility have a written policy and/or procedure related to the maintenance/management of the Unit Health Records (UHR)?	10.0	10.0
5. Does the facility have a written policy that addresses the requirements for the release of medical information?	10.0	0.0
6. Does the facility have a written policy and/or procedure related to the Chemical Agent/Use of Force process?	10.0	10.0
7. Does the Chemical Agent/Use of Force policy and/or procedure contain a decontamination process?	10.0	10.0
8. Does the facility have a written policy and/or procedure related to Chronic Care?	10.0	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 to medication management?	10.0	10.0
12. Does the facility have a written policy and/or procedure related to the sick call process?	10.0	10.0
13. Does the facility have a written policy and/or procedure related to specialty services?	10.0	0.0
14. Does the facility have a written policy and/or procedure related to ADA?	10.0	10.0
15. Does the facility have an Infection Control Plan?	10.0	10.0
16. Does the facility have a written policy and/or procedure related to Bloodborne Pathogen Exposure?	10.0	10.0
17. Does the facility have a written policy and/or procedure related to licensure and training?	10.0	0.0
18. Does the facility have a written policy and/or procedure related to Emergency Services?	10.0	10.0
Point Totals:	180.0	150.0
Final Score:		**83.3%**

CHAPTER 1 COMMENTS

1. Question 5 – The facility does not have a written policy addressing the requirements for release of medical information. This equates to 0.0% compliance.
2. Question 13 – The facility does not have a written policy and/or procedure related to specialty services. This equates to 0.0% compliance.
3. Question 17 – The facility does not have a written policy and/or procedure related to licensure and training. This equates to 0.0% compliance.

Chapter 2: Access to Health Care Information	Point Value	Points Awarded
1. Does the treating physician have access to the inmate-patient's CCHCS Electronic Unit Health Record (eUHR)?	10.0	0.0
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	0.0
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-patient's written requests for release of health care information noted in a progress note in the MCCF's shadow file in the eUHR?	10.0	N/A
9. Are all written requests for release of health care information from a third party 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 for release of health care information from a third party filed in the MCCF's shadow file and in the Medico-Legal or Miscellaneous section of the eUHR?	10.0	N/A
Point Totals:	110.0	50.0 (70.0)
Final Score:		**71.4%**

CHAPTER 2 COMMENTS

1. Question 1 –The NP could not demonstrate her ability to access the eUHR system when requested by the audit team. This equates to 0.0% compliance.
2. Question 4 – Although the facility maintains a Release of Information (ROI) log, the log does not contain all the required information such as the number of pages copied, number of pages withheld, the amount inmate-patient was charged, the date medical records were released to the inmate-patient, and the name and classification of the staff completing the request. This equates to 0.0% compliance. The facility is encouraged to update their ROI log to include these missing components in order to achieve compliance with this requirement.
3. Question 8 – Not applicable. The ROI requests are processed and copies are released by the medical records clerk; thus, this information is not documented in the progress notes of the inmate-patient's medical records. Therefore, this question was not evaluated.
4. Questions 9 through 11 – Not applicable. There were no requests for release of health care information from third parties during the audit review period; therefore, these questions were not evaluated.

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	0.0
5. Is there a local operating procedure explaining how the facility adds or removes an inmate-patient from the DPP list?	10.0	0.0
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	0.0
Point Totals:	60.0	30.0
Final Score:		**50.0%**

CHAPTER 3 COMMENTS

1. Question 4 – Although the facility has a local operating procedure (LOP) related to Disability Placement Program (DPP), the LOP does not address how the interim accommodation will be provided while a health care appliance is ordered, repaired, or in the process of being replaced. This equates to 0.0% compliance.
2. Question 5 – The facility does not have an LOP explaining the process of adding or removing an inmate-patient from the DPP list. This equates to 0.0% compliance.
3. Question 6 – The facility does not have an LOP explaining how the facility ensures and documents the establishment of effective communication between health care staff and an inmate-patient during each clinical encounter. This equates to 0.0% compliance.

Chapter 4: Chemical Agent Exposure	**Point Value**	**Points Awarded**
1. In the event of Chemical Agent Exposure, if an inmate-patient refuses decontamination, did the facility staff document that he/she was given direction on how to self-decontaminate?	10.0	N/A
2. In the event of Chemical Agent Exposure, if an inmate-patient refuses decontamination, did the health care staff monitor the inmate-patient every 15 minutes for a minimum of 45 minutes?	10.0	N/A
Point Totals:	20.0	N/A
Final Score:		**N/A**

CHAPTER 4 COMMENTS

1. Questions 1 and 2 – Not applicable. There were no inmate-patients that were 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	25.0

2. Did the PCP provide health care education to inmate-patients regarding their chronic care condition during the last Chronic Care Clinic (CCC) follow-up visit?	30.0	30.0
3. If an inmate-patient refuses CCC services, is a Refusal of Treatment form completed?	30.0	30.0
4. If an inmate-patient refuses CCC services, is the inmate-patient referred to the PCP?	30.0	30.0
Point Totals:	120.0	115.0
Final Score:		**95.8%**

CHAPTER 5 COMMENTS

Question 1 – Of the seven inmate-patient shadow medical files reviewed, five included documentation that the chronic care follow-up visit was completed within the 90-day or less timeframe, or as ordered by the PCP. One shadow medical file indicated a follow-up visit ordered in 60 days was not completed until 120 days. The other shadow medical file was not applicable because the inmate-patient refused their follow-up visit. This equates to 83.3% compliance. This is designated as a qualitative action item.

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
Point Totals:	60.0	40.0 (50.0)
Final Score:		**80.0%**

CHAPTER 6 COMMENTS

1. Question 5 – A review of the CQI meeting minutes from December 30, 2014, indicates that facility does not complete an analysis for each identified opportunity for improvement. This equates to 0.0% compliance.
2. Question 6 – Not applicable. This question automatically fails as a result of failure noted in question 6.5. Under the double-failure rule, the points for this question have therefore been removed from the total points available and the question rendered not applicable.

Chapter 7: Diagnostic Services	**Point Value**	**Points Awarded**
1. Was the diagnostic test provided to the inmate-patient within the timeframe specified by the LIP?	30.0	30.0
2. Does the PCP review, initial, and date an inmate-patient's diagnostic reports within two days of receipt?	30.0	4.3

3. Was the inmate-patient seen by a PCP for a follow-up visit for a clinically significant diagnostic test result within 14 days, or as clinically indicated, from the date the test results were reviewed by the PCP?	30.0	30.0
4. Was the inmate-patient given written notification of the diagnostic test results within two days of receipt?	30.0	17.1
Point Totals:	120.0	81.4
Final Score:		**67.8%**

CHAPTER 7 COMMENTS

1. Question 2 – Of the seven inmate-patient shadow medical files reviewed, only one included documentation that the PCP had reviewed, initialed, and dated the inmate-patient's diagnostic reports within two days of receipt. Two shadow medical files revealed no indication the diagnostic results were reviewed at all and the other four were initialed by the PCP but not dated. This equates to 14.3% compliance.
2. Question 4 – Of the seven inmate-patient shadow medical files reviewed, four included documentation that the inmate-patient was given written notification of the diagnostic test results. This equates to 57.1% compliance.

Chapter 8: Medical Emergency Services/Drills	**Point Value**	**Points Awarded**
1. Does the facility have a current Medical Emergency Response procedure?	10.0	10.0
2. Does the facility's local operating procedure pertaining to medical emergencies/response contain instructions on how to communicate, respond, and transport inmate-patients during medical emergencies?	30.0	30.0
3. Does the facility's local operating procedure contain instructions on how to obtain Emergency Medical Services (EMS) transportation 24 hours a day, seven days a week?	30.0	30.0
4. When an inmate-patient returns from a community hospital emergency department, does an RN document their review of the inmate-patient's discharge plan?	30.0	15.0
5. When an inmate-patient returns from a community hospital emergency department, does an RN document the completion of a face-to-face evaluation of the inmate-patient?	30.0	6.0
6. When an inmate-patient returns from a community hospital emergency department, does the inmate-patient receive a follow-up appointment with a PCP within five calendar days of discharge, or sooner as clinically indicated, from the day of discharge?	30.0	30.0
7. Is there documentation that the Emergency Response Review Committee has met at least once a month?	10.0	0.0
8. In the documentation of the Emergency Response Review Committee meetings, does the committee discuss and/or implement a quality improvement action after reviewing the results of an emergency medical response and/or emergency medical response drill?	10.0	N/A
9. Does the facility conduct quarterly emergency medical response (man-down) drills on each shift?	30.0	0.0
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	N/A

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	N/A
Point Totals:	270.0	121.0 (200.0)
Final Score:		**60.5%**

CHAPTER 8 COMMENTS

1. Question 4 – Of the six inmate-patient shadow medical files reviewed, three included documentation that the RN reviewed the inmate-patient's discharge plan upon return from a community hospital emergency department. This equates to 50.0% compliance.
2. Question 5 – Of the six inmate-patient shadow medical files reviewed, one included documentation that the RN completed a face-to-face evaluation of the inmate-patient. Four files did not include any documentation of a face-to-face evaluation and one was not applicable because the inmate-patient had transferred to the hub [Central California Women's Facility (CCWF)] following the discharge from the hospital. This equates to 20.0% compliance.
3. Question 7 – The facility does not hold monthly Emergency Medical Response Review Committee (EMRRC) meetings. This equates to 0.0% compliance.
4. Question 8 – Not applicable. This question automatically fails as a result of a failure noted in question 8.7. Under the double-failure rule, the points for this question have therefore been removed from the total points available and the question rendered not applicable.
5. Question 9 – Although the facility's medical staff stated that several emergency medical response drills have been conducted since the facility's activation in July 2014, no documentation was provided to support the claim. This equates to 0.0% compliance.
6. Questions 10 and 11 - Not applicable. These questions automatically fail as a result of a failure noted in question 8.7. Under the double-failure rule, the points for these questions have therefore been removed from the total points available and the questions rendered not applicable.

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	N/A
3. Does the facility have functional Portable suction?	50.0	0.0
4. Is there documentation that the Portable suction in each clinic is checked every shift for operational readiness?	30.0	N/A
5. Does the facility have oxygen tanks?	50.0	50.0
6. Is there documentation that the oxygen tanks in each clinic is checked every shift for operational readiness (at least three-quarters full)?	30.0	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
Point Totals:	320.0	210.0 (260.0)
Final Score:		**80.8%**

CHAPTER 9 COMMENTS

1. Question 2 – Not applicable. There were no medical emergencies during the audit review period; therefore, this question was not evaluated.
2. Question 3 – The facility does not have a portable suction machine. This equates to 0.0% compliance.
3. Question 4 – Not applicable. This question automatically fails as a result of failure noted in question 9.3. Under the double-failure rule, the points for this question have therefore been removed from the total points available and the question rendered not applicable.

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	0.0
2. Is 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
Point Totals:	50.0	40.0
Final Score:		**80.0%**

CHAPTER 10 COMMENTS

1. Question 1 – The inmate-patient handbook minimally addresses the health care grievance/appeal process and lacks information regarding the process for the second and third level health care appeals. The audit team recommends more details and specifics regarding the health care appeal process be added to the inmate-patient handbook. This equates to 0.0% compliance. It should be noted that all inmate-patients interviewed regarding the health care appeal process were knowledgeable about where to obtain and submit the forms, who the Appeals Coordinator is and what the response timeframes are.

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	0.0
3. Does the staff practice hand hygiene?	30.0	0.0
4. Is personal protective equipment (PPE) (i.e. gloves, masks, face shields, gowns, etc.) available for staff use?	10.0	10.0
5. Does the facility have hand sanitizers which are maintained and available for staff use?	10.0	10.0

6. Is the inmate-patient clinic area cleaned after each inmate-patient use?	10.0	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 the central storage area for biohazard materials labeled and locked?	10.0	5.0
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
Point Totals:	160.0	105.0
Final Score:		**65.6%**

CHAPTER 11 COMMENTS

1. Question 2 – The facility's clinic has one waiting room area for inmate-patients reporting for sick call. There is no separate waiting area where inmate-patients with potential communicable diseases may be isolated. The audit team pointed out to the medical staff that the facility has three holding cells in an area located near the clinic; however, staff stated that with the exception of one occasion where an inmate-patient had scabies, the cells are not utilized for isolation of inmate-patients with potential communicable diseases. If an inmate-patient presents with flu like symptoms, they are not isolated from the rest of the inmate-patients. This equates to 0.0% compliance.
2. Question 3 – The nursing staff were observed not consistently practicing proper hand hygiene by washing their hands after each encounter or before conducting pill call. This equates to 0.0% compliance.
3. Question 6 –The audit team observed that the facility medical staff were not cleaning the inmate-patient clinic area after each inmate-patient use. This equates to 0.0% compliance.
4. Question 10 – The central storage area for biohazard material is locked behind a chain link fence, but the gate is not labeled. This equates to 50.0% 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	25.7
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 timeframe? (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	0.0
12. At the initial intake screening, did all inmate-patients receive orientation regarding the procedures for accessing health care?	30.0	30.0
13. Did the inmate-patient receive a complete screening for the signs and symptoms of Tuberculosis (TB) upon arrival?	30.0	30.0
14. Did the inmate-patient receive a Tuberculin Skin Test (TS) evaluation upon arrival?	30.0	N/A
15. Does the initial intake screening take place in a manner that ensures inmate-patient confidentiality both visually and orally?	30.0	30.0
Point Totals:	450.0	265.7 (300.0)
Final Score:		**88.6%**

CHAPTER 12 COMMENTS

1. Question 2 – Of the seven inmate-patient shadow medical files reviewed, six included documentation indicating the inmate-patient received a health and appraisal (H&P) examination within 14 days of arrival at the facility. This equates to 85.7% compliance.
2. Question 3 – Not applicable. Of the seven inmate-patient shadow medical files reviewed, none indicated the inmate-patient was referred to the PCP during initial intake screening. Therefore, this question was not evaluated.
3. Questions 4 and 5 – Not applicable. There were no inmate-patients who presented with urgent medical, dental or mental health symptoms during the audit review period; therefore, these questions were not evaluated.
4. Question 6 – Not applicable. There were no inmate-patients arriving at the facility with a referral for a follow-up medical, dental, or mental health appointment during the audit review period. Therefore, this question was not evaluated.
5. Question 11 – The PCP does not document the inmate-patient H&P examinations on the CDCR 196-B, *Intake History and Physical Form*; instead the H&P examinations are documented on the GEO forms. This equates to 0.0% compliance. This is designated as a qualitative action item.
6. Question 14 – Not applicable. Due to a change in departmental policy, inmate-patients are not required to receive a Tuberculin (TB) skin test evaluation upon arrival. Inmate-patients receive a TB skin test upon arrival at the CDCR Reception Center and 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	0.0
8. Is annual training provided to medical staff?	10.0	10.0
Point Totals:	160.0	150.0
Final Score:		**93.8%**

CHAPTER 13 COMMENTS

1. Question 7 – The facility does not have a system in place to ensure that all health care staff receive training for new or revised policies based on IMSP&P. The Health Services Administrator (HSA) maintains a sign-in sheet in a policy binder for health care staff to sign off once they review the new and/or updated policy. There is no follow-up to ensure health care staff is aware of the new and/or updated expectations and requirements. This equates to 0.0% compliance. This is designated as a qualitative action item.

Chapter 14: Medication Management	**Point Value**	**Points Awarded**
1. Was the medication administered to the inmate-patient as ordered by the PCP?	30.0	0.0
2. Did the prescribing PCP document that they explained the medication to the inmate-patient?	30.0	8.6
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	0.0
5. Are inmate-patient's no shows documented on the MAR?	10.0	0.0
6. Are inmate-patient's refusals for medication administration documented on the MAR?	10.0	N/A
7. Are medication errors documented on the Incident Report-Medication Error Form?	10.0	N/A
8. Does the RN directly observe an inmate-patient taking DOT medication?	30.0	30.0
9. Does the RN check every inmate-patient's mouth, hands and cup after administering DOT medications?	30.0	30.0
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
Point Totals:	270.0	128.6 (220.0)
Final Score:		**58.5%**

CHAPTER 14 COMMENTS

1. Question 1 – Of the seven inmate-patient shadow medical files reviewed, none included documentation that the medication was administered to the inmate-patients as ordered by the PCP. This equates to 0.0% compliance.
2. Question 2 – Of the seven inmate-patient shadow medical files reviewed, two included documentation that the prescribing PCP explained the medication to the inmate-patient. This equates to 28.6% compliance.
3. Question 3 – Not applicable. This question automatically fails as a result of failure noted in question 14.5 below. Under the double-failure rule, the points for this question have therefore been removed from the total points available and the question rendered not applicable.
4. Question 4 – The nursing staff does not document on the MAR once DOT medications are administered. This equates to 0.0% compliance.
5. Question 5 – Only one inmate-patient was prescribed INH medication for tuberculosis. Upon review of this inmate-patient's MAR, no documentation was found in the medical file to indicate if the inmate-patient did not show for pill call or if the medication administered was not documented by the administering nurse. Since there was no documentation to prove either had occurred, this equates to 0.0% compliance.
6. Question 6 – Not applicable. There were no inmate-patient medication refusals during the audit review period; therefore, this question was not evaluated.
7. Question 7 – Not applicable. There were no medication errors reported during the audit review period; therefore, this question was not evaluated.

Chapter 15: Monitoring Log	**Point Value**	**Points Awarded**
1. Are inmate-patients seen within timeframes set forth in the sick call policy?	30.0	28.9
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	23.3
4. Are inmate-patients seen within timeframes as it relates to chronic care policy?	30.0	0.0
5. Are inmate-patients seen within timeframes set forth in the initial intake screening/health appraisal policy?	30.0	25.2
Point Totals:	150.0	77.4
Final Score:		**51.6%**

CHAPTER 15 COMMENTS

1. Question 1 – Based on the sick call monitoring logs submitted by facility for the audit review period, a total of 273 sick call appointment requests were reviewed, of which 263 inmate-patients were seen by RN within the specified timeframe. This equates to 96.3% compliance.

Routine		**Urgent**		**Emergent**		**Totals**	
# of requests reviewed	# within timeframe	# of requests reviewed	# within timeframe	# of requests reviewed	# within timeframe	# of requests reviewed	# within timeframe
271	262	0	0	1	1	**273**	**263**

2. Question 2 – The specialty care monitoring logs submitted by facility for the audit review period are incomplete with several columns missing mandatory information/data; as such, the audit team is unable to determine compliance with this requirement. This equates to 0.0% compliance.

3. Question 3 – Based on the emergency/hospital services monitoring logs submitted by facility for the audit review period, a total of nine inmate-patients were transported offsite for emergency services. Out of nine inmate-patients who returned from outside emergency/hospital services, seven were seen within the specified timeframe. This equates to 77.8% compliance.

4. Question 4 – The chronic care monitoring logs submitted by facility for the audit review period are incomplete with several columns missing mandatory information/data; as such, the audit team is unable to determine compliance with this requirement. This equates to 0.0% compliance.

5. Question 5 - Based on the initial intake screening/health appraisal monitoring logs submitted by facility for the audit review period, of the 88 inmate-patients requiring initial health appraisal, 74 were seen by a provider within the specified timeframe. This equates to 84.1% compliance.

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

CHAPTER 16 COMMENTS

1. Questions 1 through 3 – Not applicable. This 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, does 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, does an RN/PCP document their discussion of risk and benefits of refusing the appointment/treatment in the inmate-patient's Progress Notes section of the Electronic Medical Record?	10.0	10.0
3. If an inmate-patient did not show for their medical appointment, did the RN/LIP contact the housing unit supervisor to have the inmate-patient escorted to medical to speak with health care staff?	10.0	10.0
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	10.0
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	7.5
Point Totals:	50.0	47.5
Final Score:		**95.0%**

CHAPTER 17 COMMENTS

1. Question 5 – Of the four inmate-patient shadow medical files reviewed, three included documentation by an RN citing the reason for the inmate-patient's no-show for their medical appointment/treatment. This equates to 75.0% compliance. This is designated as a qualitative action item.

Chapter 18: Sick Call	Point Value	Points Awarded
1. Does the inmate-patient handbook or similar document explain the sick call process?	10.0	10.0
2. Is an RN reviewing all sick call request forms within one day of receipt?	30.0	30.0
3. If the sick call request reflected inmate-patient symptoms, was it reviewed by an RN within one business day?	30.0	30.0
4. Are inmate-patients seen and evaluated face-to-face by an RN/PCP if the sick call request form indicates an emergent health care need?	30.0	30.0
5. Did the inmate-patient have a face-to-face (FTF) evaluation within the next business day if the health care request slip review indicates a non-emergent health care need?	30.0	30.0
6. Was the S.O.A.P.E. note on the CDCR Form 7362, *Request for Health Care Services*, and/or CDCR Form 7230, *Interdisciplinary Progress Note*, or a CCF similar form completed?	30.0	30.0
7. If an inmate-patient was referred to the Hub or MCCF PCP by the MCCF RN, was the inmate-patient seen within the specified timeframe?	30.0	30.0
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	30.0
12. If the MCCF RN/PCP determines the inmate-patient's request for medical services are beyond the level available at the facility, does the RN schedule a sick call appointment with the Hub for the inmate-patient and process the appropriate paperwork?	30.0	30.0
13. If the MCCF RN/PCP determines the inmate-patient's request for medical services are beyond the level available at the facility, does the RN obtain approval/authorization for the Hub CME or designee?	30.0	30.0
14. If the MCCF RN/PCP determines the inmate-patient's request for medical services are beyond the level available at the facility, does the RN notify the appropriate MCCF staff to coordinate transportation?	30.0	30.0
15. Do the sick call visit locations provide for inmate-patient confidentiality both visually and orally in all housing units?	30.0	30.0
16. Are the sick call request forms readily available to inmate-patients in all housing units?	10.0	10.0
17. Are inmate-patients able to submit sick call request forms on a daily basis in secured/locked boxes in all housing units?	10.0	10.0
Point Totals:	410.0	380.0 (380.0)
Final Score:		**100%**

CHAPTER 18 COMMENTS

1. Question 8 – Not applicable. There were no inmate-patients who had presented to sick call three or more times in a one month period during the audit review period; therefore, this question was not evaluated.

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	15.0
4. Did the RN complete a FTF evaluation upon the inmate-patient's return from a specialty consultation appointment?	30.0	N/A
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	N/A
Point Totals:	180.0	75.0 (90.0)
Final Score:		**83.3%**

CHAPTER 19 COMMENTS

1. Question 3 – Of the two inmate-patient shadow medical files reviewed, one indicated an audiological consultation had been ordered by the PCP on October 28, 2014; however, there was no documentation in the shadow medical file to indicate this service had been scheduled or provided to the inmate-patient. This equates to 50.0% compliance.
2. Questions 4 through 6 – Not applicable. Of the two inmate-patient shadow medical files reviewed, one of the files had no documentation to indicate if the service had been provided to the inmate-patient or not (as noted in Question 3 comment above). The other inmate-patient had been transferred to the hub for an orthopedic consultation via telemedicine and had not returned from the hub by the completion of the audit. Therefore, these questions were not evaluated to determine compliance with these requirements.

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

CHAPTER 20 COMMENTS

None.

QUALITATIVE FINDINGS

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

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

W. Wilson – Warden
D. Zachary Stronge – NP
N. Evans – Director of Nursing (A) / HSA
M. Lucatero – RN
G. Contreras - RN
S. Barcenilla - RN
L. Gilmore - RN
K. Ceja – Medical Records Clerk
C. Villalobos – Human Resource Specialist/Executive Secretary

The following narrative represents a summary of the information gleaned through interviews of the above-listed personnel, as well as conclusions and inferences drawn from correlating observations and data collected during other portions of the audit. The findings are categorized into three areas: Operations, Emergency Medical Response Drill, and Corrective Action Issues.

SUMMARY OF QUALITATIVE FINDINGS

On April 1, 2014, the facility was selected by CDCR to house minimum-security adult female inmates. These inmates are within one year of release with a moderate to high risk to reoffend and an assessed criminogenic need as identified by CDCR. In July 2014, the facility was activated with a primary mission/objective of providing enhanced rehabilitation and recidivism reduction programs; General Education (GED) and Adult Basic Education; Life Skills programs and inmate work and training programs.

Since the activation of FCRF in July 2014, this is the facility's first health care monitoring audit conducted by Field Operations staff. As indicated by facility's overall audit score of 79.6% compliance, FCRF has numerous deficiencies that need to be addressed and resolved in a timely manner. Of the 20 ratable chapters, 2 chapters were not applicable and as such were not rated, 12 chapters scored below 85.0% compliance and only 6 chapters scored above 85.0%. FCRF's inadequacy in monitoring and lack of adequate training to the facility's medical staff has resulted in the facility's poor performance in key areas, such as medical emergency services/drills, medical emergency equipment, infection control, medication management, and monitoring logs all of which has adversely affected the overall score of this audit.

OPERATIONS

The FCRF is a very small facility, consisting of four dormitory-style living quarters, a receiving and release area with three holding cells, a visiting area, a medical clinic, laundry facilities, a centralized kitchen with dining room, and a commissary. Portable administrative offices and vocational classrooms are located outside the facility's main building. Unlike other Modified Community Correctional Facilities (MCCFs), FCRF's medical clinic consists of three examination rooms for medical appointments and one examination room for dental treatments. The clinic also has a secured waiting room area; however, there is no area where inmate-patients with potential communicable diseases may be isolated. The clinic also has two offices, one for a medical records clerk and the other one for the HSA.

This is FCRF's initial audit since the facility's activation in July, 2014. Since this was audit team's first onsite visit, upon arrival to the FCRF the audit team requested and was given a detailed tour of the facility. During the tour, the audit team observed that medical clinic and the facility appeared to be very clean and well maintained. The audit team also observed and interviewed health care and custody staff with regards to the daily operations of the facility and found both custody and medical staff very approachable and receptive to feedback provided by the audit team.

During the audit process, the audit team reviewed the facility's health care LOPs to ensure they are in compliance with the IMSP&P requirements, reviewed the facility's monitoring logs for accuracy and completeness, reviewed the facility's CQI and EMRRC meeting minutes, reviewed the inmate-patient's medical records to ensure they were seen within the specified timeframe for different types of medical services, reviewed the sick call process, observed the facility's emergency response drill and equipment, observed the medication pass. The audit team interviewed health care personnel on various medical processes and procedures.

Personnel:

Administration

With regards to administrative aspect of the audit, the audit team learned that FCRF is struggling to provide and ensure all health care staff received required training as it relates to health care policies and procedures and various medical processes. Since the activation of the facility in July 2014, none of the nursing staff or the treating NP or PCP has received any training at CCWF, the hub institution for FCRF. Currently, all MCCFs are expected to coordinate with the hub institutions to facilitate training for their health care staff on IMSP&P guidelines and nurse and physician treatment protocols practiced by CCHCS health care staff at the hub. Hence, FCRF is encouraged to work closely with CCWF to arrange for orientation and training for its entire medical staff.

Prior to the onsite audit, the audit team reviewed the monitoring logs (sick call, specialty care, emergency/hospital services, chronic care, and initial intake/health appraisal) that facility submits to PPCMU on a weekly and monthly basis and noted that all of the logs are lacking essential information/data. The audit team discussed the deficiencies and discrepancies identified on the monitoring logs with the Director of Nursing (A)/HSA and emphasized the importance of submitting accurate and complete information in a timely manner. The facility staff acknowledged there was lack of instructions and/or training provided to nursing staff with regards to completing the monitoring logs.

The audit team responded by providing a hard copy of the monitoring log instruction guide to the HSA and advised the HSA to make copies to distribute to all nursing staff assigned to this task.

FCRF Health Care Staff – Nursing

The audit team observed the nursing staff and the daily operations of the clinic. The inmate-patient sick call requests are collected from the locked boxes in the housing units twice a day by the medical records clerk. The nursing staff triage the sick call slips daily. If an inmate-patient's sick call request indicates that a higher level of care is required that is beyond the level the facility is able to provide, the RN notifies the hub institution for further directions.

With regards to medication management, the nurse auditor observed two pill calls to examine the medication administration process. The auditor noted that, with the exception of the insulin dependent diabetics, the nursing staff appear to be relying on inmate-patients to come to the pill call window for their DOT medications and the facility does not appear to have a process of checking and documenting inmate-patient no-shows for medications. The nurse auditor noted there was no documentation in the MAR of one inmate-patient, who had been prescribed INH for tuberculosis, indicating the medication was received for the month of February, 2015. The medication is prescribed to be administered twice a week; therefore, by the date of the audit, the inmate-patient should have received three to four doses. The auditor discussed this discrepancy with the HSA who called one of the nurses to enquire if she had administered the TB medication. The nurse confirmed that the medication had been administered; however, she forgot to document it. There was another issue noted where the inmate-patient, who was prescribed medication for ulcerative colitis, had refused to take the medication on several occasions and had signed a refusal form for several days. However, the NP was neither notified by the RN about the inmate-patient's refusal nor did the RN refer the inmate-patient to the NP for medication non-compliance.

Furthermore, during the staff interview, the HSA informed the audit team that the facility staff ***had destroyed the MARs from December, 2014 and earlier***. When the auditors enquired the reason, the HSA stated that when the facility sent the MARs to the hub institution for uploading into the eUHR, the hub refused to upload them because they were GEO forms. The HSA was informed that MARs are part of the inmate-patient's medical record and should have been filed with all other documents in the shadow medical file even if they were not uploaded. The audit team noted that the facility currently has CDCR's MAR forms in place; however, nursing staff does not always remember to utilize them. The audit team reminded the HSA that if medication administration is not documented on the MAR, it is assumed to not have been given. It is strongly recommended the facility provide an in-service training to its entire nursing staff primarily focusing on the importance and the value of documenting the administration of medications and notifying the NP of the cases where inmate-patients consistently refuse medication or do not show for pill line.

Since there were no new intakes at the facility during the audit, the audit team interviewed the HSA about the intake process to assess her knowledge of the process. The HSA responded that newly arriving inmates receive intake screening, tuberculosis screening, and a mental health screening. All keep on person (KOP) medications are checked against the pharmacy profile; however, inmates are not allowed to keep over-the-counter (OTC) medications on them. Inmate-patients arriving at the facility with KOP OTC medication must hand over the medication to nursing staff during intake. If OTC medication is needed, the inmate-patient is required to go to the pill call window, which is open twice a

day, and request a single dose, which must be taken at that time. Yet, if an inmate-patient requires and needs to take an additional dose either later in the day or at night, the inmate-patient is not afforded that opportunity. This process subjects the inmate-patient to undue pain and discomfort, especially if an inmate-patient is prescribed KOP OTC medication for arthritis, or even something as basic as cough drops. During the inmate interviews, some inmate-patients expressed concern of not having access to their KOP OTC medications when needed. The nurse-auditor discussed this concern with the HSA and the HSA stated that they do not give out the KOP medications for pain because they suspect the inmate-patients would abuse the prescription medications if they are allowed to keep them on their person. She also added that it is the facility's policy to dispense KOP medications twice a day during pill call. However, upon reviewing the facility's Medication Administration policy (policy #710) for their KOP medication distribution, there was no mention of KOP medication or any process describing how KOP medications are dispensed to the inmate-patients.

The facility is not compliant with IMSP&P policy related to the distribution of KOP medications to the inmate-patients. IMSP&P volume 4, chapter 11 *Medication Management* clearly states that:

"Keep on Person (KOP) medications are those medications that the prescriber believes can be safely administered by the patient. Inmates participating in this privileged program must be able to understand instructions for self-administration of medications and be able to safely store and secure his/her medications. Inmates participating in the program shall be able to produce a valid, current label for each medication they have on person and may be required to return inhalers and pill containers prior to receiving refills or additional medication."

FCRF's current practice is contrary to the guidelines stated in the IMSP&P and as a result, the inmate-patients are not being provided an opportunity to manage chronic pain, as stated by one of the inmate-patients during the interview. This practice further demonstrates the facility's inability to provide adequate care to inmate-patients, especially those in chronic pain. The facility needs to re-examine their current practice for dispensing KOP medications, come into compliance with the current CCHCS IMSP&P. Abuse of KOP medications should be dealt with on an individual level through the disciplinary process. Without proper documentation and past incidents that show an abuse of OTC medication, the facility's assumptions are just that, assumptions. The assumptions regarding inmate-patients abusing prescription medication shall not hinder providing adequate care to inmate-patients with chronic pain. This issue will be reviewed by the audit team during subsequent audits.

Lastly, it should be noted that FCRF is currently contracted with Lab Corp, a health care diagnostics company, to provide clinical laboratory services for the facility. However, all MCCFs were recently directed by Contract Beds Unit, (on the recommendation provided by CCHCS Headquarters) to obtain a contract with Quest Diagnostics, the only provider approved by CCHCS. The audit team informed the facility of this requirement and the facility indicated they will reach out to their corporate office to pursue the matter, but until such time that Geo obtains a contract with Quest Diagnostics; FCRF will continue to utilize Lab Corp's services.

FRCF Health Care Staff – Primary Care Provider (PCP)

During the onsite audit, the audit team learned *the NP does not access the eUHR*. This was directly observed by the audit team when the audit team requested the NP to access the eUHR system in their presence and the NP failed in spite of numerous attempts.

While onsite, the physician auditor observed the facility's NP during two clinical encounters and did not identify any concerns or deficiencies. The auditor also reviewed 14 inmate-patient shadow medical files (six chronic care, four sick call, four history and physical) to gauge the quality and timeliness of the medical services provided to the inmate-patients by the facility's NP and found the care provided to be adequate. With the exception of one chronic care chart missing documentation of a follow-up, no major departures were noted. This issue was discussed with the NP and the NP assured the auditor she will be more attentive to documentation. During the interview, the physician auditor also learned that the NP is not familiar with Title 15 and its application to medical necessity. The auditor discussed Title 15 and the medical necessity as it applies to the CDCR and their inmate-patients and provided NP with a copy of Title 15 for reference.

EMERGENCY MEDICAL RESPONSE DRILL

Upon request of the audit team, the facility conducted an emergency medical response drill involving a patient in cardiac arrest on February 10, 2015 during the onsite audit. The drill was staged in the yard area with a custody officer assuming the role of an unresponsive, pulse less, non-breathing patient. The drill lasted for four minutes. The drill was conducted fairly well; however, the following deficiencies were identified by the audit team and these deficiencies were discussed with the staff involved in the drill:

- The NP was present in the clinic at the time of the drill; however, did not participate in the drill;
- CPR was not started immediately by the custody officer who discovered the victim and;
- Emergency Response Bag was never opened to use the Ambu bag, oxygen, mask, airways, etc.

It should be noted that upon the audit team's request, the facility was unable to provide documentation to show that the emergency medical response drills are conducted at least quarterly on every watch nor was the facility able to provide documentation that the EMRRC meetings are being held on a monthly basis. The purpose of the monthly EMRRC meeting is to discuss the results of the drill conducted and based on the findings and deficiencies identified, implement a quality improvement plan addressing these deficiencies to ensure they do not occur during the next medical emergency and/or drill. The EMRRC is also responsible for evaluating compliance with the existing policies and procedures, medical and custody staff's response times, appropriateness of medical care provided, and documentation as per CCHCS requirements. It is imperative the facility hold an EMRRC meeting monthly and maintain minutes for all meetings held, the names of all attendees, and a quality improvement plan addressing deficiencies identified in the response procedures. It is also important the facility document and maintain meeting minutes regarding the emergency medical response drills it conducts at least quarterly on each watch.

CORRECTIVE ACTION ISSUES

As a result of the February, 2015 audit, there are 31 quantitative CAP items as identified previously in the "Quantitative Findings" section of this report, four qualitative CAP items resulting from failed questions but which are within the passing chapters, also identified in the "Quantitative Findings" section of the report and one additional qualitative CAP item discussed below.

1. *NOT ALL OF THE FACILITY'S CUSTODY STAFF AND VOCATIONAL INSTRUCTORS HAVE BASIC LIFE SUPPORT CERTIFICATIONS.* During the review of the training documentation provided by facility, it was identified that not all of the facility's custody staff and vocational instructors have current BLS certifications. As custody staff are typically first responders in case of an emergency, it is essential all custody staff know how to approach and properly respond to a medical emergency. The facility's Human Resources Specialist did indicate that all of their custody staff is currently in process of being scheduled for training. This issue will be addressed and monitored in subsequent audits.

CONCLUSION

The facility's initial audit revealed that FCRF is struggling to consistently provide adequate health care. The root causes appear to be related to insufficient documentation, lack of staff training and preparedness drills and poor internal monitoring processes. The facility is encouraged to work diligently on improving the quality of health care services being provided to the CDCR inmate-patients, develop and implement all policies and/or procedures identified as deficient, timely address and resolve all CAP items, and strive to attain at least 85.0% compliance in all areas of the audit instrument.

Although the Warden was not available to meet with the audit team in person for the exit conference/interview, she participated via telephone. During the exit conference, the audit team debriefed FCRF on the above listed deficiencies. The facility was very receptive to constructive feedback presented by the audit team and assured the audit team that the identified issues will be resolved expediently. The audit team is confident FCRF will work diligently and efficiently to resolve the concerns and deficiencies addressed in this report in order to adhere to contractual obligations and to meet the expectations and requirements set forth in the IMSP&P.

STAFFING UTILIZATION

Prior to the onsite audit at FCRF, 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, for at least four hours a day.

The FCRF's medical clinic is currently staffed with a registered nurse 24 hours a day, seven days a week. The facility also has a full time NP on staff. However, the NP does not currently have any physician oversight. The facility had been staffed with a part time PCP until December 2014 and at that time the PCP provided oversight for the NP. FRCF has been without PCP oversight since January, 2015. Currently the facility is active in their efforts to recruit a PCP to fill the vacancy.

INMATE INTERVIEWS

The intent of this portion of the audit is to elicit substantive responses from a designated number of the inmate-patients, by utilizing each question as a springboard for discussion, with appropriate follow up to identify any areas where barriers to health care access may potentially exist. In general population facilities, this is accomplished via interview of the Inmate Advisory Council (IAC) executive body. The results of the interviews conducted at FCRF 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. Regarding questions 1 through 8 – All of the six inmate-patients interviewed were aware of the sick call and health care appeal processes and had utilized the process at one point or another. One inmate-patient claimed she had a seizure a month ago and there was no follow-up completed by health care staff after the incident. The nurse-auditor discussed this concern with the HSA. The HSA advised that the seizure was just a one-time event and at the time, the inmate-patient was prescribed anti-seizure medications. The HSA added that the inmate-patient has not exhibited any symptoms indicating seizure since that incident. The auditor

recommended the HSA and nursing staff to be proactive in scheduling and seeing inmate-patients for follow-up appointments, especially for cases such as this.

2. Regarding questions 9 through 23 – There were two DPP inmate-patients housed at FCRF at the time of the audit. Both inmate-patients have a hearing impairment and wear hearing assistive devices. These inmate-patients were interviewed to gauge their understanding of the ADA process and if they were aware of the process for requesting accommodations based on their disabilities. During the interview, these inmate-patients did not express any concern regarding the medical care and accommodations provided to them. They stated that the medical staff are very friendly; the staff answer all their questions and also establish effective communication with them during each visit. The inmate-patients also stated that when the batteries in their hearing devices have to be replaced, the medical staff provide them with new batteries promptly. These inmate-patients were also interviewed regarding the health care appeal process. They stated that they have never felt the need to appeal since they don't have any complaints about any of the staff at the facility. Overall, they did not seem to have any issues regarding the accommodations or services provided to them.

Female Community Re-entry Facility, McFarland
Health Care Monitoring Audit - Corrective Action Plan
Audit Dates: February 9-10, 2015
CAP Date: Month xx, xxxx

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Reference Chap/Q		Specific Nature of Non-Compliance	Facility's Proposed Action Plan	Anticipated Completion Date	Assigned Personnel	Action Plan Status
1	5	The facility does not have a written policy that addresses the requirements for the release of medical information.				Not Completed / In Progress / Completed [DATE]
1	13	The facility does not have a written policy and/or procedure related to specialty services.				Not Completed / In Progress / Completed [DATE]
1	17	The facility does not have a written policy and/or procedure related to licensure and training.				Not Completed / In Progress / Completed [DATE]
2	1	The Nurse Practitioner (NP) could not demonstrate her ability to access the Electronic Unit Health Record.				Not Completed / In Progress / Completed [DATE]
2	4	The facility's Release of Information (ROI) log does not contain all the required information.				Not Completed / In Progress / Completed [DATE]
3	4	The facility does not have a local operating procedure (LOP) that explains provision of interim accommodation to a Disability Placement Program (DPP) inmate-patient while an appliance is ordered, repaired, or in the process of being replaced.				Not Completed / In Progress / Completed [DATE]
3	5	The facility does not have a LOP defining a process for adding to or removing an inmate-patient from a DPP list.				Not Completed / In Progress / Completed [DATE]
3	6	The facility does not have a LOP defining the requirement to establish and document effective communication between health care staff and inmate-patient during each clinical encounter.				Not Completed / In Progress / Completed [DATE]

Reference Chap/Q		Specific Nature of Non-Compliance	Facility's Proposed Action Plan	Anticipated Completion Date	Assigned Personnel	Action Plan Status
6	5	The Continuous Quality Improvement committee does not complete an analysis for each identified “opportunity for improvement” as listed on the Aspects of Care Monitoring form, or similar form.				Not Completed / In Progress / Completed [DATE]
7	2	The PCP does not consistently review, initial, and date all inmate-patient diagnostic test reports within the specified timeframe.				Not Completed / In Progress / Completed [DATE]
7	4	The inmate-patients do not consistently receive written notification of the diagnostic test results within two days of receipt.				Not Completed / In Progress / Completed [DATE]
8	4	The facility’s nursing staff does not consistently document the review of the inmate-patient’s discharge plan upon inmate-patient’s return to the facility from the community hospital emergency department.				Not Completed / In Progress / Completed [DATE]
8	5	The facility’s nursing staff does not consistently document the face-to-face evaluation of inmate-patients upon their return to the facility from the community hospital emergency department.				Not Completed / In Progress / Completed [DATE]
8	7	The facility does not hold monthly Emergency Response Review Committee meetings.				Not Completed / In Progress / Completed [DATE]
8	9	The facility does not conduct quarterly emergency medical response drills on each shift.				Not Completed / In Progress / Completed [DATE]
9	3	The facility does not have a portable suction device.				Not Completed / In Progress / Completed [DATE]
10	1	The inmate orientation manual/handbook does not explain the health care grievance/appeal process in detail.				Not Completed / In Progress / Completed [DATE]

Reference Chap/Q		Specific Nature of Non-Compliance	Facility's Proposed Action Plan	Anticipated Completion Date	Assigned Personnel	Action Plan Status
11	2	The inmate-patients who come to the clinic with a potential communicable disease are not isolated from the rest of the inmate-patients in the clinic area.				Not Completed / In Progress / Completed [DATE]
11	3	The facility's nursing staff does not consistently practice proper hand hygiene.				Not Completed / In Progress / Completed [DATE]
11	6	The inmate-patient clinic area is not being cleaned after each inmate-patient use.				Not Completed / In Progress / Completed [DATE]
11	10	The central storage area for biohazard materials is not labeled.				Not Completed / In Progress / Completed [DATE]
14	1	The nursing staff does not consistently administer medications to inmate-patients as ordered by the PCP.				Not Completed / In Progress / Completed [DATE]
14	2	The PCP does not consistently document that they explained the medication to the inmate-patient.				Not Completed / In Progress / Completed [DATE]
14	4	The nursing staff does not document on the Medication Administration Record (MAR), after the medication is administered to the inmate-patient.				Not Completed / In Progress / Completed [DATE]
14	5	The nursing staff does not consistently document on the MAR when the inmate-patient is a no show for medication administration.				Not Completed / In Progress / Completed [DATE]
15	1	Inmate-patients are not consistently seen within the specified timeframes as set forth in the sick call policy.				Not Completed / In Progress / Completed [DATE]
15	2	Inmate-patients are not consistently seen within the specified timeframes as set forth in the specialty care policy.				Not Completed / In Progress / Completed [DATE]

Reference Chap/Q		Specific Nature of Non-Compliance	Facility's Proposed Action Plan	Anticipated Completion Date	Assigned Personnel	Action Plan Status
15	3	Inmate-patients are not consistently seen within the specified timeframes as set forth in the emergency/hospital services policy.				Not Completed / In Progress / Completed [DATE]
15	4	Inmate-patients are not consistently seen within the specified timeframes as set forth in the chronic care policy.				Not Completed / In Progress / Completed [DATE]
15	5	Inmate-patients are not consistently seen within the specified timeframes as set forth in the initial intake screening policy.				Not Completed / In Progress / Completed [DATE]
19	3	The inmate-patients are not consistently seen by the specialist within the timeframe specified by the PCP.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #1		Not all of the facility's custody staff and vocational instructors have current Basic Life Support (BLS) certifications.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #2		The inmate-patient's chronic care follow-up visits are not consistently completed within the 90-day or less timeframe, or as ordered by the treating PCP.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #3		The treating PCP is not documenting the inmate-patient health appraisals/history and physical examinations on the CDCR 196-B, Intake History and Physical form.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #4		The facility does not have a system in place to ensure health care staff receives training for new or revised policies based on Inmate Medical Services Policies and Procedures requirements.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #5		The nursing staff does not consistently document the reason for the inmate-patient's no-show to their medical treatment /appointment.				Not Completed / In Progress / Completed [DATE]

Reference Chap/Q	Specific Nature of Non-Compliance	Facility's Proposed Action Plan	Anticipated Completion Date	Assigned Personnel	Action Plan Status
Name, Warden **Facility Name**		**Name,** Health Services Administrator **Facility Name**			