April 15, 2016

Cynthia Armant, Warden
Desert View Modified Community Correctional Facility
10450 Rancho Road
Adelanto, CA 92301

Dear Warden Armant:

The staff from California Correctional Health Care Services (CCHCS) completed an onsite health care monitoring audit at Desert View Modified Community Correctional Facility (DVMCCF) from February 2 through 4, 2016. The purpose of this audit was to ensure that DVMCCF is meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006.

On March 31, 2016, a draft report was sent to you providing the opportunity to review and dispute any findings presented in the draft report. On April 4, 2016, your facility submitted a response disputing 32 of the audit team's findings. The attached document reflects 4 of the 32 items disputed which have been reconsidered. Acceptance of these questions has resulted in the removal of three items from the list of Outstanding Critical issues. Refer to the attached documents for the CCHCS's detailed response to questions and items disputed by DVMCCF.

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

The audit findings reveal that during the audit review period, DVMCCF failed to provide adequate health care to CDCR patients housed at the facility. The facility's continued struggle with internal monitoring, specifically as it relates to the completion of the weekly and monthly monitoring logs, completion of timely peer review for facility's providers, patient's access to care, chronic care management, diagnostic services, emergency services, health appraisal/health care transfer process and emergency medical response training drills and maintenance of the emergency medical response equipment, has resulted in barriers that prevented patients from receiving adequate level of care.

Additionally, the facility continues to struggle with the high turnover rate and inconsistency in the nursing and provider staffing, making it a challenge to provide continuous and quality care to its patient population. These deficiencies require the facility's immediate attention and resolution and can be brought to compliance by the facility's strict adherence to the established policies and procedures outlined in the *Inmate Medical Services Policies and Procedures*, contract, and the standard nursing and physician practice.

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 Rita Lowe, Health Program Manager II (HPM II) (A), Private Prison Compliance and Monitoring Unit (PPCMU), Field Operations, Corrections Services, CCHCS, at (916) 691-4831 or via email at Rita.Lowe@cdcr.ca.gov.

Sincerely,
Don Meier, Deputy Director
Field Operations, Corrections Services
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
Kathleen Allison, Director (A), Division of Adult Institutions (DAI), CDCR
Roscoe L. Barrow, Chief Counsel, CCHCS
Ricki Barnett, M.D., Assistant Statewide Medical Executive and Deputy Director, Medical Services, CCHCS
Jeffrey Carrick, M.D., Deputy Medical Executive, Utilization Management, CCHCS
Cheryl Schutt, Statewide Chief Nurse Executive, Nursing Services, CCHCS
Jay Virbel, Associate Director, Female Offender Programs and Services/Special Housing, DAI, CDCR
Joseph W. Moss, Chief, Contract Beds Unit, California Out-of-State Correctional Facility (COCF), DAI, CDCR
Michael J. Williams, Chief Deputy Administrator, Contract Beds Unit, COCF, DAI, CDCR
Penny Shank, Chief Executive Officer, California State Prison, Los Angeles County, CCHCS
Grace Song, M.D., Physician Advisor, Southern Region, Utilization Management, CCHCS
Ada Rivera, M.D., Chief Medical Officer, Geo Group, Inc.
Joseph Williams, Correctional Administrator, Field Operations, Corrections Services, CCHCS
Luzviminda Pareja, Nurse Consultant Program Review, Field Operations, Corrections Services, CCHCS
Linda Larabee, Manager, Division of Internal Oversight and Research, CDCR
Rita Lowe, HPM II (A), PPCMU, Field Operations, Corrections Services, CCHCS
Kanika Broussard, HPM I, PPCMU, Field Operations, Corrections Services, CCHCS
Vera Lastovskiy, Health Program Specialist I, Field Operations, Corrections Services, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT

Desert View Modified Community Correctional Facility

February 2-4, 2016

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DATE OF REPORT

April 15, 2016

INTRODUCTION

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

As one of several means to ensure the prescribed health care standards are provided, CCHCS staff developed a tool to evaluate the effectiveness, efficiency and compliance of the health care processes implemented at each contracted facility to facilitate patient access to health care. This audit instrument is intended to measure the facility's compliance with various elements of patient access to health care and to assess the quality of health care services provided to the patient population housed in these facilities.

This report provides the findings associated with the onsite audit conducted between February 2 and 4, 2016, at Desert View Modified Community Correctional Facility (DVMCCF) located in Adelanto, California, as well as findings associated with the review of various documents and patient medical records for the review period of August 2015 through January 2016. At the time of the audit, CDCR's *Weekly Population Count*, dated January 22, 2016, indicated a budgeted bed capacity of 700 beds, of which 619 were occupied with CDCR inmates.

EXECUTIVE SUMMARY

From February 2 through 4, 2016, the CCHCS audit team conducted an onsite health care monitoring audit at DVMCCF. The audit team consisted of the following personnel:

G. Song, MD, Regional Physician Advisor
L. Pareja, RN, MSN, Nurse Consultant Program Review
V. Lastovskiy, Health Program Specialist I

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

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

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

Based on the quantitative reviews and clinical case reviews completed for the 15 applicable operational areas/quality indicators during the audit, DVMCCF achieved an overall point value of **0.4** which resulted in an overall audit rating of ***inadequate.***

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

Executive Summary Table

Operational Area/Quality Indicator	Case Review Rating	Quantitative Review Score	Quantitative Review Rating	Overall Indicator Rating	Points Scored
1. Administrative Operations	N/A	84.2%	Inadequate	**Inadequate**	0.0
2. Internal Monitoring & QM	N/A	87.4%	Adequate	**Adequate**	1.0
3. Licensing/Certification, Training & Staffing	N/A	82.6%	Inadequate	**Inadequate**	0.0
4. Access to Care	Inadequate	85.8%	Adequate	**Inadequate**	0.0
5. Chronic Care Management	Inadequate	84.8%	Inadequate	**Inadequate**	0.0
6. Community Hospital Discharge	Adequate	83.3%	Inadequate	**Adequate**	1.0
7. Diagnostic Services	Inadequate	83.8%	Inadequate	**Inadequate**	0.0
8. Emergency Services	Inadequate	N/A	N/A	**Inadequate**	0.0
9. Health Appraisal/Health Care Transfer	Inadequate	78.0%	Inadequate	**Inadequate**	0.0
10. Medication Management	Adequate	84.4%	Inadequate	**Adequate**	1.0
11. Observation Cells	N/A	N/A	N/A	**N/A**	N/A
12. Specialty Services	Adequate	82.0%	Inadequate	**Adequate**	1.0
13. Preventive Services	N/A	N/A	N/A	**N/A**	N/A
14. Emergency Medical Response/Drills & Equipment	N/A	57.7%	Inadequate	**Inadequate**	0.0
15. Clinical Environment	N/A	91.3%	Proficient	**Proficient**	2.0
16. Quality of Nursing Performance	Inadequate	N/A	N/A	**Inadequate**	0.0
17. Quality of Provider Performance	Inadequate	N/A	N/A	**Inadequate**	0.0
				Average	**0.4**
				Overall Audit Rating	**Inadequate**

NOTE: For specific information regarding any non-compliance findings indicated in the tables above, please refer to the Identification of Critical Issues (located on page 11 of this report), or to the detailed audit findings by quality indicator (located on page 14) sections of this report.

BACKGROUND AND PROCESS CHANGES

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

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

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

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

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

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

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

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

Quantitative Review

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

To maintain a metric-oriented monitoring program that evaluates medical care delivery consistently at each correctional facility, CCHCS identified 14 medical and 3 administrative indicators of health care to measure. The medical components cover clinical categories directly relating to the health care provided

to patients, whereas the administrative components address the organizational functions that support a health care delivery system.

The 14 medical program components are: *Access to Care, Chronic Care Management, Community Hospital Discharge, Diagnostic Services, Emergency Services, Health Appraisal/Health Care Transfer, Medication Management, Observation Cells, Specialty Services, Preventive Services, Emergency Medical Response/Drills and Equipment, Clinical Environment, Quality of Nursing Performance* and Quality of Provider Performance. The 3 administrative components are: *Administrative Operations, Internal Monitoring and Quality Management and Licensing/Certifications, Training and Staffing.*

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

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

The compliance score for each question is expressed as a percentage rounded to the nearest tenth. For example, a question scored 13 'Yes', 3 'N/A', and 4 'No".
Compliance Score = 13 'Yes' / 17 (13 'Yes' + 4 'No') = .764 x 100 = 76.47 rounded up to 76.5%.

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

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

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

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

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

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

Qualitative Review

The *qualitative* portion of the audit consists of case reviews conducted by CCHCS clinicians. The CCHCS clinicians include physicians and registered nurses. The clinicians evaluate areas of clinical access and the provision of clinically appropriate care which tends to defy numeric definition, but which nonetheless have a potentially significant impact on performance. The intention of utilizing the case reviews is to determine how the various medical system components inter-relate and respond to stress, exceptionally high utilization, or complexity.

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

The CCHCS physician and nurse case reviews are comprised of the following components:

1. Nurse Case Review

The CCHCS nursing staff perform two types of case reviews:

a. Detailed reviews - A retrospective review of ten selected patient health records is completed in order to evaluate the quality and timeliness of care provided by the facility's nursing staff during the audit review period. A majority of the patients selected for retrospective review are the ones with a high utilization of nursing services, as these patients are most likely to be affected by timely appointment scheduling, medication management, and referrals to health care providers.

b. Focused reviews – Five cases are selected from the audit review period of which three cases consist of patients who were transferred into the facility. The cases are reviewed for appropriateness of initial nurse health screening, referral, timeliness of provider evaluations, and continuity of care. The remaining two cases selected for review are patients, who were transferred out of the facility with pending specialty or chronic care appointments. These cases are reviewed to ensure that transfer forms contain all necessary documentation.

2. Physician Case Review

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

Overall Quality Indicator Rating

The overall quality of care provided in each health care operational area (or chapter) is determined by reviewing the rating obtained from clinical case reviews and the ratings obtained from quantitative review. The final outcome for each operational area is based on the critical nature of the deficiencies identified during the case reviews and the standards that were identified deficient in the quantitative reviews. For all those chapters under the *Medical Quality Indicator* section, whose compliance is

evaluated utilizing both quantitative and clinical case reviews, more weight is assigned to the rating results from the clinical case reviews, as it directly relates to the health care provided to patients. However, the overall quality rating for each operational area is not determined by clinical case reviews alone. This is determined on a case by case basis by evaluating the deficiencies identified and their direct impact on the overall health care delivery at the facility.

The physician and nurse auditors discuss the ratings obtained as a result of their case reviews and ratings obtained from quantitative review to arrive at the overall rating for each operational area. Based on the collective results of the case reviews and quantitative reviews, each quality indicator is rated as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*.

Overall Audit Rating

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

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

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

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

- **Adequate** - A threshold value of 1.0 has been determined to be the minimum value required to achieve a quality rating of *adequate*. Therefore, any value falling between 1.0 and 1.7 will be rated as *adequate*.

- **Inadequate** - A threshold value falling between the range of 0.0 and 0.9 will be assigned a rating of *inadequate*.

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

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

Scoring for Non-Applicable Questions and Double-Failures:

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

Resolution of Critical Issues

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

IDENTIFICATION OF CRITICAL ISSUES

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

Critical Issues – Desert View Modified Community Correctional Facility	
Question 1.2	The facility does not have local operating procedures/policies that are in compliance with the *Inmate Medical Services Policies and Procedures*.
Question 1.5	The facility's mid-level provider does not access the California Correctional Health Care Services patients' electronic unit health record (eUHR) system. *This is a new critical issue.*
Question 2.1	The facility does not consistently hold a Quality Management Committee meeting a minimum of once per month.
Question 2.7	The facility does not accurately document all the dates on the hospital stay/emergency department monitoring log. *This is a new critical issue.*
Question 2.13	The facility does not consistently process first level health care appeals within the required time frame. *This is a new critical issue.*
Question 3.2	The facility's custody staff are not all current on their cardiopulmonary resuscitation certification. *This is a new critical issue.*
Question 3.9	The peer review of the facility's provider is not being completed within the required time frames. *This is a new critical issue.*
Question 4.5	The registered nurses do not consistently conduct a focused subjective/objective assessment based upon the patient's chief complaint.
Question 4.6	The registered nurses do not consistently document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data.
Question 4.8	The registered nurses do not consistently document that effective communication was established and that education was provided to the patient related to treatment plan.
Question 4.11	The registered nurses do not consistently refer the patient to a provider if the patient presented to sick call three or more times for the same medical complaint.
Question 5.2	The patient's chronic care medications are not consistently received by the patient without interruption.
Question 6.1	The registered nurses do not consistently review the discharge plan upon patient's return from a community hospital admission or the hub institution.
Question 6.2	The registered nurses do not consistently complete a face-to-face assessment prior to the patient being re-housed upon return from the community hospital admission or the hub institution. *This is a new critical issue.*
Question 7.1	The patients' diagnostic tests are not consistently completed within the time frame specified by the provider.

Question 9.1	The facility does not consistently provide patients with an initial health screening upon their arrival at the facility.
Question 9.2	The registered nurses do not consistently document an assessment of the patient was completed if the patient answered 'yes' to any of the medical problems listed on the *Initial Health Screening* form.
Question 9.8	The patients do not consistently receive a complete screening for the signs and symptoms of tuberculosis upon their arrival at the facility.
Question 9.9	The patients do not consistently receive a health appraisal within seven calendar days of their arrival at the facility.
Question 9.10	The patients arriving at the facility with existing medication orders do not consistently receive their prescribed medications timely.
Question 9.11	The registered nurses do not consistently document scheduled specialty services appointments that were not completed on a CDCR Form 7371, *Health Care Transfer Information*, when the patient transfers out of the facility.
Question 10.2	The initial dose of newly prescribed medications is not consistently administered to the patient as ordered by the provider.
Question 10.5	The registered nurses interviewed regarding the process of administering direct observation therapy medications were not fully knowledgeable on the process.
Question 12.3	The registered nurses do not consistently complete a face-to-face assessment of the patient upon his return from specialty consult appointment or community hospital emergency department visit.
Question 12.5	The provider does not consistently review the specialty consultant's report, hub provider's report or the community emergency department provider's discharge summary and complete a follow-up appointment with the patient within the required time frame.
Question 14.1	The facility does not conduct emergency medical response drills quarterly on each shift. *This is a new critical issue.*
Question 14.4	The facility does not consistently hold an Emergency Medical Response Review Committee (EMRRC) meeting a minimum of once per month.
Question 14.5	The incident packages, submitted to EMRRC for review, do not include all the required documents and forms. *This is a new critical issue.*
Question 14.6	The facility's emergency medical response bag is not inspected on each shift to ensure the bag is secured with a seal. *This is a new critical issue.*
Question 14.7	The facility's emergency medical response bag is not consistently re-supplied and re-sealed before the end of the shift, if the emergency medical response and/or drill warranted an opening of the bag.
Question 14.8	The facility's emergency medical response bag is not consistently inventoried monthly, if the emergency medical response and/or drill warranted an opening of the bag. *This is a new critical issue.*
Question 14.16	The facility's 12-lead electrocardiogram machine, although found functional was not operational ready. *This is a new critical issue.*
Question 15.4	Not all of the facility's health care staff adhere to universal hand hygiene precautions. *This is a new critical issue.*

Question 15.8	The facility is not completing environmental cleaning of common clinic areas with high foot traffic at least once a day.
Question 15.11	The facility's sharps container in the main clinic area was found stored in the cabinet and was not attached to the wall; it did not appear to be utilized by health care staff. *This is a new critical issue.*

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

AUDIT FINDINGS – DETAILED BY QUALITY INDICATOR

1. ADMINISTRATIVE OPERATIONS

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
84.2% [Inadequate]

Overall Rating:
Inadequate

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

The facility received a compliance score of 84.2% in the *Administrative Operations* indicator, equating to the overall rating of *inadequate*. As evidenced by the rating below, the facility's policies and LOPs were found not in compliance with IMSP&P guidelines and were not specific to DVMCCF. This issue was addressed during the entrance and exit conferences at which time the Warden stated the LOPs/policies are already in the process of being revised and updated. The Warden also stated she will personally review all updated/revised polices to ensure compliance with IMSP&P and will implement a process to ensure future updates to IMSP&P are incorporated into the facility's LOPs, as applicable. Refer to the *Comments* section, following the table below, for information on additional deficiencies identified in this area.

Quantitative Review Results

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

Administrative Operations		**Yes**	**No**	**Compliance**
1.1	Does health care staff have access to the facility's health care policies and procedures and know how to access them?	5	0	100%
1.2	Does the facility have written health care policies and/or procedures that are in compliance with *Inmate Medical Services Policies and Procedures* guidelines?	1	15	6.3%
1.3	Does the facility have current contracts/agreements for routine oxygen tank maintenance service, hazardous waste removal, and repair, maintenance, inspection, and testing of biomedical equipment?	3	0	100%

1.4	Does the patient orientation handbook/manual or similar document explain the sick call and health care grievance/appeal processes?	2	0	100%
1.5	Does the facility's health care staff access the California Correctional Health Care Services patients' electronic medical record?	5	1	83.3%
1.6	Does the facility maintain a Release of Information log that contains all the required data fields?	1	0	100%
1.7	Are all patients' written requests for health care information documented on a CDCR Form 7385, *Authorization for Release of Information*, and scanned/filed into the patient's medical record?	20	0	100%
1.8	Are all written requests from third parties for release of patient medical information accompanied by a CDCR Form 7385, *Authorization for Release of Information*, from the patient and scanned/filed into the patient's medical record?	Not Applicable		
	Overall Quantitative Review Score:			**84.2%**

Comments:

1. Question 1.2 – Of the 16 policies/procedures submitted by facility, only one, *Chemical Agents/Use of Force Process,* was found compliant with IMP&P guidelines. The remaining policies and/or local operating procedures (LOPs) were all Correct Care Solutions (CCS) corporate policies and were not specific to the facility or in compliance with IMSP&P guidelines/requirements. This equates to 6.3% compliance.
2. Question 1.5 – Based on the review of the Contractor's Log-in Report provided to PPCMU by CCHCS IT staff, the facility's physician assistant (PA) does not log-in or access the electronic Unit Health Record (eUHR) system at least once a month. The PA's eUHR account was created on July 9, 2015 and the staff member last logged in to eUHR on August 18, 2015. This issue was addressed during the exit conference and the physician auditor stressed the importance of the facility's providers having access to the eUHR at all times to allow them to review the patient's historical information such as laboratory results and notes. Currently, the nursing staff are periodically asked to print patients' medical records from eUHR for provider's review. This equates to 83.3% compliance. It should be noted the PA's access to the eUHR system was reset on the last day of the onsite audit, February 4, 2016.
3. Question 1.8 – Not Applicable. There were no requests received from third parties requesting release of patient health care information during the audit review period; therefore, this question could not be evaluated.

2. INTERNAL MONITORING & QUALITY MANAGEMENT

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
87.4% [Adequate]
Overall Rating:
Adequate

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

DVMCCF received a compliance score of 87.4% in the *Internal Monitoring and Quality Management* indicator, equating to an overall quality rating of *adequate*. Six of the 13 questions assessed in this component scored in the *proficient* range (90% and above), 4 questions scored in the *adequate* range, and 3 questions scored in the *inadequate* range (below 85.0% compliance). As mentioned in the Comments section below and evidenced by ratings of Questions 2.1 and 2.13, the facility is not consistently holding QMC meetings monthly and does not respond timely to patients' first level health care appeals. Another area where the facility appears to struggle is the timely submission and accurate reporting of data on the monitoring logs. The facility failed to submit the monthly chronic care and initial intake screening monitoring logs on time for three out of the six months.

In September 2015, PPCMU distributed updated versions of all the monitoring logs with a detailed monitoring log instruction guide to all contract facilities. Following the implementation of the new monitoring logs, considerable improvement in data entry was evident on all the monitoring logs, predominantly on the chronic care log. However, it should be noted that a number of entries on the monitoring logs could not be verified due to the missing or incomplete documentation in the patient's medical record. The facility should be diligent in sending the patient medical records to the hub institution timely and regularly for uploading into the electronic medical record system.

Quantitative Review Results

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

Internal Monitoring & Quality Management		**Yes**	**No**	**Compliance**
2.1	Does the facility hold a Quality Management Committee meeting a minimum of once per month?	4	2	66.7%
2.2	Does the Quality Management Committee's review process include documented corrective action plan for the identified opportunities for improvement?	4	0	100%
2.3	Does the Quality Management Committee's review process include monitoring of defined aspects of care?	4	0	100%
2.4	Does the facility submit all monitoring logs (sick call, specialty care, hospital stay/emergency department, chronic care and initial intake screening) by the scheduled date per Private Prison Compliance and Monitoring Unit program standards?	52	7	88.1%
2.5	Are the dates documented on the sick call monitoring log accurate?	30	4	88.2%
2.6	Are the dates documented on the specialty care monitoring log accurate?	6	1	85.7%

2.7	Are the dates documented on the hospital stay/emergency department monitoring log accurate?	6	4	60.0%
2.8	Are the dates documented on the chronic care monitoring log accurate?	34	2	94.4%
2.9	Are the dates documented on the initial intake screening monitoring log accurate?	18	3	85.7%
2.10	Are the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* readily available to patients in all housing units?	8	0	100%
2.11	Are patients able to submit the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* on a daily basis in all housing units?	8	0	100%
2.12	Does the facility maintain a CCHCS Health Care Appeals log and does the log contain all the required information?	1	0	100%
2.13	Are the first level health care appeals being processed within specified time frames?	2	1	66.7%
	Overall Quantitative Review Score:			**87.4%**

Comments:

Questions 2.4 through 2.9 were assessed for the period of October 2015 through January 2016.

1. Question 2.1 – Of the six QMC meetings required to have been completed within the audit review period, the facility completed four meetings. The QMC meetings were not held in the months of August and October 2015. This equates to 66.7% compliance.

2. Questions 2.2 and 2.3 – These questions were rated based on the four QMC meetings that were conducted during the audit review period. The two QMC meetings that were not held by facility for the months of August and October 2015 were excluded from these ratings per the double failure rule.

3. Question 2.4 – During the review period of October 2015 through January 2016, 59 submissions of monitoring logs were required. Of the 59 monitoring logs submitted, 52 were submitted on time. The chronic care and initial intake/health screening monitoring logs were not submitted in October and November 2015. This equates to 88.1% compliance. See table below for additional information and details.

Type of Monitoring Log	Required Frequency of Submission	Number of Required Submissions for the Audit Review Period	Number of Timely Submissions	Number of Late Submissions
Sick Call	weekly	17	16	1
Specialty Care	weekly	17	16	1
Hospital Stay/Emergency Department	weekly	17	16	1
Chronic Care	monthly	4	2	2
Initial Intake Screening	monthly	4	2	2
	Totals:	**59**	**52**	**7**

4. Question 2.5 – A total of 34 entries were randomly selected from the weekly sick call monitoring logs to assess the accuracy of the dates reported on the log. Of the 34 entries reviewed, 30 were found to be accurate with dates matching the dates of service reflected in the patients' medical records. Discrepancies identified within the remaining four entries were within the dates the sick call request was received and the dates the sick call request was reviewed. One entry recorded on the log could not be validated as the progress note in the eUHR was not dated, therefore, the auditor was unable to validate the date the patient was seen by provider. This equates to 88.2% compliance.

5. Question 2.6 – A total of seven entries were randomly selected from the weekly specialty care monitoring logs to assess the accuracy of the dates reported on the log. Of the seven entries reviewed, six were found to be accurate with dates matching the dates of service reflected in the patients' medical records. Discrepancy identified within the remaining one entry was due to an incorrect PCP referral date documented on the log. This equates to 85.7% compliance.

6. Question 2.7 – A total of 10 entries were selected from the weekly hospital stay/emergency department monitoring logs to assess the accuracy of the dates reported on the log. Of the 10 entries reviewed, 6 were found to be accurate with dates matching the dates of service reflected in the patients' medical records. Discrepancies identified within the remaining four entries were due to missing documentation indicating the patient was seen by an RN and provider upon return from the hub institution and incorrect date of patient's return to MCCF from the hub institution. This equates to 60.0% compliance.

7. Question 2.8 – A total of 36 entries were randomly selected from the monthly chronic care monitoring logs to assess the accuracy of the dates reported on the log. Of the 36 entries reviewed, 34 were found to be accurate with dates matching the dates of service reflected in the patients' medical records. One discrepancy was due to missing documentation of patient's chronic care visit and one discrepancy was due to incorrect date of last assessment reported on the log. This equates to 94.4% compliance.

8. Question 2.9 – A total of 21 entries were selected from the monthly initial intake screening monitoring logs to assess the accuracy of the dates reported on the log. Of the 21 entries reviewed, 18 were found to be accurate with dates matching the dates of service reflected in the patients' medical records. In the remaining 3 entries, 2 were found deficient due to missing documentation of CDCR Form 7277 in eUHR and one was deficient due to the wrong arrival date documented on the log. This equates to 85.7% compliance.

9. Question 2.13 – Nine health care appeals were submitted by patients for first level review during the audit review period. Of the nine appeals submitted, one was forwarded to dental department at the hub institution for review and response (as of 02/04/16 no response was received from the hub). The other two dental appeals were forwarded to DVMCCF's dental provider for review and response, both of which were withdrawn by patient within 30 days of submitting the appeal. Of the remaining six health care appeals, three were withdrawn by patient within 30 days of submitting an appeal, one has not been responded to, and the other two have not yet exceeded the 30 day response time frame. This equates to 66.7% compliance.

3. LICENSING/CERTIFICATIONS, TRAINING, & STAFFING

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
82.6% [Inadequate]
Overall Rating:
Inadequate

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

DVMCCF received a compliance score of 82.6% in the *Licensing/Certifications, Training & Staffing* indicator, resulting in an overall rating of *inadequate*. Five of the six questions assessed in this component scored in the *proficient* range and one scored in the *inadequate* range.

It is worth noting that although Question 3.2 scored in the proficient range (95.8% compliance); it was found that not all custody staff, at the time of the onsite audit, had current medical emergency response certifications as required per IMSP&P. Four custody staff members did not have their cardiopulmonary resuscitation (CPR) training completed; however, they were already scheduled for a later date to attend the CPR training offered onsite.

Additionally, during the onsite audit health care staff interviews, the audit team learned that the facility's mid-level provider (physician assistant) was not supervised by a physician and the facility was unsure whose responsibility it was to provide oversight. Therefore, the 60-day follow-up peer review was not completed within the required time frame.

The physician auditor requested a *Delegation of Services Agreement* between CCS and GEO Corporation be submitted to Headquarters for review to determine the supervision responsibility of the mid-level provider. The agreement was produced two weeks following the onsite audit and based on the date recorded on the document (February 4, 2016), it is evident the agreement was not in existence prior to the onsite audit. State law and regulations relating to the practice of physician assistants (PA) mandate the *Delegation of Services Agreement* for practicing PAs. Refer to the *Comments* section, following the table below, for health care staffing information and any additional details related to the deficiencies identified in this area.

Quantitative Review Results

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

Licensing/Certifications, Training, & Staffing		Yes	No	Compliance
3.1	Are all health care staff licenses current?	7	0	100%
3.2	Are health care and custody staff current with required medical emergency response certifications?	91	4	95.8%
3.3	Did all health care staff receive training on the facility's policies based on Inmate Medical Services Policies and Procedures requirements?	Not Applicable		
3.4	Is there a centralized system for tracking licenses, certifications, and training for all health care staff?	2	0	100%
3.5	Does the facility have the required provider staffing complement per contractual requirement?	1	0	100%
3.6	Does the facility have the required nurse staffing complement per contractual requirement?	5.2	0	100%

3.7	Does the facility have the required clinical support staffing complement per contractual requirement? (COCF Only)?	Not Applicable		
3.8	Does the facility have the required management staffing complement per contractual requirement? (COCF Only)	Not Applicable		
3.9	Are the peer reviews of the facility's providers completed within the required time frames?	0	1	0.0%
	Overall Quantitative Review Score:			**82.6%**

Comments:

1. Question 3.2 – A total of 7 health care and 88 custody staff members were assessed for compliance with this requirement. All health care staff had current emergency response certifications. Of 88 custody staff members assessed, 84 had current CPR certifications. This equates to 95.8% compliance. As the facility was found less than 100% compliant with this requirement, it is identified as a critical issue and will be evaluated during the subsequent audit.
2. Question 3.3 – Per the double failure rule, this question was found not applicable as the facility was rated non-compliant on the related policy question 1.2. The facility is in process of revising their LOPs as they are currently not in compliance with IMSP&P guidelines. However, all health care staff are receiving training on the updates and revisions to IMSP&P. The Health Services Administrator (HSA) prints out the revised policy and has health care staff review and sign off acknowledging they read and understood the new requirement. The training records are kept in the Training Binder onsite.
3. Question 3.5 – The facility signed a new contract on December 2, 2015 which requires the facility to be staffed with one physician, eight hours a day, five days a week. As of the date of the onsite audit, the facility had a PA on staff 20 to 40 hours a week working varied days and a physician temporarily filling in, working eight hours a day (from 0900 to 1700 hours), Monday through Friday until DVMCCF hires a permanent full time physician. The facility is currently meeting the required provider staffing per contractual requirement.
4. Question 3.6 – At the time of the audit, the facility had one vacant registered nurse (RN) position; however, this position was covered with part time RN positions. The facility is in process of recruiting a full time RN. DVMCCF is currently providing 24/7 nursing coverage.
5. Questions 3.7 and 3.8 – These questions are not applicable to in-state correctional facilities.
6. Question 3.9 – The PA did not have a 60-day follow-up peer review completed following the initial peer review done on July 15, 2015. This equates to 0.0% compliance.

4. ACCESS TO CARE

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

For *Access to Care* indicator, the case review and quantitative review processes yielded different results. The case review received an *inadequate* rating while the quantitative review resulted in overall score of 85.8% compliance, equating to a quality rating of *adequate*. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the magnitude of all deficiencies identified in both processes and their potential impact on patient's health care condition. The case review identified multiple deficiencies related to access to medical care. The quantitative review revealed similar deficiencies, in addition to the compliance score barely falling into the adequate range. Therefore, the care review's *inadequate* rating was deemed a more accurate reflection of the appropriate overall rating.

Case Review Rating:
Inadequate
Quantitative Review Score [Rating]:
85.8% [Adequate]
Overall Rating:
Inadequate

Case Review Results

The CCHCS clinicians reviewed 113 provider and nursing encounters related to *Access to Care* – 91 nursing encounters and 22 provider encounters. Out of 113 total encounters, 33 deficiencies were found, of which 19 were related to nursing performance and 14 were related to provider's performance. Specific examples of deficiencies and areas of concern identified by CCHCS nurse consultant are as follows:

- In Cases 3, 4, 5, 8, 9, and 10, the nursing staff did not conduct adequate subjective and objective assessments related to patient's complaint.
- In Cases 3 and 4, the nursing staff did not perform appropriate nursing actions. For example, in Case 3, the patient was seen by a nurse for complaint of ear pressure following a prolonged treatment for infection. The nurse failed to refer the patient to a provider for follow-up. In the same case, the patient submitted a sick call request stating he has been congested and has a bad cough with chest tightness. The nurse assessed the patient and provided cough drops, which are not part of the Upper Respiratory Infection (URI) protocol. Same deficiency was identified in Case 4 where on two occasions (sick call visits), the patient was issued cough drops that are not part of the protocol plan.
- In Case 2, the RN failed to document that education was provided to patient regarding blood typing process. In the same case but on a different occasion, the patient submitted a CDCR Form 7362 requesting assistance with completing dental paperwork. The sick call request was triaged by an LVN, contrary to the IMSP&P guidelines that requires the RNs to triage/review the sick call requests submitted by patients.
- In Case 3, the patient submitted a sick call request for a dental complaint. The nurse assessed the patient using Dental protocol; however, the nurse failed to refer the patient to the PCP or dental provider regarding swollen red gums.

Out of 22 total provider encounters reviewed, 64 percent (14 encounters) were found deficient/inadequate. Specific examples of deficiencies and areas of concern identified by CCHCS physician are as follows:

- In Case 5, during the history and physical evaluation, the patient was diagnosed with major depressive disorder and was ordered to return for a follow-up visit in 14 days. During the follow-up visit, the provider again noted anxiety/depression and offered patient to return in two weeks to see CDCR counselor for potential transfer closer to family. The provider should avoid addressing custody areas so as not to provide false hope which may potentially cause increase in anger/stress if patient cannot be transferred to another facility closer to home.
- In Cases 3 and 8, there was either missing or incomplete documentation to support the actions taken by provider. For example, in Case 3 the patient was referred to the hub for ENT consult; however, no exam was noted on the day the referral was made nor a complete history was taken on etiology of oral lesions.
- In Cases 3, 9, 11, and 12, the medical action taken by provider was not suitable to the diagnosis or patient's medical complaint. For example, in Case 3, the patient was seen by a PCP for recurring issue with oral cavity; however, elevated blood pressure (BP) (154/96) was not addressed; the provider circled BP on the form but did not document further. In the same case but on a different occasion, the patient was ordered antibiotics for viral infection despite the patient stating he was feeling better.
- In Case 9, it was found that a nurse filled out CDCR Form 7410, *Comprehensive Accommodation Chrono*, which is only to be filled out and signed by a PCP, who is required to justify accommodations. The facility was informed of this requirement previously; however, the health care staff appears to continue following the old process.
- Illegible handwriting on documents; the physician's printed name/title and signature are similar (Case 12).

While the majority of the appointments occurred within the required time frames and were appropriate, many of the deficiencies were of such magnitude that poor health care access (e.g. fragmented care provided by multiple short term PCPs, care provided by the PCP that primarily worked late evening hours for convenience) contributed significantly to the *inadequate* rating of clinical case reviews.

Quantitative Review Results

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

Access to Care		**Yes**	**No**	**Compliance**
4.1	Does the registered nurse review the CDCR Form 7362, *Health Care Services Request*, or similar form on the day it is received?	30	0	100%
4.2	Following the review of the CDCR Form 7362, or similar form, does the registered nurse complete a face-to-face evaluation of a patient within the specified time frame?	30	0	100%
4.3	Does the registered nurse document the patient's chief complaint in the patient's own words?	27	3	90.0%

4.4	Does the registered nurse document the face-to-face encounter in Subjective, Objective, Assessment, Plan, and Education (SOAPE) format?	30	0	100%
4.5	Is the focused subjective/objective assessment conducted based upon the patient's chief complaint?	17	13	56.7%
4.6	Does the registered nurse document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data?	14	16	46.7%
4.7	Does the registered nurse implement a plan based upon the documented subjective/objective assessment data that is within the nurse's scope of practice or supported by the nursing sick call protocols?	29	1	96.7%
4.8	Did the registered nurse document that effective communication was established and that education was provided to the patient related to the treatment plan?	20	10	66.7%
4.9	If the registered nurse determines a referral to the primary care provider is necessary, is the patient seen within the specified time frame?	26	2	92.9%
4.10	If the registered nurse determines the patient's health care needs are beyond the level of care available at the facility, does the nurse contact or refer the patient to the hub institution? (MCCF Only)	6	1	85.7%
4.11	If the patient presented to sick call three or more times for the same medical complaint, does the registered nurse refer the patient to the primary care provider?	4	1	80.0%
4.12	Does nursing staff conduct daily rounds in segregated housing units? (COCF only)	Not Applicable		
4.13	Does nursing staff conduct daily rounds in segregated housing units to collect CDCR Forms 7362, *Health Care Services Request*, or similar forms? (COCF only)	Not Applicable		
4.14	Are CDCR Forms 7362, *Health Care Services Request*, or similar forms readily accessible to patients in all housing units?	8	0	100%
4.15	Are patients in all housing units able to submit the CDCR Forms 7362, *Health Care Services Request*, or similar forms on a daily basis?	8	0	100%
	Overall Quantitative Review Score:			**85.8%**

Comments:

For questions 4.1 through 4.11, a random sample of 30 patient medical records were reviewed for the audit review period of August 2015 through January 2016.

1. Question 4.3 – Twenty-seven patient medical records reviewed reflect that the RN documented patient's chief complaint in his own words. For the three non-compliant records, this documentation could not be found. This equates to 90.0% compliance.
2. Question 4.5 – Seventeen medical records reviewed reflect that the RN conducted a focused subjective/objective assessment based on the patient's chief complaint. The remaining 13 were found non-compliant; 12 records showed an incomplete nursing assessment and one assessment was completed by a licensed vocational nurse (LVN) and not a RN. This equates to 56.7% compliance.
3. Question 4.6 – Fourteen patient medical records included documentation of a nursing diagnosis related to subjective/objective assessment data. The 16 non-compliant cases did not include such documentation. This equates to 46.7% compliance.
4. Question 4.7 – Twenty-nine patient medical records reflect that a plan was implemented by a RN based upon the subjective/objective assessment data. This equates to 96.7% compliance.
5. Question 4.8 – Twenty patient medical records reflect that effective communication was established and education related to the treatment plan was provided to the patient. The remaining 10 cases were

missing nurse's documentation of effective communication having been established. This equates to 66.7% compliance.

6. Question 4.9 – Two of the 30 medical records reviewed were found not applicable to this question as the patient did not require a referral to the provider. Twenty-eight patient medical records included documentation that following the RN's referral, the patient was seen by a provider within the required time frame. For the remaining two records, one did not have a referral time frame specified by the RN and the other record was rated non-compliant because, although the RN had referred the patient to the PCP to be seen within 14 days, the patient was not seen until 25 days later. This equates to 92.9% compliance.
7. Question 4.10 – Twenty-three of the 30 medical records reviewed were found not applicable to this question as the patient's health care needs were not beyond the level of care available at DVMCCF. Six medical records included documentation that the RN contacted and referred that patient to the hub institution for higher level of care and one medical record was missing documentation of DVMCCF RN contacting the hub institution for a mental health evaluation. This equates to 85.7% compliance.
8. Question 4.11 – Twenty-five of the 30 medical records reviewed were found not applicable to this question as the selected patients did not submit a sick call request three or more times for the same medical complaint. Of the remaining five records, one was found non-compliant. The patient submitted multiple sick call requests over several months for the same symptoms of sore throat and congestion. The nurse had been providing the patient with medications such as Chlorpheniramine, cough drops, and Ibuprofen during each sick call visit; however, the nurse failed to refer the patient to the PCP. This equates to 80.0% compliance.
9. Questions 4.12 and 4.13 – Not applicable. These questions do not apply to in-state correctional facilities.

5. CHRONIC CARE MANAGEMENT

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

The case review and quantitative review findings both resulted in an *inadequate* rating. Therefore, the overall indicator rating is determined to be *inadequate.*

Case Review Rating:
Inadequate
Quantitative Review Score [Rating]:
84.8% [Inadequate]
Overall Rating:
Inadequate

Case Review Results

The CCHCS clinicians reviewed 31 encounters related to Chronic Care Management - 13 nursing encounters and 18 provider encounters. Out of 31 total encounters, 13 deficiencies were found, all of which were related to provider's performance. Two of the 13 deficiencies were with regards to health information management. The remaining physician deficiencies identified include:

- In Case 1, there was missing documentation of daily BP checks ordered by PCP. In the same case, the patient was seen in the chronic care clinic for diabetes mellitus (DM) follow-up appointment at which time the provider reviewed the patient's progress with glucose checks

and documented a plan to discontinue blood sugar checks; however, no order was found in the medical record. The provider should consider continuing some form of glucose checks on diet controlled diabetics as patients could worsen on glucose control and medical would not detect until patient's next clinic visit. Additionally in the same case, the patient was seen for a sick call request for a low bunk renewal. The provider circled the BP value of 151/86 but did not document diagnosis or treatment plan. The patient is morbidly obese and has prior history of elevated BP values. The provider failed to address BP as risk factor in morbidly obese patient with DM; the patient is at risk for cardiovascular disease.

- In Case 2, the patient was seen for a follow-up appointment in chronic care clinic for gastroesophageal reflux disease (GERD). The patient is currently on Omeprazole medication. During this visit, the provider failed to discuss diet and lifestyle modifications to eliminate use of proton pump inhibitors (PPI) medication. Additionally, the provider failed to address the risk of long term PPI use. Three months later, the patient again was seen in a chronic care clinic for three chronic care conditions: psoriasis, GERD, and allergies. The provider again failed to discuss and recommend lifestyle and diet modifications for GERD management rather than continue Omeprazole.
- In Cases 3, 7 and 15, the provider on four different occasions, ordered unnecessary laboratory tests and did not document the rationale or necessity for ordering the tests. During the previous audit, the CCHCS physician addressed this issue of the facility providers ordering tests not appropriate and unnecessary based on patients' age and diagnosis.
- Inadequate knowledge on Hepatitis C management (Case 9).
- In Case 10, the provider failed to counsel/inform the patient on the current status of Hepatitis C virus even though the laboratory results confirmed the virus to be no longer active.
- In Case 15, the patient was transferred to hub institution; however, no clear reason/rationale for transfer was documented.

The findings of the clinical case review reveal the facility performed very poorly as indicated by deficiencies listed above. Overall, the CCHCS clinicians found the quality of physician and nursing care in chronic care management services was ***inadequate***.

Quantitative Review Results

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

Chronic Care Management		**Yes**	**No**	**Compliance**
5.1	Is the patient's chronic care follow-up visit completed as ordered?	21	2	91.3%
5.2	Are the patient's chronic care medications received by the patient without interruption within the required time frame?	12	7	63.2%
5.3	If a patient refuses his/her chronic care keep-on-person medications, is the refusal documented on the CDCR Form 7225, *Refusal of Examination and/or Treatment*, or similar form?	1	0	100%

5.4	If a patient does not show or refuses the nurse administered/direct observation therapy chronic care medication for three consecutive days or 50 percent or more doses in a week, is the patient referred to a primary care provider?	Not Applicable
5.5	If a patient does not show or refuses the nurse administered/direct observation therapy chronic care medication for three consecutive days or 50 percent or more doses in a week, is the patient seen by a primary care provider within seven calendar days of the referral?	Not Applicable
5.6	If a patient does not show or refuses his/her insulin, is the patient referred to a primary care provider for medication non-compliance?	Not Applicable
	Overall Quantitative Review Score:	**84.8%**

Comments:

For questions 5.1 through 5.6, a random sample of 23 patient medical records were reviewed for the audit review period of August 2015 through January 2016.

1. Question 5.1 – Twenty-one patient medical records included documentation the patient's chronic care follow-up visit was completed as ordered by the provider and two were non-compliant. One patient was ordered a three month follow-up, but was not seen for five months. Other patient's medical record was missing documentation of prior chronic care visit. This equates to 91.3% compliance.
2. Question 5.2 – Four of the 23 medical records reviewed were found not applicable as the patients refused their prescribed chronic care medications. Twelve patient medical records showed that the patient received his chronic care medication without interruption and seven were found not compliant with this requirement. This equates to 63.2% compliance. See below for additional information regarding the seven non-compliant record reviews:
    - Records 1 through 4 - According to the KOP reports reviewed, there was no documentation/data reflecting that the patients received their KOP medications.
    - Record 5 – The patient should have been prescribed medication for treatment of hypertension on July 1, 2015 when initially identified. No PCP order was found in the patient's medical record for Lisinopril or for blood pressure checks until September 10, 2015. Consequently, the patient did not receive the prescription until the next follow-up chronic care appointment on September 14, 2015.
    - Record 6 – The patient arrived at DVMCCF on April 9, 2015, and medication order was written on April 29, 2015. However, there was no documentation reflecting patient received the prescribed medication until September 4, 2015.
    - Record 7 – There were gaps in medication receipts from August to September 2015.
3. Questions 5.4 and 5.5 – Not applicable. The patients selected for review were either not prescribed NA/DOT medications or have not refused their chronic care medication for three consecutive days or 50% or more doses in one week period; therefore, these questions could not be evaluated.
4. Question 5.6 – Not applicable. There were no patients prescribed insulin during the audit review period; therefore, this question could not be evaluated.

6. COMMUNITY HOSPITAL DISCHARGE

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

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
83.3% [Inadequate]
Overall Rating:
Adequate

During the audit review period of August 2015 through January 2016, a total of 13 patients were sent to community hospital emergency department (ED) for higher level of care. Ten of these patients returned to the hub institution and/or MCCF on the same day and only three were actually admitted to the community hospital (patient was under observation for over 24 hours).

For *Community Hospital Discharge* indicator, the case review and quantitative review processes yielded different results. The quantitative review resulted in overall score of 83.3%, equating to a quality rating of *inadequate*, while the case review resulted in an *adequate* rating. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the degree of the deficiencies identified during case reviews and their potential impact on patient's health care condition. The case review results revealed just one minor deficiency which did not significantly impact the patient's access to health care and the quantitative review score of 83.3% is very close to the adequate range. As a result, the CCHCS clinicians determined the appropriate overall rating for this indicator was *adequate*.

Case Review Results

As mentioned above, there were only a few cases where the patients were transferred to community hospital ED for higher level of care; therefore, limiting the number of cases available for evaluation. Of the four patient encounters/visits reviewed, related to *Community Hospital Discharge* process, one deficiency was found in nursing care.

- In Case 8, the face-to-face (FTF) assessment of the patient upon his return from the community hospital ED/hub institution, and review of the discharge plan was completed by a LVN, contrary to the policy. The policy requires the RN to conduct a FTF evaluation and review of the discharge plan when the patient returns from the community hospital ED admission.

As this deficiency was minor in nature and did not significantly affect patient care, the case review resulted in *adequate* rating for this indicator.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review which may consist of onsite inspections/observations, review of patient medical records, and/or review of various documents and

tracking logs. Following this table is a brief narrative addressing each standard being measured which received less than a 100% compliance rating.

Community Hospital Discharge		Yes	No	Compliance
6.1	*For patients discharged from a community hospital or returned from the hub:* Does the registered nurse review the discharge plan upon patient's return?	2	1	66.7%
6.2	*For patients discharged from a community hospital or returned from the hub:* Does the registered nurse complete a face-to-face assessment prior to the patient being re-housed?	2	1	66.7%
6.3	*For patients discharged from a community hospital or returned from the hub:* Is the patient seen by the primary care provider for a follow-up appointment within five calendar days of return?	3	0	100%
6.4	*For patients discharged from a community hospital or returned from the hub:* Are all prescribed medications administered/delivered to the patient per policy or as order by the primary care provider?	2	0	100%
		Overall Quantitative Review Score:		**83.3%**

Comments:

For questions 6.1 through 6.4, only three patient medical records were applicable for determining compliance with the above listed requirements.

1. Question 6.1 – Two patient medical records reviewed were found compliant with this requirement. One record was found non-compliant as the discharge plan was not reviewed by a RN upon the patient's return from the community hospital admission/hub institution. This equates to 66.7% compliance.
2. Question 6.2 – Two patient medical records reviewed were found compliant with this requirement. One record was found non-compliant as upon return from the community hospital admission/hub institution, the face-to face-assessment was completed by an LVN and not a RN. This equates to 66.7% compliance.

7. DIAGNOSTIC SERVICES

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

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

This indicator is one of the areas where DVMCCF performed poorly. Although the compliance results were very close to the adequate range, the case review findings showed that there is much room for improvement in many areas related to diagnostic services. Taking into account the findings of the quantitative and case review

processes, DVMCCF received an overall rating of *inadequate* performance in *Diagnostic Services* indicator.

Case Review Results

During the review of 15 cases, there were very few instances/encounters found relative to diagnostic services provided by facility's clinicians. Of the 14 diagnostic related events reviewed, CCHCS clinicians found 11 deficiencies, 3 in nursing care and 8 in provider care.

Specific examples of deficiencies and areas of concern identified by CCHCS nurse consultant are as follows:

- In Case 3, the patient requested to refuse laboratory work and the RN appropriately counseled the patient on risk and benefits; however, there was not signed refusal form found in the patient's medical record.
- In Case 6, the nursing staff failed to complete physician's routine laboratory orders timely. A routine laboratory order was requested by the provider on September 17, 2015; however, the order was not carried out by nursing staff until 40 days later on October 27, 2015. Per policy, routine laboratory orders should be completed within 14 days of order.
- In Case 8, there was no documentation in the patient's medical record to indicate the laboratory tests were completed as ordered by the provider.

There were eight deficiencies found out of a total of 10 provider encounters assessed, one as a result of inappropriate diagnostic tests ordered and the remaining due to delays in notifying patients of laboratory test results.

- In Cases 1, 7, 9, and 13, the provider on several occasions failed to notify the patient of the diagnostic test results within two days of receipt of results. In one case, the facility relied on the hub institution to review the patient's lab test results and meet the two day *Plata* deadline.
- In Case 13, there was a 35 day delay in notifying the patient of his laboratory test results. In the same case, the provider ordered an inappropriate amount of laboratory tests without following evidence-based medical guidelines. The facility provider should adhere to the clinical guidelines on screening based on age, risk factors, and gender before ordering diagnostic tests.

It should be noted that during the previous audit, the CCHCS physician auditor recommended for nursing staff to start tracking all laboratory tests ordered by the provider, when test results are received by facility, and when written notifications are due to patients. The facility's nursing staff implemented the CCHCS physician's recommendation and began tracking all laboratory orders and results on the log. The nursing staff initiate laboratory review notification forms and print out test results for the provider to review approximately 48 hours after laboratory tests are completed.

Although the quantitative review indicated clinicians' adequate performance in this area, due to 11 deficiencies having been identified within 14 encounters assessed, the case review resulted in an *inadequate* rating for this indicator.

Quantitative Review Results

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

Diagnostic Services		Yes	No	Compliance
7.1	Is the diagnostic test completed within the time frame specified by the primary care provider?	15	9	62.5%
7.2	Does the primary care provider review, sign, and date all patients' diagnostic test report(s) within two business days of receipt of results?	19	2	90.5%
7.3	Is the patient given written notification of the diagnostic test results within two business days of receipt of results?	19	2	90.5%
7.4	Is the patient seen by the primary care provider for clinically significant/abnormal diagnostic test results within 14 days of the provider's review of the test results?	11	1	91.7%
		Overall Quantitative Review Score:		**83.8%**

Comments:

For questions 7.1 through 7.4, a random sample of 24 patient medical records were reviewed for the audit review period of August 2015 through January 2016.

1. Question 7.1 – Fifteen patient medical records included documentation that the diagnostic test was completed within the time frame specified by the PCP and nine were non-compliant with this requirement. This equates to 62.5% compliance. See below for additional information regarding the nine non-compliant record reviews:

    - Records 1 through 3 – The diagnostic reports could not be located in the patients' medical record showing the tests were completed as ordered by provider.

      Record 4 – The diagnostic test was ordered by PCP on August 31, 2015; however, the routine lab draw was not completed until three weeks later, on September 21, 2015.

      Record 5 - The diagnostic test was ordered by PCP on September 29, 2015; however, the routine lab draw was not completed until five weeks later, on November 6, 2015.
    - Record 6 – The diagnostic test was ordered by PCP on October 20, 2015; however, there was no documentation found in the patient's medical record indicating the test was completed or that the patient refused.
    - Records 7 through 9 – The diagnostic tests were completed weeks after the tests were ordered by the PCP.

2. Question 7.2 – Three of the 24 patient medical records reviewed were deemed not applicable per the double failure rule. Nineteen patient medical records include documentation that the provider reviewed, signed, and dated the patient's diagnostic test report within two business days of receipt of results. For the two non-compliant cases, the diagnostic test results were not reviewed and signed by the PCP within two business days. One report was reviewed by PCP 10 days later and the other report was not signed by PCP acknowledging review of the diagnostic test results. This equates to 90.5% compliance.

3. Question 7.3 – Three of the 24 patient medical records reviewed were deemed not applicable per the double failure rule. Nineteen patient medical records were found compliant with this requirement. For the two non-compliant cases, no documentation could be located in the patient's medical record showing written notification of the diagnostic test results was provided to the patient within two business days of the facility's receipt of results. This equates to 90.5% compliance.
4. Question 7.4 – Twelve of the 24 cases reviewed were found not applicable to this question as the patients did not require a follow-up appointment with the provider. Eleven patient medical records included documentation that the patient was seen by the provider for clinically significant/abnormal diagnostic test results within 14 days and one record was found non-compliant with this requirement. One patient with abnormal diagnostic results was not seen by PCP until three weeks later. This equates to 91.7% compliance.

8. EMERGENCY SERVICES

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

Case Review Rating:
Inadequate
Quantitative Review Score [Rating]:
Not Applicable
Overall Rating:
Inadequate

This quality indicator is evaluated by CCHCS clinicians entirely through the review of patient medical files and facility's documentation of emergency medical response process. There are no quantitative scores in relation to this indicator and therefore, the overall rating is solely based on the results of the clinical case reviews.

Case Review Results

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

From August 2015 to January 2016, a total of 13 patients were sent to the community hospital ED for a higher level of care which resulted in a limited number of encounters being available for evaluation. Nevertheless, of the 15 urgent/emergent encounters reviewed by both CCHCS nurse consultant and physician auditors, six deficiencies were identified, four in nursing performance and two in provider's performance. Specific examples of deficiencies and areas of concern identified by CCHCS nurse consultant are as follows:

- In Cases 3 and 7, there was no documentation found in patient's medical record indicating the nurse completed a FTF assessment of the patient upon his return to the facility from community hospital visit.

- In Case 2, a patient was seen for a complaint of a pulling sensation in left shoulder and was noted to have low blood pressure, and thready pulse. The patient was assessed by the RN and referred to provider for follow-up; however, the nurse failed to monitor vital signs and to conduct a neurological or cardiac assessment.
- In Case 3, the patient presented to medical with complaint of dull ache on the left side of chest lasting for six days. Although the patient was referred to provider for follow-up, the RN failed to conduct a subjective or objective assessment of the patient in accordance with the Chest Pain protocol.

The two deficiencies identified by the CCHCS physician are as follows:

- In Case 7, the patient was sent to Desert Valley community hospital ED based on the hub institution's notification of the patient's diagnostic test results. The facility's provider did not document the conversation with the patient or the hub provider nor did the provider evaluate the patient's symptomology including a current glucose check to see the need for an ED visit. Due to delays in testing logistics, the provider should have screened the patient based on current symptomology rather than transport the patient to an ED based on laboratory tests completed a few days ago.

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

9. HEALTH APPRAISAL/HEALTH CARE TRANSFER

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

Case Review Rating:
Inadequate
Quantitative Review Score [Rating]:
78.0% [Inadequate]
Overall Rating:
Inadequate

The facility performed very poorly both in the quantitative and clinical case review sections. The deficiencies were mainly due to incomplete nursing documentation, delay in administering the prescribed medications to patients upon their arrival at the facility, failure to assess the patient during the Health Screening Process, and the provider failing to complete the health appraisals timely. It should be noted, until the month of October 2015, many of the patient medical records were missing the *Initial Health Screening* forms (CDCR Form 7277), resulting in a very low compliance score for Questions 1 and 2 as indicated below. Based on the clinical case review and quantitative findings, DVMCCF received an *inadequate* rating in the *Health Appraisal/Health Care Transfer* indicator.

Case Review Results

During the audit review period, there were a few cases where the patients transferred into and out of the facility; therefore, limiting the number of cases available for evaluation. Nevertheless, of the 12 patient encounters/visits reviewed, related to *Health Appraisal/Health Care Transfer Process*, four deficiencies were found, all in nursing care.

Overall, DVMCCF nursing staff's performance was *inadequate* in both the transfer-in and transfer-out processes.

- In cases 8 and 13, nursing staff failed to countersign the *Health Care Transfer Information* form completed by the sending institution to indicate the patient's medical information received from the transferring facility had been reviewed.
- In Case 14, there was no documentation in the patient's medical record that an initial health screening was completed upon the patient's arrival at the facility.
- The one deficiency found with patients transferring out of DVMCCF was due to incomplete nursing documentation of significant medical information on the CDCR 7371, *Health Care Transfer Information,* form (Case 12).

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

Quantitative Review Results

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

Health Appraisal/Health Care Transfer		**Yes**	**No**	**Compliance**
9.1	Does the patient receive an initial health screening upon arrival at the receiving facility by licensed health care staff?	9	5	64.3%
9.2	If "YES" is answered to any of the medical problems on the *Initial Health Screening* form (CDCR 7277/7277A or similar form), does the registered nurse document an assessment of the patient?	2	1	66.7%
9.3	If a patient presents with emergent or urgent symptoms during the initial health screening, does the registered nurse refer the patient to the appropriate provider?	1	0	100%
9.4	If a patient is not enrolled in the chronic care program but during the initial health screening was identified as having a chronic disease/illness, does the registered nurse refer the patient to the primary care provider to be seen within the required time frame??	1	0	100%

9.5	If a patient was referred to an appropriate provider during the initial health screening, was the patient seen within the required time frame?	2	0	100%
9.6	If a patient was enrolled in a chronic care program at a previous facility, is the patient scheduled and seen by the receiving facility's primary care provider within the time frame ordered by the sending facility's chronic care provider?	2	0	100%
9.7	If a patient was referred by the sending facility's provider for a medical, dental, or a mental health appointment, is the patient seen within the time frame specified by the provider?	Not Applicable		
9.8	Does the patient receive a complete screening for the signs and symptoms of tuberculosis upon arrival?	11	3	78.6%
9.9	Does the patient receive a complete health appraisal within seven calendar days of arrival?	6	8	42.9%
9.10	If a patient had an existing medication order upon arrival at the facility, were the nurse administered medications administered without interruption and keep-on-person medications received within one calendar day of arrival?	2	1	66.7%
9.11	When a patient transfers out of the facility, are the scheduled specialty services appointments that were not completed, documented on a Health Care Transfer Information Form (CDCR 7371) or a similar form?	7	11	38.9%
9.12	Does the Inter-Facility Transfer Envelope contain all the patient's medications, current Medication Administration Record and Medication Profile?	2	0	100%
	Overall Quantitative Review Score:			**78.0%**

Comments:

For questions 9.1 through 9.10, a random sample of 14 patient medical records were reviewed for the audit review period of August 2015 through January 2016.

1. Question 9.1 – Nine patient medical records reviewed included documentation that the patient received an initial health screening upon arrival at the facility and five records were found non-compliant with this requirement. This equates to 64.3% compliance.
2. Question 9.2 – A total of three patient medical records out of 14 reviewed were found applicable to this question. Of the three patient medical records reviewed, two included documentation that the RN assessed the patient if the patient answered 'yes' to any of the medical problems listed on the *Initial Health Screening* form. This equates to 66.7% compliance.
3. Question 9.8 – Eleven patient medical records reviewed included documentation that the patient was screened for signs and symptoms of tuberculosis upon arrival at the facility. Three patient medical records were missing such documentation. This equates to 78.6% compliance.
4. Question 9.9 – Six patient medical records reviewed included documentation that the patient received a complete health appraisal within seven calendar days of arrival. Eight medical records were found non-compliant with this requirement. Seven patients were not seen by a PCP within seven calendar days of arrival and one patients' medical record was missing documentation of the health appraisal having been completed. This equates to 42.9% compliance.
5. Question 9.10 – A total of three patient medical records out of 14 reviewed were found applicable to this question. Of the three patient medical records reviewed, two included documentation that the patient, upon arrival at the facility, received his existing medications without interruption. This equates to 66.7% compliance.
6. Question 9.11 – Of the 18 patient medical records reviewed for the audit review period, seven included documentation of the patients' pending scheduled specialty service appointments, which were not

completed at the sending facility, on the *Health Care Transfer Information* Form. For the 11 non-compliant cases, no CDCR Form 7371 could be located in the patients' medical record. This equates to 38.9% compliance.

10. MEDICATION MANAGEMENT

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

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
84.4% [Inadequate]
Overall Rating:
Adequate

For *Medication Management* indicator, the case review and quantitative review processes yielded different results. The quantitative review resulted in overall score of 84.4%, equating to a quality rating of *inadequate*, while the case review resulted in an *adequate* rating. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the critical nature of the deficiencies identified during case reviews and their potential impact on patient's health care condition. The case review resulted in numerous deficiencies; however, a majority of the deficiencies were minor in nature and did not have a significant impact on care provided to patients. As a result, the CCHCS clinicians determined the appropriate overall rating for this indicator was *adequate*.

Case Review Results

The CCHCS clinicians reviewed a total of 139 encounters related to medication management and found 74 deficiencies, 67 in nursing performance and 3 in provider's performance. Seventy-eight percent (52) of the nursing deficiencies involved no documentation of nurses' names and initials on the keep-on-person (KOP) MAR, which did not have a significant impact on patient care. However, a few problems were identified which may be used for quality improvement purposes:

- In Case 3, the patient refused his KOP medication; however, the auditor could not locate a refusal form in the medical record. In the same case, there was a three day delay in patient receiving his prescribed Cetirizine medication.
- In Cases 7, 9, and 10, on several occasions, there was a delay in administering the prescribed medication to the patient.
- In Case 2, the RN failed to conduct an assessment of a patient who requested antibiotic for a minor cut. In the same case, on three occasions, the RN failed to inform the patient of his medication refill schedule. Additionally, for two instances, the auditor could not locate documentation in the eUHR indicating the patient received his medications as ordered by provider.

The three provider deficiencies identified involved missing or insufficient documentation in the patient's medical record to support the ongoing use of medications (Cases 2, 5, and 6).

As the above listed deficiencies were minor in nature and did not significantly affect patient care, the case review resulted in an *adequate* rating for this indicator.

Quantitative Review Results

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

Medication Management		**Yes**	**No**	**Compliance**
10.1	Does the prescribing primary care provider document that the patient was provided education on the newly prescribed medications?	21	3	87.5%
10.2	Is the initial dose of the newly prescribed medication administered to the patient as ordered by the provider?	18	6	75.0%
10.3	Does the nursing staff confirm the identity of a patient prior to the delivery and/or administration of medications?	1	0	100%
10.4	Does the same medication nurse who administers the nurse administered/direct observation therapy medication prepare the medication just prior to administration?	2	0	100%
10.5	Does the medication nurse directly observe a patient taking direct observation therapy medication?	0	2	0.0%
10.6	Does the medication nurse document the administration of nurse administered/direct observation therapy medications on the Medication Administration Record once the medication is given to the patient?	2	0	100%
10.7	Are medication errors documented on the Medication Error Report form?	2	0	100%
10.8	Are refrigerated drugs and vaccines stored in a separate refrigerator that does not contain food and/or laboratory specimens?	1	0	100%
10.9	Does the health care staff monitor and maintain the appropriate temperature of the refrigerators used to store drugs and vaccines twice daily?	60	2	96.8%
10.10	Does the facility employ medication security controls over narcotic medications assigned to its clinic areas?		Not Applicable	
10.11	Are the narcotics inventoried at the beginning and end of each shift by licensed health care staff?		Not Applicable	
10.12	Do patients, housed in Administrative Segregation Unit, have immediate access to the Short Acting Beta agonist inhalers and/or nitroglycerine tablets? (COCF only)		Not Applicable	
	Overall Quantitative Review Score:			**84.4%**

Comments:

For questions 10.1 and 10.2, a random sample of 24 patient medical records were reviewed for the audit review period of August 2015 through January 2016.

1. Question 10.1 – Twenty-one patient medical records reviewed included documentation that the provider educated the patient on the newly prescribed medication(s), and three records were missing such documentation. This equates to 87.5% compliance.
2. Question 10.2 – Eighteen patient medical records reviewed included documentation reflecting the initial dose of the newly prescribed medications was administered to the patients as ordered by the provider. The six non-compliant cases reflect the patient received the prescribed medication late or did not receive the medication as ordered by provider. This equates 75.0% compliance.
3. Question 10.5 – The facility did not have any patients on nurse administered (NA)/direct observation therapy (DOT) medications at the time of the onsite audit; therefore, compliance for this requirement was based on nursing staff interviews. Two nurses were interviewed regarding this process and both failed to mention conducting cup checks to ensure the patient did not leave the medication in his cup. This equates to 0.0% compliance.
4. Question 10.9 – During the onsite audit, the refrigerator log for the month of January 2016 was reviewed. On two shifts, the temperature was noted to be below 35 degrees Fahrenheit. Per IMSP&P guidelines, the refrigerator temperature is to be maintained between 36 and 46 degrees Fahrenheit. This equates to 96.8% compliance.
5. Questions 10.10 and 10.11 – Not applicable. DVMCCF does not store narcotic medications at the facility; therefore, these questions could not be evaluated.
6. Question 10.12 – Not applicable. This question does not apply to the in-state correctional facilities.

11. OBSERVATION CELLS

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

This quality indicator does not apply to DVMCCF as the facility does not have any inpatient cells onsite. Patients requiring admission to inpatient housing are transferred to the hub institution.

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
Not Applicable

Overall Rating:
Not Applicable

12. SPECIALTY SERVICES

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

For *Specialty Services* indicator, the case review and quantitative review processes yielded different results. The quantitative review resulted in overall score of 82.0%, equating to a quality rating of *inadequate*, while the case review resulted in an *adequate* rating. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the magnitude of the deficiencies identified during case reviews and their potential impact on patient's health care condition. The case review results revealed just one minor deficiency which did not impact the patient's access to health care. As a result, the CCHCS clinicians determined the appropriate overall rating for this indicator was *adequate*.

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
82.0% [Inadequate]
Overall Rating:
Adequate

Case Review Results

The CCHCS clinicians reviewed 15 events related to *Specialty Services* and found one minor deficiency associated with nursing care. The CCHCS physician case reviews did not identify any lapses in care provided by the DVMCCF's providers. The nursing deficiency involved the health information management process where the nurse failed to document that a patient received his eyeglasses and if they were effective. As this deficiency was minor in nature and did not affect patient care, the case review resulted in *adequate* rating for this indicator.

Quantitative Review Results

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

Specialty Services		**Yes**	**No**	**Compliance**
12.1	Is the primary care provider's request for specialty services approved or denied within the specified time frame? (COCF Only)	Not Applicable		
12.2	Is the patient seen by the specialist for a specialty services referral within the specified time frame? (COCF Only)	Not Applicable		
12.3	Upon return from the hub, a specialty consult appointment or community emergency department visit, does a registered nurse complete a face-to-face assessment prior to the patient's return to the assigned housing unit?	14	8	63.6%
12.4	Upon return from the hub, a specialty consult appointment or community emergency department visit, does a registered nurse notify the primary care provider of any immediate orders or follow-up instructions provided by the hub, a specialty consultant, or emergency department physician?	2	0	100%
12.5	Does the primary care provider review the specialty consultant's report, hub provider's report or the community emergency department provider's discharge summary and complete a follow-up appointment with the patient within the required time frame?	14	3	82.4%
	Overall Quantitative Review Score:			**82.0%**

Comments:

For questions 12.3 through 12.5, a random sample of 22 patient medical records were reviewed for the audit review period of August 2015 through January 2016.

1. Questions 12.1 and 12.2 – Not applicable. These questions do not apply to in-state correctional facilities.
2. Question 12.3 – Fourteen patient medical records reviewed included documentation of the RN completing a FTF assessment prior to the patient's return to the assigned housing unit. Two patient records were missing documentation of RN's FTF assessment of the patient and the remaining six medical records showed the assessment was completed by an LVN and not a RN. This equates to 63.6% compliance.
3. Question 12.5 – Fourteen patient medical records reviewed included documentation of PCP completing a follow-up appointment upon patient's return from a specialty care appointment or community ED. Three patient medical records were found non-compliant; one patient was not seen by a PCP within 14 days upon return and two records were missing documentation of PCP reviewing the specialty consultant's report and following-up with a patient within the required time frame. This equates to 82.4% compliance.

13. PREVENTIVE SERVICES

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

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

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

During the current audit, the facility was not rated on this quality indicator as none of the compliance questions listed below applied to the facility for the audit review period of August 2015 through January 2016. Refer to the *Comments* section, following the table below, for additional information and details. The questions and requirements found not applicable during the current audit will be evaluated during the subsequent audit.

Quantitative Review Results

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

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

Comments:

1. Questions 13.1 through 13.3 – Not applicable. There were no patients who were prescribed TB medications during the audit review period of August 2015 through January 2016; therefore, these questions could not be evaluated.
2. Questions 13.4 and 13.5 – Per the methodology, these questions are evaluated once per calendar year and during the audit review period when the annual TB testing occurs per the master calendar on Lifeline. As the audit review period for DVMCCF's current audit did not encompass the month when the facility provided annual TB testing and screening to its CDCR patient population, these questions could not be evaluated for compliance with this requirement.
3. Question 13.6 – Per the methodology, these questions are evaluated once per calendar year during the time when the onsite audit is conducted within the first half of the fiscal year (July through December). As the current onsite audit for DVMCCF was not conducted during the first half of the fiscal year, this question will be evaluated during the subsequent audit.
4. Question 13.7 – Per the methodology, these questions are evaluated once per calendar year during the time when the onsite audit is conducted within the first half of the fiscal year (July through December). As the current onsite audit for DVMCCF was not conducted during the first half of the fiscal year, this question will be evaluated during the subsequent audit.
5. Questions 13.8 and 13.9 – Not applicable. These questions only apply to correctional facilities housing female patient population.

14. EMERGENCY MEDICAL RESPONSE/DRILLS & EQUIPMENT

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
57.7% [Inadequate]
Overall Rating:
Inadequate

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

The facility performed very poorly in this area and received a compliance score of 57.7%, resulting in an *inadequate* overall rating for the *Emergency Medical Response/Drills & Equipment* indicator. Seven out of 13 questions rated below an adequate range of 85.0% compliance and require facility's immediate attention in resolving these deficiencies.

Prior to and during the onsite visit, it was learned the facility did not hold any EMRRC meetings prior to January 2016. The facility also failed to conduct the required emergency medical response drills in spite of this issue having been addressed during the previous audit. The audit team provided recommendation to the HSA regarding more efficient ways and methods to document the daily inventory checks of emergency medical response equipment. Refer to the *Comments* section, following the table below, for additional information and details on the deficiencies identified during the quantitative review of this indicator.

Quantitative Review Results

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

Emergency Medical Response/Drills & Equipment		Yes	No	Compliance
14.1	Does the facility conduct emergency medical response drills quarterly on each shift when medical staff is present?	2	2	50.0%
14.2	Does a Basic Life Support certified health care staff respond without delay after emergency medical alarm is sounded during an emergency medical response (man-down) and/or drill?	3	0	100%
14.3	Does a registered nurse or a primary care provider respond within eight minutes after emergency medical alarm is sounded for an emergency medical response (man-down) and/or drill?	3	0	100%
14.4	Does the facility hold an Emergency Medical Response Review Committee meeting a minimum of once per month?	1	5	16.7%

14.5	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required documents?	0	1	0.0%
14.6	Is the facility's clinic Emergency Medical Response Bag secured with a seal?	0	62	0.0%
14.7	If the emergency medical response and/or drill warrant an opening of the Emergency Medical Response Bag, is the bag re-supplied and re-sealed before the end of the shift?	1	2	33.3%
14.8	If the emergency medical response bag has not been used for emergency medical response and/or drill, is it being inventoried at least once a month?	3	3	50.0%
14.9	Does the facility's Emergency Medical Response Bag contain only the supplies identified on the Emergency Medical Response Bag Checklist in compliance with Inmate Medical Services Policies and Procedures requirements?	1	0	100%
14.10	Is the facility's Medical Emergency Crash Cart secured with a seal? (COCF Only)	Not Applicable		
14.11	If the emergency medical response and/or drill warrant an opening and use of the medical emergency crash cart, is the crash cart re-supplied and re-sealed before the end of the shift? (COCF Only)	Not Applicable		
14.12	If the medical emergency crash cart has not been used for a medical emergency and/or drill, was it inventoried at least once a month? (COCF Only)	Not Applicable		
14.13	Does the facility's crash cart contain all the medications as required/approved per *Inmate Medical Services Policies and Procedures*? (COCF Only)	Not Applicable		
14.14	Does the facility's crash cart contain the supplies identified on the facility's crash cart checklist? (COCF Only)	Not Applicable		
14.15	Does the facility have a functional Automated External Defibrillator with electrode pads located in the medical clinic?	1	0	100%
14.16	Does the facility have a functional 12-lead electrocardiogram machine with electrode pads?	0	1	0.0%
14.17	Does the facility have a functional portable suction device?	1	0	100%
14.18	Does the facility have a portable oxygen system that is operational ready?	1	0	100%
	Overall Quantitative Review Score:			**57.7%**

Comments:

1. Question 14.1 – For this question, the audit team assessed the facility's compliance with this requirement for the third and fourth quarters of 2015 (July through December 2015). During this time frame, DVMCCF conducted a total of two emergency medical response training drills, one in August 2015 and October 2015. Both of these drills were conducted on second shift and none were conducted on first shift. Per IMSP&P, Volume 4, Chapter 12, Policy 4.12.3, the "emergency medical response training drills shall be conducted at least quarterly and on each shift". This equates to 50.0% compliance.

2. Question 14.4 – Of the six Emergency Medical Response Review Committee (EMRRC) meetings the facility was required to conduct during the audit review period, the facility only held one in January 2016. This equates to 16.7% compliance. This issue was addressed during the exit conference and the facility was strongly encouraged to start holding the EMRRC meetings monthly.

3. Question 14.5 – The compliance rating for this question was based on one EMRRC meeting conducted by the facility. Although an EMRRC meeting was held in January 2016, the required documents (Form 7462 and Form 7463) for code blue were not attached/included in the incident package submitted for EMRRC's review. This equates to 0.0% compliance.

4. Question 14.6 – The facility maintains one emergency medical response (EMR) bag. Review of the EMR Bag log for the month of January 2016 indicates the bag was checked two to three times a day (based on nursing staff signatures); however, the seal numbers were not documented on the log. The IMSP&P

states, in part, that bags are to be inspected each watch (in which staff are posted) to ensure seals are intact. As the seal number was missing from the documentation produced by the facility, the audit team was unable to determine whether the EMR bag was in fact inspected each shift to ensure the seal was intact. This equates to 0.0% compliance.

5. Question 14.7 – All three emergency medical responses/drills reviewed warranted an opening of the EMR bag. The EMR bag logs reviewed for the three incidents reflect only one bag was restocked and re-sealed before the end of the shift. This equates to 33.3% compliance.
6. Question 14.8 – For the months of August 2015 through October 2015, the facility did not document the number of the seal attached to the EMR bag. From November 2015 through January 2016, DVMCCF started tracking and documenting the seal numbers when the EMR bags were resupplied and resealed. This equates to 50.0% compliance.
7. Questions 14.10 through 14.14 – Not applicable. These questions do not apply to in-state correctional facilities as they do not maintain a medical emergency crash cart.
8. Question 14.16 – The facility has a 12-lead electrocardiogram (ECG) machine with electrode pads in their clinic; however, the electrode pads were not connected to the machine nor were anywhere near the machine. This equates to 0.0% compliance.

15. CLINICAL ENVIRONMENT

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
91.3% [Proficient]

Overall Rating:
Proficient

The facility received a compliance score of 91.3% in the *Clinical Environment* indicator, equating to an overall rating of *proficient*. The facility received 100% compliance in 14 of the 17 standards/requirements measured; meaning the facility is performing at a *proficient* level in those areas. In the remaining three areas DVMCCF scored below the adequate range of 85.0%. Refer to *Comments* section following the table below for additional information on the deficiencies.

Quantitative Review Results

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

Clinical Environment		Yes	No	Compliance
15.1	Are packaged sterilized reusable medical instruments within the expiration dates shown on the sterile packaging?	14	0	100%
15.2	If autoclave sterilization is used, is there documentation showing weekly spore testing?	1	0	100%
15.3	Are disposable medical instruments discarded after one use into the biohazard material containers?	2	0	100%
15.4	Does clinical health care staff adhere to universal hand hygiene precautions?	1	1	50.0%
15.5	Is personal protective equipment readily accessible for clinical staff use?	1	0	100%
15.6	Is the reusable non-invasive medical equipment disinfected between each patient use when exposed to blood-borne pathogens or bodily fluids?	1	0	100%
15.7	Does the facility utilize a hospital grade disinfectant to clean common clinic areas with high foot traffic?	1	0	100%
15.8	Is environmental cleaning of common clinic areas with high foot traffic completed at least once a day?	11	10	52.4%
15.9	Is the biohazard waste bagged in a red, moisture-proof biohazard bag and stored in a labeled biohazard container in each exam room?	2	0	100%
15.10	Is the clinic's generated biohazard waste properly secured in the facility's central storage location that is labeled as a "biohazard" area?	2	0	100%
15.11	Are sharps/needles disposed of in a puncture resistant, leak-proof container that is closeable, locked, and labeled with a biohazard symbol?	1	1	50.0%
15.12	Does the facility store all sharps/needles in a secure location?	1	0	100%
15.13	Does the health care staff account for and reconcile all sharps at the beginning and end of each shift?	62	0	100%
15.14	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	1	0	100%
15.15	Is the facility's biomedical equipment serviced and calibrated annually?	9	0	100%
15.16	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	2	0	100%
15.17	Does the clinic visit location ensure the patient's visual and auditory privacy?	1	0	100%
	Overall Quantitative Review Score:			**91.3%**

Comments:

1. Question 15.1 – Although the facility was found 100% compliant on this requirement, the audit team recommends specifying whether the stamped date on the packaging refers to the date of the sterilization or the expiration date.

2. Question 15.4 – During the onsite audit, two nurses were observed for compliance with this requirement, and one was found not fully adhering to the universal hand hygiene precautions. During one of the FTF assessments of a patient resulting from the sick call request, the nurse while still wearing her gloves went to the pharmacy/medication room to get medications for the patient and then went to the copy machine to copy records. After making a copy of the records, the nurse returned to the exam room and provided the medication and instructions to the patient. The nurse did not practice procedural hand hygiene precautions and failed to remove and discard the gloves prior to completing other functions such as copying records and obtaining medications from the pharmacy. This equates to 50.0% compliance.

3. Question 15.8 – The facility's cleaning logs for the month of January 2016 were reviewed. Of the 21 days which the clinic was operational (Saturday and Sundays excluded), 10 days (January 1, 4-8, 11-13 and

January 29, 2016) were missing documentation confirming the clinic had been cleaned at least once a day on those days. This equates to 52.4% compliance.

4. Question 15.11 – The facility currently has two sharps containers, one located in the pharmacy/medication room and the other one in the main clinic area. The sharps container in the main clinic area was found stored in the cabinet and not attached to the wall and does not appear to be utilized by health care staff. This equates to 50.0% compliance.

16. QUALITY OF NURSING PERFORMANCE

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

Case Review Rating:
Inadequate
Quantitative Review Score [Rating]:
Not Applicable

Overall Rating:
Inadequate

Case Review Results

The *Quality of Nursing Performance* at DVMCCF was rated *inadequate*. This determination was based upon the detailed case review of all the nursing services provided to 10 patients housed at DVMCCF during the audit review period of August 2015 through January 2016. Of the 10 detailed case reviews conducted by CCHCS nurse consultant, none were found *proficient*, seven were *adequate*, and three were found *inadequate*. Of 257 total nursing encounters/visits assessed within the 10 detailed case reviews, 95 deficiencies were identified related to nursing care and performance. The majority of the deficiencies involved the health information management, nursing assessment, and the medication management processes. The nursing services found to be inadequate/deficient at DVMCCF include:

- Incomplete nursing subjective and objective assessments related to patients' chief medical complaints (identified in Cases 3, 4, 5, 8, 9 and 10).
- Inappropriate nursing action taken [i.e., nursing staff providing medications not part of the nursing protocol and not referring patient to PCP when needed] (identified in Cases 3 and 4).
- A LVN rendering FTF assessment of the patient and review of the discharge plan (identified in Case 8).
- Sick call request triaged by LVN, contrary to the policy (identified in Case 2).
- Missing documentation reflecting that laboratory exams were completed within the prescribed time frame or as ordered by the provider (identified in Cases 6 and 8).
- Inadequate nursing objective assessments regarding a patient's emergent complaints (identified in Cases 2 and 3).
- Missing and/or incomplete documentation of RN's FTF assessment of the patient upon his return from community hospital ED or hub institution (identified in Cases 3 and 7).

- Failure of facility's nursing staff to countersign the *Health Care Transfer Information* form completed by the sending institution indicating review of the patient's medical information was completed (identified in Cases 8 and 13; refer to pages 32 and 33 for additional information).
- Delays in administration of ordered medications (identified in Cases 3, 7, 9, and10).
- Missing documentation of the patient receiving prescribed medications (identified in Case 2).

Case Number	Deficiencies
Case 1	***Adequate.*** A fifty-three year old patient enrolled in the DM chronic care program. The patient's DM is controlled by diet. During the audit review period, the patient was prescribed Aspirin ASA 81 mg and had received Visine for dry itchy eyes. Additionally, the patient received an ophthalmology specialty service for annual vision check due to his DM and was prescribed single vision glasses. The nursing deficiencies in this case were due to the auditor unable to locate documentation of the patient receiving eyeglasses recommended by the specialty service provider. Also, the MARs did not have nurses' names, initials or signatures.
Case 2	***Inadequate.*** A forty-five year old patient diagnosed with GERD and was prescribed the following medications: fiber tabs for constipation, Tylenol for pain, Visine for dry eyes, Omeprazole for GERD, Simethicone for gas and selenium sulfide for scalp treatment. The patient frequently submitted CDCR Forms 7362 requesting to be weighed and requested medication refills too early. The nursing staff addressed all of patient's requests for services timely; however, in the auditor's opinion, DVMCCF missed multiple opportunities to educate the patient on how and when to submit 7362 request for refill of medications. For the most part, the nursing services provided were adequate; however, on two occasions, the RNs failed to conduct an appropriate assessment for urgent/emergent symptoms, thus resulting in an inadequate rating for this case. The patient submitted a sick call request complaining of a cut on finger; however, no documentation could be found of the RN completing an assessment of the cut. Additionally, the RN failed to conduct a cardiac or neurological assessment for the patient complaining of "pulling sensation in left shoulder" and dizziness. One of the sick call requests was triaged by a LVN and not an RN. Lastly, nurses' names and initials or signatures were not found on MARs.
Case 3	***Inadequate.*** A thirty-seven year old patient who paroled from DVMCCF in September 2015. During the audit review period, the patient was seen on multiple occasions for complaint of throat and neck swelling and treatment for otitis media. The patient was prescribed Cetirizine, ranitidine, amoxicillin, and ibuprofen. The patient was assessed for preventative services and received vaccinations per protocol and was also offered fecal occult blood test (FOBT) but refused it on two occasions. The nursing services provided to the patient were inadequate due to the following issues: • Patient was seen by the RN for continued complaint of pain and swelling of neck and throat. The RN did not document an assessment of the patient's compliance with antibiotics or refer the patient to the PCP for unresolved symptoms of infection; • The RN did not conduct a subject/objective assessment of the patient for complaint of swollen gums and headache; • The RN did not conduct an objective assessment of patient's finger with complaint of swelling and "pus"; • No documentation of the RN referring patient to a PCP or dentist for continued complaint of swollen gums; • The RN provided medications or treatment that are not part of the nursing protocol or ordered by a PCP;

	• There was a delay in patient receiving requested refill medications; • Missing documentation of RN's assessment of patient upon return from community hospital visit via hub institution; • The auditor was unable to locate refusal form reflecting patient's refusal of KOP medication.
Case 4	***Inadequate.*** A thirty-six year old patient was seen in medical for complaint of sore throat and itching feet during the audit review period. The patient was also seen by the ophthalmologist and had received prescription eye glasses. The nursing services were inadequate due to the following: The RN provided treatment that was not part of the nursing protocol and failed to refer the patient to the PCP after patient's third visit for the same unresolved symptoms. Also, the RN failed to complete a subjective/objective assessment related to patient's complaints and no documentation could be located indicating that effective communication was established during patient's clinical encounter.
Case 5	***Adequate.*** A twenty-seven year old patient who arrived at DVMCCF in September 2015. Upon arrival at DVMCCF, the patient expressed anxiety with difficulty sleeping and was seen at the hub institution by mental health provider. The patient was admitted to Mental Health Crisis Bed in November 2015 and to date remains at the hub institution. One deficiency was found where the RN failed to conduct a visual or physical assessment of the patient complaining of testicular pain. The RN referred the patient to the PCP; however, the patient was not seen until five days later.
Case 6	***Adequate.*** A forty-four year old patient enrolled in chronic care program for hypertension (HTN), dyspepsia, and tinea corporis. During the review period, the patient had one episode of chest pain and shortness of breath and was brought to Desert View Hospital ED. Lab work-ups were negative for myocardial infarction. Minor deficiencies noted in this case include: the nursing staff noted ASA was given on the nursing protocol; however, there was no documentation on the MAR noting ASA was given. Provider's laboratory orders were not carried out timely by nursing staff. Although nursing consistently did not document their names and signatures on the MAR, there were no other significant deficiencies noted. This was a matter of nursing documentation, which had no adverse effect on patient care.
Case 7	***Adequate.*** A thirty-four year old patient with chronic diagnoses of plantar fasciitis and onychomycosis. During the review period, the patient complained of arthritic pain on his knees, left ankle swelling and pain due to twisting his ankle while playing basketball. The patient was sent to community hospital ED where x-rays were done and no fracture was noted. The patient was diagnosed with grade 3 ankle sprain and placed on stirrup splint. The nursing deficiencies include: the nursing staff did not administer patient's medications timely and did not document nurses' name and initials on the MAR. Also, there was no documentation found in the patient's medical record of the RN conducting a FTF assessment of the patient upon his return from the hub institution, following a discharge from the community hospital ED.
Case 8	***Adequate.*** A forty-three year old patient with history of ulcer, gastrointestinal bleed, and thalassemia. During the review period, the patient complained of left upper quadrant (LUQ) abdominal pain, diaphoresis, and vomiting. The patient was sent to Desert Valley Hospital where laparoscopic cholecystectomy was done. The following day patient returned to the hub institution for post hospitalization treatment. During the patient's walk-in visit to medical complaining of LUQ pain and diaphoresis, the RN did not conduct an adequate assessment related to the patient's complaint. The nurse failed to document level of pain, absence or presence of bowel sounds, the patient's overall appearance, and nursing diagnosis. Upon patient's return back to DVMCCF, the RN did not countersign the *Health Care Transfer Information* form completed by the sending institution to indicate that nursing staff reviewed documents from the hub institution. Additionally, the FTF assessment and review of the discharge plan was completed by a LVN, contrary to the policy. The policy requires the RN to conduct a FTF evaluation and review of the discharge plan upon the patient's return from a

	community hospital visit. The auditor was also unable to locate results of the provider ordered laboratory examinations to determine if they were done within the prescribed time frame. Lastly, the KOP MARs did not contain nurses' name and signature or initial.
Case 9	***Adequate.*** A thirty-nine year old patient with chronic diagnoses of hypertension and migraine headaches. During the review period, the patient complained of upper respiratory tract problem secondary to allergies. The patient also complained of headache and was given pain medications such as ibuprofen and naproxen. Several minor deficiencies identified in this case include: the nursing staff did not consistently document name, signature or initial on the MARs and the date when the patient received his medications; the RNs did not consistently conduct adequate subjective and objective nursing assessment related to the patient's complaint and did not consistently state proper nursing diagnosis.
Case 10	***Adequate.*** A forty-one year old patient with chronic diagnoses of irritable bowel syndrome, history of colon polyps, hypertension, fatty liver disease, and hypothyroidism. During the review period, the patient repeatedly submitted sick call requests for medication refills such as Tylenol and Fiber Lax. The patient was once sent to the hub institution for colonoscopy but refused the procedure. The minor deficiencies noted were mostly related to documentation and did not have significant impact on patient care. The most common deficiency was the absence of nurses' names and signatures or initials on the MAR as required by the IMSP&P when dispensing KOP medications and the medications were not administered to the patient timely. Additionally, during one of the patient's walk-in sick call visits complaining of dizziness/heaviness and shortness of breath, the RN failed to conduct adequate subjective and objective assessment of the patient's medical complaint.

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

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

- Consider implementing a process where nursing, providers, and custody meet at the beginning of the work day to discuss:
  - patients to be seen that day;
  - patients who were sent out or returned from a community hospital ED visit or hospitalization;
  - patients seen on an urgent basis in the last 24 hours;
  - patients non-compliant with medications or ordered treatments/therapies; and
  - new arrivals with chronic health conditions.
- Implement a process that ensures chronic care medications are ordered and received by the patient prior to the patient finishing the existing supply.

- ❖ Implement a process to ensure nursing documents the administration of all medications. This is to include the one time medications ordered by the provider, prescribed chronic care medications, and vaccinations.
- ❖ Implement a process where all the medical records are sent to the hub institution timely for scanning and uploading into the eUHR and implement an internal auditing process to verify if the medical records have been scanned and filed into the patient's medical record.

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

17. QUALITY OF PROVIDER PERFORMANCE

In this indicator, the CCHCS physicians provide a qualitative evaluation of the adequacy of provider care at the facility. Appropriate evaluation, diagnosis, and management plans are reviewed for programs including, but not limited to, nursing sick call, chronic care programs, specialty services, emergency services, and specialized medical housing.

Case Review Rating:
Inadequate
Quantitative Review Score [Rating]:
Not Applicable
Overall Rating:
Inadequate

Case Review Results

Based on the 15 in-depth case reviews completed by CCHCS clinician, the facility provider performance was *inadequate*. Of the 15 detailed case reviews conducted by CCHCS physician, none were found *proficient*, 10 were found *adequate*, and 5 were *inadequate*. Out of a total of 70 physician encounters/visits assessed, 40 deficiencies were identified. These deficiencies ranged from severe to minor and a number of deficiencies were due to missing documentation in the patients' electronic medical record. The physician services found to be inadequate/deficient at DVMCCF include:

- Inappropriate discussion of housing/placement (identified in Case 5).
- Lack of documentation to support actions taken (identified in Cases 2, 3, 4, 12, 14, and 15).
- Medication prescribed without clinical indication (identified in Case 3).
- Insufficient documentation regarding long term use of medication for treatment of GERD (identified in Case 2).
- Improvement and education needed regarding Hepatitis C diagnosis guidelines (identified in Cases 9 and 10).
- Delay in notifying patients of diagnostic laboratory results (identified in Cases 1, 7, and 13).
- Unnecessary laboratory tests ordered (identified in Cases 1, 7, 13 and 15).

Case Number	Deficiencies
Case 1	***Inadequate.*** A fifty-three year old patient diagnosed with adult onsite DM, followed in chronic care clinic. During the six month period, was seen twice for a follow-up chronic care appointment, laboratory results notification, sick call and specialty services follow-up appointment. The physician deficiencies consisted of: excess amount of laboratory tests ordered without evidence-based rationale; pre-diabetes diagnosis written without acknowledging CCHCS progress notes and history of diabetes diagnosis; failure to address patient's elevated blood pressure on the assessment/plan.
Case 2	***Adequate***. A forty-five year old patient enrolled in chronic care clinic for multiple chronic diseases: GERD, gas, allergies, and psoriasis. During the chronic care follow-up visits, the provider failed on two occasions to document a plan that addressed long term GERD management; also, there was insufficient documentation to support the patient's ongoing use of medications. The provider needs to conduct more in-depth review of the patients' chronic diseases to see if his medication regimen can be decreased or eliminated. Overall, no major lapses in care were noted.
Case 3	***Inadequate.*** A thirty-seven year old patient was seen by RN multiple times for oral lesions and seen by the PCP several times for the same issue. The symptoms persisted for about two months. The provider referred the patient to a hub specialist; however, no exam was noted on the day referral was made. During one of the sick call visits, the patient's elevated BP was not addressed. Additionally, there was a six day delay in patient receiving routine cough medication and the provider inappropriately prescribing antibiotics for improving viral infection.
Case 4	***Adequate.*** A thirty-six year old patient who was seen several times by RN for cough drops and antifungal cream. The provider addressed patient's request for foot cream and cough drops for throat; however, the provider failed to document description of symptoms and duration of the issue and failed to conduct an exam of the throat. Not examining the patient may potentially result in possible misdiagnosis.
Case 5	***Adequate.*** A twenty-seven year old patient who utilized clinic services frequently for anxiety and depression over endorsement to MCCF. The provider documented plans to work with counselor to move patient closer to family. It was appropriate for the provider to refer patient to mental health; however, the provider should not discuss transfer or address custody areas. Additionally, there was no scrotal exam completed on patient who complained of intermittent scrotal pain. Overall, no major lapses in care were noted.
Case 6	***Adequate.*** A forty-three year old patient sent to community hospital ED for abdominal pain resulting in laparoscropic cholecystectomy. Followed post-operatively. One minor deficiency noted in provider not addressing diet modification during patient's chronic care follow-up appointment.
Case 7	***Inadequate.*** A sixty-two year old patient with poorly controlled DM. Physician deficiencies identified include: inappropriate lab orders and inadequate diabetes management whereby patient was sent to the ED for elevated glucose. Patient should have had a finger-stick glucose test in the clinic instead of sending immediately to ED based on phone call from the hub institution. Patient was not interviewed for symptoms of hyperglycemia.
Case 8	***Inadequate.*** A thirty-six year old patient developed hernia in July 2015, seen by the PCP at DVMCCF; DVMCCF was advised to send the patient to community hospital ED by LAC RN; routine hernia repair done in November 2015. Subjective complaints did not match the normal vital signs and objective physical findings.
Case 9	***Adequate.*** A thirty-four year old patient enrolled in chronic care clinic for Hepatitis C. Provider's laboratory orders indicate lack of understanding and inadequate knowledge on Hepatitis C management.

Case 10	***Adequate.*** A thirty-seven year old patient enrolled in chronic care clinic for Hepatitis C. During the chronic care follow-up appointment, the provider failed to counsel/inform the patient on the current status of Hepatitis C virus when, based on laboratory results, it was determined to be no longer active.
Case 11	***Adequate.*** A twenty-seven year old patient sent to ED for hematuria and vasovagal syncope. Subsequently treated for prostatitis and improved with antibiotics. Urinary discomfort was treated with Bactrim; however, no urinary testing done or physical exam findings noted. A young male diagnosed with chronic prostatitis without urinalysis and STD screening.
Case 12	***Adequate.*** A thirty-one year old enrolled in chronic care clinic for GERD with history of ulcer, asthma, and osteoarthritic pain. There is scant documentation on chronic diagnoses. Additionally, provider ordered a bottom bunk for chronic belly pain; however, there was insufficient rationale to provide a bottom bunk.
Case 13	***Adequate.*** A forty-seven year old male followed for Hypertension, DM, and Hepatitis C. Inappropriate amount of labs were ordered by provider without following evidence-based medicine guidelines. Additionally, on one occasion, there was a 37 day delay in provider notifying patient of the diagnostic test results.
Case 14	***Adequate.*** A forty-one year old patient seen for toenail fungus complaint. Provider ordered clotrimazole for treatment of toenail fungus. Additionally, patient was sent to ED for facial abscess. Although appropriate management and treatment was provided, the provider did not document her own note but rather noted on physician's order form.
Case 15	***Inadequate.*** A sixty-six year old patient with upward trending prostate-specific antigen (PSA). During the chronic care follow-up appointment, the provider ordered 'yearly lab work'; however, there was not adequate rationale noted for this action. Also, there was incomplete documentation on the plan to address increasing PSA in 66 year old male. Rising PSA from 3.5 in 2012 to 8.1 in November 2015 was not documented by provider to reflect sense of urgency.

DVMCCF has made great strides in eliminating the backlogs that existed during the August 2015 audit. The inability to staff the facility with a quality clinician that provides full time care has impacted the audit findings once again. There are indeed indications of good clinical care and sound decision-making by various providers. The overall quality of care is still rated as *inadequate* based on the findings above and the recommendations made below. Following are some recommendations provided by CCHCS physician on how to improve the provider's performance at DVMCCF:

- Initiate use of eUHR immediately to review historical labs and notes. This information is key to reducing unnecessary blood work and repeat work up in general.
- Document rationale for diagnoses and plans; Perform exams on body systems related to diagnoses on clinic encounter (e.g. Psoriasis and seborrheic dermatitis should have skin examination; If providing cough drops for sore throat, then the throat should be examined; scrotal pain complaints should be followed with a testicular exam).
- Providers and not RNs should fill out CDCR Forms 7410 accommodation chronos.
- Utilize the Chronic Care Guidelines provided by CCHCS. Topics include Hepatitis C - diagnosis, monitoring, and management; Diabetes management, Hypertension diagnosis and management.

- Discontinue use of medications for cosmetic reasons or if the medication requested by patient has no value (e.g. antibiotics for viral infection already improving; topical antifungal cream for onychomycosis).
- Do not prescribe medications for GERD and abdominal pain for extended periods without review of symptoms.
- Order laboratory tests based on evidence-based guidelines; utilize UpToDate, Choosing Wisely, and other resources to support the use of screening labs (e.g. do not order FOBT in male in 30's with no risk factors).
- Study Prostate Screening Guidelines; order PSA after discussing the risks and benefits of screening.
- Obtain supporting documentation for mid-level provider's supervision by a physician — Delegation of Services Agreement.
- Utilize CCHCS Health Care Compliance and Monitoring Audit Findings in Quality Improvement Projects.

PRIOR CRITICAL ISSUE RESOLUTION

The previous audit resulted in the identification of 76 quantitative critical issues; however, five of these are not longer rated by the Health Care Operations Monitoring Audit. It should be noted that some of the critical issues previously identified are no longer measured in the new audit instrument due to elimination of those questions from the audit instrument resulting from the revisions to IMSP&P and other CCHCS standards that govern the delivery of patient health care services. Several questions that measured similar requirements have been merged into one question and a couple of new questions have been added.

During the current audit, auditors found 30 of the 71 outstanding issues resolved. The remaining 41 critical issues were not resolved to within the established compliance threshold. Below is a discussion of each previous critical issue:

1. *Part of Question 1.2 (Formerly Question 1.1.2) - ALTHOUGH THE FACILITY HAS A WRITTEN LOCAL POLICY AND PROCEDURE THAT ADDRESSES THE MAINTENANCE/MANAGEMENT OF PATIENT MEDICAL RECORDS, THE POLICY IS NOT IN FULL COMPLIANCE WITH IMSP&P GUIDELINES.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

During the previous audit, it was found that although the facility did have a policy/LOP that addressed the maintenance/management of patient medical records, it was not in full compliance with IMSP&P guidelines. During the current audit, the facility submitted CCS corporate policies as their LOPs which are not specific to DVMCCF and are not in compliance with IMSP&P guidelines, again resulting in 0.0% compliance. The importance of maintaining facility specific LOPs that are in compliance with IMSP&P requirements was addressed during the entrance and exit conferences, at which time the management staff assured the audit team that this issue will become a priority and will be corrected promptly. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

2. *Part of Question 1.2 (Formerly Question 1.1.3) - ALTHOUGH THE FACILITY HAS A WRITTEN LOCAL POLICY AND PROCEDURE THAT ADDRESSES THE REQUIREMENTS FOR THE RELEASE OF MEDICAL INFORMATION, THE POLICY IS NOT IN FULL COMPLIANCE WITH IMSP&P GUIDELINES.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

The previous audit findings showed that the facility had a written LOP that addressed the requirements for the release of medical information; however, it was not in full compliance with IMSP&P guidelines. As mentioned above, for the current audit the facility submitted CCS corporate policies as their LOPs which were not in compliance with IMSP&P guidelines, again resulting in 0.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

3. *Part of Question 1.2 (Formerly Question 1.1.4) - ALTHOUGH THE FACILITY HAS A WRITTEN LOCAL POLICY AND PROCEDURE RELATED TO THE CHEMICAL AGENT/USE OF FORCE PROCESS, THE POLICY IS NOT IN FULL COMPLIANCE WITH IMSP&P GUIDELINES.*

Prior Compliance	Current Compliance	Status
0.0%	100%	**Resolved**

During the current audit, the facility's policy/LOP related to the chemical agents/use of force process was found compliant with IMSP&P guidelines. Therefore, this critical issue is considered resolved.

4. *Part of Question 1.2 (Formerly Question 1.1.5) - ALTHOUGH THE FACILITY HAS A WRITTEN LOCAL POLICY AND PROCEDURE RELATED TO THE CHRONIC CARE MANAGEMENT, THE POLICY IS NOT IN FULL COMPLIANCE WITH IMSP&P GUIDELINES.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

The findings of the previous audit showed that facility's chronic care management policy was not in compliance with IMSP&P guidelines. Current audit findings showed that DVMCCF's chronic care policy was not updated to ensure compliance with IMSP&P, again resulting in 0.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

5. *Part of Question 1.2 (Formerly Question 1.1.6) - ALTHOUGH THE FACILITY HAS A WRITTEN LOCAL POLICY AND PROCEDURE RELATED TO THE HEALTH CARE TRANSFER PROCESS, THE POLICY IS NOT IN FULL COMPLIANCE WITH IMSP&P GUIDELINES.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

During the current audit, the facility produced a CCS corporate policy related to health care transfer process as their LOP, which was found not in compliance with IMSP&P guidelines. This again resulted in 0.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

6. *Part of Question 1.2 (Formerly Question 1.1.7) - ALTHOUGH THE FACILITY HAS A WRITTEN LOCAL POLICY AND PROCEDURE RELATED TO MEDICATION MANAGEMENT PROCESS, THE POLICY IS NOT IN FULL COMPLIANCE WITH IMSP&P GUIDELINES.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

The policy/LOP related to medication management process produced by DVMCCF for the current audit was a CCS corporate policy, which, as already mentioned in previous policy related questions was found not compliant with IMSP&P guidelines. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

7. *Part of Question 1.2 (Formerly Question 1.1.8) - ALTHOUGH THE FACILITY HAS A WRITTEN LOCAL POLICY AND PROCEDURE RELATED TO THE ACCESS TO CARE (SICK CALL) PROCESS, THE POLICY IS NOT IN FULL COMPLIANCE WITH IMSP&P GUIDELINES.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

A CCS corporate policy related to access to care was produced by facility for the current audit. Review of the policy shows that it is not facility specific nor is it in compliance with IMSP&P guidelines. This resulted in 0.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

8. *Part of Question 1.2 (Formerly Question 1.1.9) - ALTHOUGH THE FACILITY HAS A WRITTEN LOCAL POLICY AND PROCEDURE RELATED TO THE SPECIALTY SERVICES, THE POLICY IS NOT IN FULL COMPLIANCE WITH IMSP&P GUIDELINES.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

For the current audit, the facility submitted a CCS corporate policy related to specialty services. Review of the policy shows that it is not facility specific nor is it in compliance with IMSP&P guidelines. This resulted in 0.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

9. *Part of Question 1.2 (Formerly Question 1.1.10) - THE FACILITY DOES NOT HAVE A WRITTEN POLICY AND PROCEDURE THAT ADDRESSES AMERICANS WITH DISABILITIES ACT (ADA) REQUIREMENTS AND THAT IS IN COMPLIANCE WITH IMSP&P GUIDELINES AND ARMSTRONG REMEDIAL PLAN.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

Although during the current audit the facility produced a one page LOP, it did not address all the required components of the ADA process, resulting in 0.0% compliance. For additional information, refer to the comment section for critical issue #30. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

10. *Part of Question 1.2 (Formerly Question 1.1.11) - ALTHOUGH THE FACILITY HAS A WRITTEN INFECTION CONTROL PLAN, THE POLICY IS NOT IN FULL COMPLIANCE WITH THE CALIFORNIA CODE OF REGULATIONS, TITLE 8.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

During the previous audit, it was found the facility's infection control plan was not in full compliance with California Code of Regulations (CCR), Title 8. During the current audit, the facility produced CCS corporate policy related to the infection control plan. The written policy/procedure is not specific to DVMCCF and was found non-compliant with CCR, Title 8, again resulting in 0.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

11. *Part of Question 1.2 (Formerly Question 1.1.12) - ALTHOUGH THE FACILITY HAS A WRITTEN BLOOD-BORNE PATHOGEN EXPOSURE POLICY, THE POLICY IS NOT IN FULL COMPLIANCE WITH THE CALIFORNIA CODE OF REGULATIONS, TITLE 8.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

The previous audit findings showed the facility's written LOP, related to the blood-borne pathogen exposure process, was not in full compliance with CCR, Title 8. The current audit findings showed that DVMCCF does not have a blood-borne pathogen exposure plan specific to its facility and instead utilizes a CCS corporate policy, resulting in 0.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

12. *Part of Question 1.2 (Formerly Question 1.1.13) - THE FACILITY DOES NOT HAVE A WRITTEN POLICY AND PROCEDURE RELATED TO THE HEALTH CARE STAFF LICENSURE AND TRAINING, WHICH IS IN COMPLIANCE WITH IMSP&P.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

The written policy and procedure the facility submitted during the previous audit, related to the health care staff licensure and training requirements, was found non-compliant with IMSP&P guidelines. During the current audit, the facility produced a CCS corporate policy relate to this matter, which was found not compliant with IMSP&P requirements, resulting in 0.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

13. *Part of Question 1.2 (Formerly Question 1.1.14) - ALTHOUGH THE FACILITY HAS A WRITTEN LOCAL POLICY AND PROCEDURE RELATED TO THE EMERGENCY MEDICAL RESPONSE AND DRILLS, THE POLICY IS NOT IS FULL COMPLIANCE WITH IMSP&P.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

The finding of the August 2015 audit showed that facility's written LOP related to the emergency medical response and drills was not in full compliant with the IMSP&P guidelines. The findings of the current audit show the facility does not have a facility specific LOP but instead utilizes the one produced by CCS, which was found non-compliant with IMSP&P guidelines. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

14. *Part of Question 1.3 (Formerly Question 1.1.15) - THE FACILITY DOES NOT HAVE A CURRENT CONTRACT FOR ROUTINE OXYGEN TANK MAINTENANCE SERVICE.*

Prior Compliance	Current Compliance	Status
0.0%	100%	**Resolved**

This comment applies to this and the following two critical issues (#14 through #16). In the audit instrument, these three questions (formerly Questions 1.1.15 through 1.1.17) were combined into one as they address similar requirements. During the previous audit, the facility

did not have current contracts for routine oxygen tank maintenance, for hazardous waste removal, and no contract for repair, maintenance, inspections, and testing of biomedical equipment. This resulted in 0.0% compliance. During the pre-audit documentation production process, the facility submitted all three current contracts. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

15. *Part of Question 1.3 (Formerly Question 1.1.16) - THE FACILITY DOES NOT HAVE A CURRENT CONTRACT FOR THE REPAIR, MAINTENANCE, INSPECTION, AND TESTING OF BIOMEDICAL EQUIPMENT.*

Prior Compliance	Current Compliance	Status
0.0%	100%	**Resolved**

Refer to critical issue #14 comments above. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

16. *Part of Question 1.3 (Formerly Question 1.1.17) - THE FACILITY DOES NOT HAVE A CURRENT CONTRACT FOR THE REMOVAL OF HAZARDOUS WASTE.*

Prior Compliance	Current Compliance	Status
0.0%	100%	**Resolved**

Refer to critical issue #14 comments above. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

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

Prior Compliance	Current Compliance	Status
0.0%	100%	**Resolved**

During the previous audit, the facility's patient orientation handbook/manual did not accurately address the health care grievance/appeal process. Subsequent to the previous audit, the facility updated and revised their *Inmate Orientation Manual (Rev 2016)* to include accurate information on the first, second, and third level health care appeal processes. During the current audit, DVMCCF was found fully compliant with this requirement. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

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

Prior Compliance	Current Compliance	Status
0.0%	100%	**Resolved**

The findings of the August 2015 audit reflected the facility's patient orientation handbook/manual did not clearly and accurately address the sick call process. Subsequent to the previous audit, the facility updated their *Inmate Orientation Manual (Rev 2016).*, which adequately addressed the sick call process, resulting in 100% compliance. The findings show

that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

19. *Part of Question 1.2 (Formerly Question 1.2.1) - ALTHOUGH THE FACILITY HAS A WRITTEN LOCAL POLICY AND PROCEDURE RELATED TO CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS, THE POLICY IS NOT IN FULL COMPLIANCE WITH IMSP&P GUIDELINES.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

The previous audit findings showed that the facility did not have a CQI policy in compliance with IMSP&P guidelines, which resulted in 0.0% compliance. The current audit findings are not different from the previous audit's findings. The facility again failed to produce a written LOP/policy that is compliant with IMSP&P guidelines, resulting in 0.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

20. *Question 2.1 (Formerly Question 1.2.2) - THE FACILITY IS NOT CONSISTENT IN HOLDING CQI MEETINGS MONTHLY.*

Prior Compliance	Current Compliance	Status
16.7%	66.7%	**Unresolved**

During the previous audit's review period of six months, the facility held one CQI meeting, which resulted in 16.7% compliance. The CQI meeting minutes submitted for the current audit review period showed that facility held four out of six required CQI meetings, resulting in 66.7% compliance. Although an improvement from the previous audit, the facility failed to achieve a compliance rating of 85.0% or above. Therefore, this critical issue remains unresolved and will continue to be monitored in subsequent audits.

21. *Part of Question 2.4 (Formerly Question 1.3.1) - THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE SICK CALL MONITORING LOGS TIMELY.*

Prior Compliance	Current Compliance	Status
76.9%	94.1%	**Resolved**

The previous audit findings showed that during the six month period, 76.9% of the weekly sick call monitoring logs were submitted on time. The current audit findings reflect that from October 2015 through January 2016, 94.1% of the submissions were timely. The findings show that DVMCCF has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

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

Prior Compliance	Current Compliance	Status
75.0%	88.2%	**Resolved**

A random sample of 52 entries was selected for review during the previous audit, of which 39 were accurately recorded on the sick call log, resulting in 75.0% compliance. A random sample of 34 entries was selected for review during the current audit, of which 30 were found to have

been accurately recorded on the log, resulting in 88.2% compliance. The findings show that DVMCCF has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

23. *Part of Question 2.4 (Formerly Question 1.3.4) - THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE SPECIALTY CARE MONITORING LOGS TIMELY.*

Prior Compliance	Current Compliance	Status
76.9%	94.1%	**Resolved**

The August 2015 audit findings showed that within the six month review period, 76.9% of the weekly specialty care monitoring logs were submitted on time. The current audit findings reflect a significant improvement where from October 2015 through January 2016, 94.1% of the submissions were timely. The findings show that DVMCCF has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

24. *N/A (Formerly Question 1.3.5) - THE SPECIALTY CARE MONITORING LOG(S) SUBMITTED BY THE FACILITY DOES NOT CONSISTENTLY CONTAIN ALL THE REQUIRED INFORMATION.*

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

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

Prior Compliance	Current Compliance	Status
76.9%	94.1%	**Resolved**

The findings of the previous audit showed that within the six month review period, 76.9% of the weekly hospital stay/emergency department monitoring logs were submitted on time. The current audit findings reflect a significant improvement where from October 2015 through January 2016, 94.1% of the submissions were timely. The findings show that DVMCCF has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

26. *Part of Question 2.4 (Formerly Question 1.3.10) - THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE CHRONIC CARE MONITORING LOGS TIMELY.*

Prior Compliance	Current Compliance	Status
66.7%	50.0%	**Unresolved**

The August 2015 audit findings showed that within the six month review period, 66.7% of the monthly chronic care monitoring logs were submitted on time. The current audit findings reflect a decline; from October 2015 through January 2016, only 50.0% of the submissions were timely. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

27. *Part of Question 2.4 (Formerly Question 1.3.13) - THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE INITIAL INTAKE SCREENING MONITORING LOGS TIMELY.*

Prior Compliance	Current Compliance	Status
83.3%	50.0%	**Unresolved**

The previous audit findings showed that within the six month review period, 83.3% of the monthly initial intake screening monitoring logs were submitted on time. The current audit findings reflect a decline; from October 2015 through January 2016, only 50.0% of the submissions were timely. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

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

Prior Compliance	Current Compliance	Status
70.5%	85.7%	**Resolved**

A random sample of 44 entries was selected for review during the previous audit, 31 of which were accurately recorded on the initial intake screening monitoring log, resulting in 70.5% compliance. A random sample of 21 entries was selected for review during the current audit, 18 of which were found to have been accurately recorded on the log, resulting in 85.7% compliance. This represents an improvement of 15.2 percentage points. The findings show that DVMCCF has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

29. *N/A (Formerly Question 1.4.3) - THE FACILITY DOES NOT CONSISTENTLY SEND LOOSE DOCUMENTS TO THE HUB TO BE SCANNED INTO THE ELECTRONIC UNIT HEALTH RECORD.*

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

30. *Part of Question 1.2 (Formerly Question 1.5.1) - THE FACILITY DOES NOT HAVE A LOCAL OPERATING PROCEDURE TO TRACK AND MONITOR DISABILITY PLACEMENT PROGRAM (DPP) PATIENTS AND THEIR ACCOMMODATIONS TO ENSURE DPP PATIENT NEEDS ARE ADDRESSED.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

This comment applies to this and the following four critical issues (#30 through #34). In the audit instrument, these five questions (formerly Questions 1.5.1 through 1.5.5) were combined into one as they address one process/requirement. During the previous audit, it was found DVMCCF did not have a written policy or any LOPs in place to address and monitor DPP patient's needs per the Armstrong Remedial Plan guidelines, resulting in 0.0% compliance. There were no logs in place tracking the provision of health care appliances for DPP patients or any logs tracking the order, repair, and/or replacement of the health care appliance for DPP patients. There was no LOP that provided directions on how to ensure and document that effective communication was established during each patient clinical encounter. During the current audit, the facility produced a one page LOP. However, the facility's policy/LOP did not address

all of the required elements and components per IMSP&P and Armstrong Remedial Plan, resulting in 0.0% compliance. The LOP just refers the reader to the guidelines outlined in IMSP&P Volume 4, Chapter 23.1, Attachment A. Although the facility rarely receives patients with severe or significant disabilities requiring ADA accommodations, the facility is required to maintain a current policy/LOP outlining and addressing the facility's process as it relates to DPP patients and their ADA accommodations. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

31. *Part of Question 1.2 (Formerly Question 1.5.2) - THE FACILITY DOES NOT HAVE A LOCAL OPERATING PROCEDURE FOR TRACKING THE PROVISION OF HEALTH CARE APPLIANCES FOR ALL DPP PATIENTS TO ENSURE HEALTH CARE APPLIANCES ARE PROVIDED IN A TIMELY MANNER.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

Refer to critical issue #30 comments above. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

32. *Part of Question 1.2 (Formerly Question 1.5.3) - THE FACILITY DOES NOT HAVE A LOCAL OPERATING PROCEDURE FOR TRACKING THE ORDER, REPAIR, AND/OR REPLACEMENT OF A HEALTH CARE APPLIANCE FOR THE DPP PATIENTS.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

Refer to critical issue #30 comments above. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

33. *Part of Question 1.2 (Formerly Question 1.5.4) - THE FACILITY DOES NOT HAVE A LOCAL OPERATING PROCEDURE THAT PROVIDES DIRECTIONS ON PROVISION OF INTERIM ACCOMMODATIONS WHILE A PATIENT'S HEALTH CARE APPLIANCE IS BEING ORDERED, REPAIRED, OR REPLACED.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

Refer to critical issue #30 comments above. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

34. *Part of Question 1.2 (Formerly Question 1.5.5) - THE FACILITY DOES NOT HAVE A LOCAL OPERATING PROCEDURE THAT PROVIDES DIRECTIONS ON HOW TO ENSURE EFFECTIVE COMMUNICATION IS ESTABLISHED AND DOCUMENTED DURING EACH CLINICAL ENCOUNTER.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

See comment for critical issue #30.

35. *N/A (Formerly Question 1.5.6) - THE HEALTH CARE STAFF ARE NOT ALL KNOWLEDGEABLE ON THE PROCESS OF ESTABLISHING AND DOCUMENTING EFFECTIVE COMMUNICATION DURING PATIENT HEALTH CARE ENCOUNTERS.*

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

36. *Part of Question 3.4 (Formerly Question 1.7.2) - THE FACILITY DOES NOT HAVE A PROPER CENTRALIZED TRACKING SYSTEM FOR TRACKING HEALTH CARE STAFF LICENSES.*

Prior Compliance	Current Compliance	Status
0.0%	100%	**Resolved**

    During the previous audit, the facility did not have a system in place to track licenses for all health care staff, resulting in 0.0% compliance. As part of the pre-audit documentation submission process, DVMCCF provided a tracking log listing all health care staff licensing and certifications data, resulting in 100% compliance. Moreover, during the onsite visit, a binder was produced showing health care staff's copies of current licenses and certifications. This information is being tracked by a Health Services Administrator (HSA). The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

37. *N/A (Formerly Question 1.7.5) - THE FACILITY DOES NOT HAVE A METHOD IN PLACE TO ADDRESS THE EXPIRING BASIC LIFE SUPPORT AND ADVANCED CARDIOVASCULAR LIFE SUPPORT CERTIFICATIONS.*

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

38. *Part of Question 3.4 (Formerly Question 1.7.6) - THE FACILITY DOES NOT HAVE A PROPER CENTRALIZED TRACKING SYSTEM FOR TRACKING HEALTH CARE STAFF TRAINING.*

Prior Compliance	Current Compliance	Status
0.0%	100%	**Resolved**

    Findings of the previous audit showed the facility did not have a centralized system in place to track training provided for all health care staff, which resulted in 0.0% compliance. As part of the pre-audit documentation submission process, DVMCCF provided tracking logs for all health care staff listing the types and dates of training completed by health care staff, resulting in 100% compliance. Furthermore, during the onsite visit, the HSA explained the process of how training requirements for all health care staff are being tracked and met. Although, in the auditor's opinion, the training tracking process could be more efficient and well-organized, the facility's current tracking process is adequate. Subsequent to the onsite audit, the HPS I auditor sent the HSA an Excel file of the training tracking log the HSA may want to incorporate for a more efficient tracking of health care staff licensing/certifications and training information. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

39. *Question 3.3 (Formerly Question 1.7.7) - THE HEALTH CARE STAFF HAVE NOT RECEIVED TRAINING FOR NEW OR REVISED POLICIES BASED ON IMSP&P REQUIREMENTS.*

Prior Compliance	Current Compliance	Status
0.0%	N/A	**Unresolved**

During the previous audit, the audit team was unable to determine compliance with this requirement as the facility did not have a system in place to track health care staff's training, resulting in 0.0% compliance. During the current audit, per the double failure rule, this question was found not applicable as the facility was rated non-compliant on the related policies Question 1.2. The facility is in process of revising their LOPs as they are currently not in compliance with IMSP&P guidelines. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

40. *Question 5.1 (Formerly Question 2.2.1) - THE PATIENTS ARE NOT CONSISTENTLY BEING SEEN FOR CHRONIC CARE FOLLOW-UP VISITS.*

Prior Compliance	Current Compliance	Status
70.4%	91.3%	**Resolved**

Findings of the previous audit showed that 19 out of 27 patient medical records reviewed included documentation that the patient was seen for a chronic care follow-up appointment within the time frame ordered by provider. This resulted in 70.4% compliance. Out of 23 patient medical records reviewed during the current audit, 21 records included documentation of the patient being seen timely for his follow-up chronic care appointment, resulting in 91.3% compliance. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

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

Prior Compliance	Current Compliance	Status
44.0%	63.2%	**Unresolved**

During the previous audit, 11 of the 14 medical records reviewed reflected patients' chronic care keep on person (KOP) medications were not consistently received by the patient without interruption. These findings resulted in 44.0% compliance. During the current audit's electronic medical record review, 19 medical records were evaluated. Of the 19 patient medical records reviewed, 12 included documentation that the patient received the prescribed chronic care KOP medications on time and without interruption, resulting in 63.2% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

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

Prior Compliance	Current Compliance	Status

0.0%	100%	**Resolved**

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

43. *Question 7.1 (Formerly Question 2.3.1) - THE FACILITY DOES NOT CONSISTENTLY COMPLETE PATIENT DIAGNOSTIC TESTS WITHIN THE SPECIFIED TIME FRAMES.*

Prior Compliance	Current Compliance	Status
81.8%	62.5%	**Unresolved**

Findings of the August 2015 audit showed that of the 11 patient medical records reviewed, nine included documentation that the diagnostic tests were completed within the time frame specified by the provider, resulting in 81.8% compliance. Findings of the current audit's medical record review showed a decline in compliance of 19.3 percentage points. Of the 24 patient medical records reviewed, 15 included documentation that the patient's diagnostic tests were completed as ordered by provider, resulting in 62.5% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

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

Prior Compliance	Current Compliance	Status
40.0%	90.5%	**Resolved**

This issue was initially identified during the May 2014 health care audit and persisted through the August 2015. During the August 2015 audit, four of the ten patient medical records reviewed included documentation of the provider timely reviewing, signing, and dating patients' diagnostic reports, which resulted in 40.0% compliance. The current medical record findings showed that 19 of 21 patient medical records reviewed were in compliance with this requirement, resulting in 90.5% compliance. The findings show that DVMCCF has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

45. *Question 7.3 (Formerly Question 2.3.3) - PATIENTS DO NOT CONSISTENTLY RECEIVE WRITTEN NOTIFICATION OF DIAGNOSTIC TESTS WITHIN THE SPECIFIED TIME FRAME.*

Prior Compliance	Current Compliance	Status
50.0%	90.5%	**Resolved**

The previous audit findings showed that five of ten patient medical records reviewed included documentation of the patient receiving written notification of diagnostic test results within two days of facility's receipt of results, resulting in 50.0% compliance. The current audit findings reflect a significant improvement in compliance; 19 of the 21 patient medical records reviewed included documentation that the patient received written notification of diagnostic test results,

resulting in 90.5% compliance. The findings show that DVMCCF has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

46. *Question 7.4 (Formerly Question 2.3.4) - THE PATIENTS ARE NOT CONSISTENTLY SEEN BY THE PROVIDER FOR CLINICALLY SIGNIFICANT/ABNORMAL DIAGNOSTIC TEST RESULTS WITHIN 14 DAYS OF PROVIDERS' REVIEW OF THE TEST RESULTS.*

Prior Compliance	Current Compliance	Status
14.3%	91.7%	**Resolved**

This issue was initially identified during the health care audit conducted in May 2014 and persisted through the August 2015 audit. Based on the review of seven patient medical records during the previous audit, it was found that the patients were not consistently seen by the provider for clinically significant diagnostic test results within 14 days of providers' review of the test results. These findings resulted in 14.3% compliance. The current audit findings reflect a significant improvement of 77.4 percentage points in compliance; 11 of the 12 patient medical records reviewed were compliant with this requirement, resulting in 91.7% compliance. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

47. *Question 14.4 (Formerly Question 2.4.6) - THE FACILITY IS NOT HOLDING EMERGENCY MEDICAL RESPONSE REVIEW COMMITTEE MEETINGS ONCE A MONTH.*

Prior Compliance	Current Compliance	Status
66.7%	16.7%	**Unresolved**

The Emergency Medical Response Review Committee (EMRRC) meeting minutes reviewed during the previous audit showed that the facility was not consistently holding monthly EMRRC meetings. Of the six meetings required to be held, the facility completed four, resulting in 66.7% compliance. During the current audit, the facility only produced one EMRRC meeting minutes for the meeting that was held in January 2016, resulting in 16.7% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

48. *Question 14.7 (Formerly Question 2.4.9) - THE FACILITY IS NOT RE-SUPPLYING AND RE-SEALING THE EMERGENCY MEDICAL RESPONSE BAG BEFORE THE END OF THE SHIFT WHEN IT HAS BEEN OPENED.*

Prior Compliance	Current Compliance	Status
0.0%	33.3%	**Unresolved**

During the previous audit, it was found that the facility did not maintain a tracking log documenting when the EMR bag's seal was replaced and the contents of the bag restocked, resulting in 0.0% compliance. The current audit's review of the EMR documentation revealed that of the three EMR drills that took place which warranted opening of the bag; only one EMR bag was resealed and restocked after having been utilized for the drill. This results in 33.3% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

49. *Question 14.9 (Formerly Question 2.4.11) - THE EMERGENCY MEDICAL RESPONSE BAGS DO NOT CONTAIN ALL THE SUPPLIES IDENTIFIED ON THE FACILITY'S EMERGENCY MEDICAL RESPONSE BAG CHECKLIST.*

Prior Compliance	Current Compliance	Status
0.0%	100%	**Resolved**

During the August 2015 onsite visit, the inspected emergency medical response bag did not include all the required items on the checklist. This resulted in 0.0% compliance. During the February 2016 onsite visit, the inspected emergency medical response bag contained only the supplies/items identified on the EMR Bag Checklist, resulting in 100% compliance. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

50. *Question 15.15 (Formerly Question 2.4.21) - THE FACILITY DOES NOT HAVE THEIR BIOMEDICAL EQUIPMENT SERVICED ANNUALLY.*

Prior Compliance	Current Compliance	Status
0.0%	100%	**Resolved**

During the previous onsite audit, it was found the facility did not have their biomedical equipment services annually, resulting in 0.0% compliance. During the current audit's onsite visit, the nurse auditor inspected the biomedical equipment and found all were within the expiration dates noted on the sticker decal, resulting in 100% compliance. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

51. *Question 6.4 (Formerly Question 2.5.3) - THE FACILITY DOES NOT CONSISTENTLY ADMINISTER OR DELIVER ALL PROVIDER PRESCRIBED MEDICATIONS TO THE PATIENTS AS ORDERED OR PER POLICY FOLLOWING THEIR DISCHARGE AND RETURN FROM A COMMUNITY HOSPITAL.*

Prior Compliance	Current Compliance	Status
66.7%	100%	**Resolved**

Six patient medical records during the previous audit were reviewed for compliance with this requirement. Of the six records reviewed, four included documentation that the patient received his prescribed medication upon return to the facility from a community hospital ED or hub institution, resulting in 66.7% compliance. During the current audit review period, there were only three patients who returned to the facility from a community hospital admission; however, only two patients were prescribed medications. Both of these patients, upon return from a community hospital admission, received their prescribed medication as ordered by provider, resulting in 100% compliance. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

52. *Question 6.1 (Formerly Question 2.5.5) - THE FACILITY NURSING STAFF DO NOT CONSISTENTLY REVIEW THE PATIENTS' DISCHARGE PLAN UPON THEIR DISCHARGE AND RETURN FROM THE COMMUNITY HOSPITAL AND/OR HUB INSTITUTION.*

Prior Compliance	Current Compliance	Status

83.3%	66.7%	**Unresolved**

During the previous audit, five out of six patient medical records reviewed included documentation that a nurse reviewed the patients' discharge plan upon his return from a community hospital admission or the hub institution, resulting in 83.3% compliance. The current audit findings reflect a decline in compliance; two out of three patient medical records reviewed included documentation that the nurse reviewed the patient's discharge plan upon his return to the facility, resulting in 66.7% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

53. *Question 6.3 (Formerly Question 2.5.7) - THE PATIENTS DO NOT CONSISTENTLY RECEIVE A FOLLOW-UP BY THE PRIMARY CARE PROVIDER WITHIN FIVE CALENDAR DAYS OF THEIR DISCHARGE AND RETURN FROM A COMMUNITY HOSPITAL AND/OR HUB INSTITUTION.*

Prior Compliance	Current Compliance	Status
83.3%	100%	**Resolved**

This issue was initially identified during the February 2015 audit and persisted through the August 2015 audit. Five of the six patient medical records reviewed during the previous audit, included documentation that the provider saw the patient within five calendar days of the patient's return to the facility from a community hospital and/or hub institution. This resulted in 83.3% compliance. During the current audit, only three cases were available for review for compliance with this requirement. All three medical records reviewed included documentation that the patient was seen by a provider within five calendar days of the patient's return from the hub institution following a discharge from community hospital admission. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

54. *Question 15.8 (Formerly Question 2.6.8) - THE FACILITY IS NOT DOCUMENTING THAT CLEANING OF COMMON CLINIC AREAS WITH HIGH FOOT TRAFFIC IS COMPLETED ON A DAILY BASIS.*

Prior Compliance	Current Compliance	Status
0.0%	52.4%	**Unresolved**

During the previous audit, it was found the facility did not utilize a cleaning log to track environmental cleaning of common clinic areas, which resulted in 0.0% compliance. During the current onsite visit, the facility's cleaning logs for the month of January 2016 were reviewed. Of the 21 days reviewed (Saturday and Sundays excluded), 10 days were missing documentation of the clinic having been cleaned at least once a day, resulting in 52.4% compliance. Although a significant improvement from the previous audit, the facility did not attain a compliance rating of 85.0% or above; therefore, this critical issue is considered unresolved and will continue to be monitored during subsequent audits.

55. *Question 15.10 (Formerly Question 2.6.10) - THE FACILITY DOES NOT HAVE THEIR BIOHAZARD MATERIAL CONTAINERS EMPTIED ON A REGULAR BASIS.*

Prior Compliance	Current Compliance	Status
0.0%	100%	**Resolved**

The audit team, during the August 2015 onsite visit, found that the facility did not have their biohazard material containers emptied on a regular basis, which resulted in 0.0% compliance. The February 2016 onsite visit revealed the biohazard material containers are emptied on a regular basis and the facility has a current contract in place for this service. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

56. *Question 9.2 (Formerly Question 2.7.2) - THE FACILITY NURSING STAFF DO NOT CONSISTENTLY DOCUMENT AN ASSESSMENT OF THE PATIENT IF THE PATIENT ANSWERED "YES" TO ANY OF THE QUESTIONS ON THE INITIAL INTAKE SCREENING FORM.*

Prior Compliance	Current Compliance	Status
66.7%	66.7%	**Unresolved**

The findings of the current audit reflect no change in compliance from the previous audit. Of the three patient medical records reviewed during previous audit, two included documentation that the nurse assessed the patient if 'yes' was answered to any medical problems listed on the Initial Intake Screening form. This resulted in 66.7% compliance. The current audit findings reflect the same scenario. There was no documentation in two of the three patients' medical records reviewed that the RN completed an assessment of the medical problem noted by a patient during initial intake screening process. This again resulted in 66.7% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

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

Prior Compliance	Current Compliance	Status
66.7%	100%	**Resolved**

During the previous audit, of the 20 cases selected, only three were applicable to this question. Of the three applicable cases reviewed, two included documentation of the patient having been seen by the facility's provider within the specified time frame, which resulted in 66.7% compliance. During the current audit, two patient medical records were reviewed and both were found compliant with this requirement. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

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

Prior Compliance	Current Compliance	Status
44.4%	66.7%	**Unresolved**

The previous audit findings showed that of the nine patient medical records reviewed, four included documentation that the patient received his NA/DOT and/or KOP medications without interruption upon arrival to the facility. The current audit's findings showed that of the three patient medical records reviewed, two were found compliant with this requirement, resulting in

66.7% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

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

Prior Compliance	Current Compliance	Status
21.1%	42.9%	**Unresolved**

Nineteen cases were reviewed during the August 2015 audit. Four of the 19 patient medical records reviewed included documentation that the patient received a complete health appraisal by a provider within seven calendar days. The remaining five cases were non-compliant due to no documentation having been found in the patients' medical records indicating the health appraisal was completed timely, resulting in 21.1% compliance. Of the 14 cases reviewed during the current audit, 6 included documentation that the patient was seen by a provider within seven calendar days of arrival to DVMCCF, resulting in 42.9% compliance.

It should be noted that prior to and during the previous audit's exit meeting, the facility was made aware of the change in the policy for the providers to complete a health appraisal within seven calendar days of patient's arrival at the facility versus the previous 14 calendar days. Subsequently, this requirement was reiterated during the monthly medical conference calls with CBU and in-state correctional facilities. The facility is strongly encouraged to take immediate action to successfully resolve this issue. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

60. *Question 9.6 (Formerly Question 2.7.9) - THE FACILITY DOES NOT CONSISTENTLY DOCUMENT THAT, PATIENTS ENROLLED IN THE CHRONIC CARE PROGRAM AT A PREVIOUS FACILITY, WERE SEEN BY THE FACILITY PROVIDER WITHIN THE TIME FRAME ORDERED BY THE SENDING FACILITY'S PROVIDER.*

Prior Compliance	Current Compliance	Status
66.7%	100%	**Resolved**

Of the six cases reviewed during the previous audit for compliance with this requirement, four included documentation that the patient was seen by a provider for a pending chronic care appointment as specified by a sending facility's provider. This resulted in 66.7% compliance. The current review of two patient medical records revealed that patients are seen in a chronic care clinic within the time frames specified by the sending facility's provider. Two patients' medical charts reviewed were found 100% compliant with this requirement. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

61. *Question 9.8 (Formerly Question 2.7.10) - THE PATIENTS ARE NOT RECEIVING A COMPLETE SCREENING FOR THE SIGNS AND SYMPTOMS OF TUBERCULOSIS UPON THEIR ARRIVAL TO THE FACILITY.*

Prior Compliance	Current Compliance	Status
0.0%	78.6%	**Unresolved**

Twenty patient medical records were reviewed during the August 2015 audit; none of which included documentation that the patients received complete screening for signs and symptoms of tuberculosis upon arrival at the facility. This resulted in 0.0% compliance. Eleven of the 14 patient medical records reviewed during the current audit included such documentation, resulting in 78.6% compliance. Although a significant improvement from the previous audit, the facility did not attain a compliance benchmark rating of 85.0% or above; therefore, this critical issue is considered unresolved and will continue to be monitored during subsequent audits.

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

Prior Compliance	Current Compliance	Status
0.0%	38.9%	**Unresolved**

During the previous audit, three patient medical records were reviewed for compliance with this requirement. Of the three cases reviewed, none included documentation of the patients' scheduled specialty appointments on the transfer form (CDCR Form 7371). This resulted in 0.0% compliance. During the current audit, 7 of the 18 patient medical records reviewed included documentation of the patients' pending specialty appointments recorded on the transfer form, resulting in 38.9% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

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

Prior Compliance	Current Compliance	Status
77.8%	87.5%	**Resolved**

The findings of the previous audit showed providers did not consistently educate the patients on the newly prescribed medications. Fourteen of the 18 patient medical records reviewed were found compliant with this requirement, resulting in 7.8% compliance. The findings of the current audit reflect slight improvement in this area where 21 of 24 patient medical records reviewed were found compliant with this requirement, resulting in 87.5% compliance. The findings show that DVMCCF has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

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

Prior Compliance	Current Compliance	Status
50.0%	75.0%	**Unresolved**

Eighteen patient medical records were reviewed during the previous audit. Nine of the 18 records included documentation that the initial dose of the newly prescribed medication was administered to the patient as ordered by provider, resulting in 50.0% compliance. Deficiencies were a result of the missing documentation in the medical record and delay in administering the

prescribed medication to the patient. During the current audit, 18 of 24 patient medical records evaluated were found compliant with this requirement, resulting in 75.0% compliance. The six non-compliant cases were a result of the patient receiving the prescribed medication late or not as ordered by the provider. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

65. *Question 10.5 (Formerly Question 2.8.5) - THE MEDICATION NURSE DOES NOT OBSERVE THE PATIENT TAKING HIS DIRECT OBSERVATION THERAPY MEDICATION.*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	**Unresolved**

During the previous onsite visit, one nurse was found not following proper nursing protocols when administering the DOT medication to the patient. The nurse did not place the medication in the patient's hands nor checked the patient's mouth after the patient has taken his medication. This resulted in 0.0% compliance. During the current audit, there were no patients on DOT medication; therefore, compliance with this standard was based on nursing staff interviews. Two nurses were interviewed regarding this process and both did not mention conducting a cup check to ensure the patient did not leave the medication in his cup, resulting in 0.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

66. *Question 4.5 (Formerly Question 2.12.6) - THE NURSING STAFF DOES NOT CONSISTENTLY DOCUMENT A FOCUSED SUBJECTIVE/OBJECTIVE ASSESSMENT WAS CONDUCTED BASED ON THE PATIENT'S CHIEF COMPLAINT.*

Prior Compliance	Current Compliance	Status
75.0%	56.7%	**Unresolved**

The medical record review conducted during the previous audit showed that 21 of 28 patient medical records reviewed included documentation that a focused subjective/objective assessment was conducted by the RN based on patient's chief complaint. This resulted in 75.0% compliance. The current audit's medical record review reflects a decline in compliance; 17 out of 30 patient medical records assessed met this requirement, resulting in 56.7% compliance. Deficiencies were due to incomplete nursing assessment (12 records) and a FTF assessment having been completed by a LVN and not a RN (one record). This critical issue remains unresolved and will continue to be monitored in subsequent audits.

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

Prior Compliance	Current Compliance	Status
60.7%	46.7%	**Unresolved**

Of the 28 patient medical records reviewed during the August 2015 audit, 17 included documentation that the RN documented a nursing diagnosis related to the documented subjective/objective assessment data. These findings resulted in 60.7% compliance. During the current audit, 30 patient medical records were reviewed, 14 of which were found compliant

with this requirement, resulting in 46.7% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

68. *Question 4.7 (Formerly Question 2.12.8) - THE NURSING STAFF DOES NOT CONSISTENTLY IMPLEMENT A NURSING DIAGNOSIS RELATED TO THE DOCUMENTED SUBJECTIVE/OBJECTIVE ASSESSMENT DATA THAT IS WITHIN THE NURSE'S SCOPE OF PRACTICE.*

Prior Compliance	Current Compliance	Status
82.1%	96.7%	**Resolved**

The facility was found 82.1% compliant during the previous audit; 23 out of 28 patient medical records reviewed included documentation that nursing staff implemented a nursing diagnosis related to the documented subjective/objective assessment. Current audit's medical record review found facility 96.7% compliant with this requirement as 29 out of 30 patient medical records assessed included such documentation. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

69. *Question 4.8 (Formerly Question 2.12.9) - THE NURSING STAFF DOES NOT CONSISTENTLY DOCUMENT THAT EDUCATION WAS PROVIDED TO THE PATIENT RELATED TO THE TREATMENT PLAN AND THAT EFFECTIVE COMMUNICATION WAS ESTABLISHED.*

Prior Compliance	Current Compliance	Status
82.1%	66.7%	**Unresolved**

The previous audit findings showed that 23 out of 28 patient medical records reviewed included documentation that the nurse established effective communication with the patient and provided education on the treatment plan. This resulted in 82.1% compliance. The current audit findings reflect a 15.4 percentage points decline in compliance; 10 out of 30 patient medical records reviewed were missing nurse's documentation of effective communication having been established. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

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

Prior Compliance	Current Compliance	Status
14.3%	92.9%	**Resolved**

During the August 2015 audit, seven patient medical records were evaluated for compliance. Of these, only one included documentation that the patient was seen timely by a medical provider, following the RN's referral. This resulted in 14.3% compliance. The medical record review completed during the February 2016 audit showed that out of 28 patients referred by an RN to a provider, 26 were seen by provider within the required time frame, resulting in 92.9% compliance. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

71. *Question 4.10 (Formerly Question 2.12.12) - THE NURSING STAFF DOES NOT CONSISTENTLY DOCUMENT WHEN THEY CONTACT THE HUB INSTITUTION WHEN THE PATIENT'S HEALTH CARE NEEDS ARE BEYOND THE LEVEL OF CARE AVAILABLE AT THEIR FACILITY.*

Prior Compliance	Current Compliance	Status
50.0%	85.7%	**Resolved**

During the previous audit, only two cases were available for review for compliance with this requirement. Only one of the two patient medical records reviewed included documentation of nursing staff contacting the hub institution when patient's health care needs were determined to be beyond the level of care available at DVMCCF. This resulted in 50.0% compliance. During the current audit, seven patient medical records were reviewed, six of which included nursing staff's progress notes documenting the hub institution was contacted for referral, resulting in 85.7% compliance. The findings show that DVMCCF has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

72. *Question 4.11 (Formerly Question 2.12.13) - THE NURSING STAFF IS NOT CONSISTENTLY REFERRING PATIENTS TO THE PRIMARY CARE PROVIDER WHEN THEY PRESENT TO SICK CALL THREE OR MORE TIMES FOR THE SAME MEDICAL COMPLAINT.*

Prior Compliance	Current Compliance	Status
50.0%	80.0%	**Unresolved**

Of the 29 patient medical records reviewed during the previous audit, only four were found applicable to this question. Two of the four medical records included documentation that the nursing staff referred the patient to a provider after the patient has presented to sick call three or more time for the same medical complaint. This resulted in 50.0% compliance. During the current audit review period, five patients from the sample population selected presented to sick call three or more times for the same medical complaint. Four of these patients were referred by the nurse to a provider, resulting in 80.0% compliance. Although a substantial improvement from the previous audit, the facility did not attain a compliance benchmark rating of 85.0% or above; therefore, this critical issue is considered unresolved and will continue to be monitored during subsequent audits.

73. *N/A (Formerly Question 2.12.14) - THE PATIENTS ARE NOT CONSISTENTLY SEEN FOR A FOLLOW-UP APPOINTMENT WITHIN THE SPECIFIED TIME FRAME.*

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

74. *Question 12.3 (Formerly Question 2.13.8) - THE FACILITY NURSING STAFF DOES NOT CONSISTENTLY DOCUMENT THAT THEY COMPLETE A FACE-TO-FACE ASSESSMENT OF THE PATIENT PRIOR TO BEING RETURNED TO HIS ASSIGNED HOUSING UNIT, WHEN A PATIENT RETURNS FROM A SPECIALTY CONSULT APPOINTMENT OR A COMMUNITY HOSPITAL EMERGENCY DEPARTMENT VISIT.*

Prior Compliance	Current Compliance	Status
63.6%	63.6%	**Unresolved**

The findings of the current audit reflect no change in compliance from the previous audit. Seven of the 11 patient medical records reviewed during the August 2015 audit included documentation that the RN completed a FTF assessment of the patient upon his return from a specialty consult appointment. This resulted in 63.6% compliance. During the February 2016 audit, 14 out of 22 patient medical records reviewed included documentation that the nurse conducted a FTF of the patient upon his return from a specialty care appointment and six were found non-compliant. The six deficiencies were due to missing documentation of RN's FTF assessment of the patient (two records) and the FTF assessment having been completed by a LVN and not a RN (six records). This again resulted in 63.6% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

75. *Question 12.4 (Formerly Question 2.13.10) - THE FACILITY NURSING STAFF DOES NOT CONSISTENTLY DOCUMENT THAT THEY NOTIFIED THE PROVIDER OF ANY IMMEDIATE MEDICATION ORDERS OR FOLLOW-UP INSTRUCTIONS BY THE SPECIALTY CARE CONSULTANT OR COMMUNITY HOSPITAL PROVIDER WHEN A PATIENT RETURNS FROM A SPECIALTY CONSULT APPOINTMENT OR A COMMUNITY HOSPITAL EMERGENCY DEPARTMENT VISIT.*

Prior Compliance	Current Compliance	Status
33.3%	100%	**Resolved**

Of the 11 patient medical records reviewed during the previous audit, 3 were found applicable to this question. Only one of the three medical records included documentation that the RN notified the PCP of any immediate medication or specialty care follow-up order upon the patient's return to the facility from a specialty care appointment. This resulted in 33.3% compliance. During the current audit review period, only two patients from the sample population selected were applicable to this question. Review of both records revealed 100% compliance with this requirement. The findings show that DVMCCF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

76. *Question 12.5 (Formerly Question 2.13.11) - THE PRIMARY CARE PROVIDER IS NOT CONSISTENTLY DOCUMENTING THAT THEY REVIEWED THE SPECIALTY CONSULTANT'S REPORT, HUB PROVIDERS REPORT OR THE COMMUNITY EMERGENCY PROVIDER'S DISCHARGE SUMMARY AND COMPLETED A FOLLOW-UP APPOINTMENT WITH THE PATIENT UPON THE PATIENT'S RETURN FROM A SPECIALTY CONSULT APPOINTMENT OR A COMMUNITY HOSPITAL EMERGENCY DEPARTMENT VISIT.*

Prior Compliance	Current Compliance	Status
27.3%	82.4%	**Unresolved**

During the previous audit, 3 of the 11 patient medical records reviewed included documentation that the PCP reviewed the specialty consultant's report and completed a follow-up appointment with the patient within the specified time frame. This resulted in 27.3% compliance. The current audit findings showed that 14 out of 17 patient medical records reviewed included such documentation, resulting in 82.4% compliance. Three patient medical records were found non-compliant; one patient was not seen by a PCP within 14 days upon return and two records were missing documentation of PCP reviewing the specialty consultant's report and following-up with a patient within the required time frame. Although a significant improvement from the previous audit, the facility did not attain a compliance benchmark rating of 85.0% or above; therefore,

this critical issue is considered unresolved and will continue to be monitored during subsequent audits.

NEW CRITICAL ISSUES

As a result of the current audit, there were 15 new critical issues identified. There were no new qualitative critical issues identified. All of the quantitative review existing and new critical issues are addressed in the "Audit Findings – Detailed by Quality Indicator" section of this report.

CONCLUSION

During the current audit, the facility's overall performance was rated *inadequate*. Of the 15 quality indicators evaluated, CCHCS found one *proficient*, four *adequate*, and ten *inadequate* (see Executive Summary Table on page 4). Although the facility has resolved 30 of the 71 outstanding critical issues, 57.7% (41 items) of those critical issues to date have not been resolved. It is critical that the management and supervisors of DVMCCF hold their staff accountable and reiterate the importance of correcting the remaining, as well as any newly identified critical issues.

Some of the specific issues that raise the audit team's concern, which the facility has been struggling with are: the facility's lack of LOPs that are in compliance with the IMSP&P guidelines, lack of supervision of the mid-level provider, inability to timely process the first level health care appeals, inconsistency in holding the QMC and EMRRC meetings monthly, inconsistency in conducting the emergency medical response drills quarterly as required by policy, patients not receiving their KOP medications timely or as ordered by provider, not completing the diagnostic tests within the time frame specified by PCP, not completing the initial health screening and health appraisal within the required time frames, not administering the prescribed medication as ordered by PCP, not properly managing the emergency medical response equipment and inventory and most importantly, missing or incomplete documentation in the patients' medical records. These are some of the more critical issues that remain unresolved from the previous audits which create barriers preventing the patients from receiving adequate level of care. The audit team recommended the facility establish self-auditing tools and processes in the areas that require a more focused approach and close monitoring to ensure compliance with the established protocols and guidelines.

Additionally, it should be noted that as of the date of the onsite audit, the facility was unable to hire a permanent full time physician and one full time RN, resulting in the CCS Regional Medical Director temporarily filling in for the provider and existing nursing staff working overtime in order to comply with the contractual staffing requirements. It should also be noted that the HSA currently performs both duties of the RN and administrator during the day shift. One staff member accountable for both tasks makes it difficult to effectively complete nursing duties as well as manage administrative responsibilities simultaneously.

At the conclusion of the onsite visit on Thursday, February 4, 2016, the audit team met with the Warden, the HSA and the facility's physician to present the findings of the audit. This meeting afforded the audit team an opportunity to provide feedback and recommendations on the case review, the chart

review and the onsite findings. The facility staff were receptive and open to the findings presented by the audit team. The Warden indicated that she is still fairly new to the facility, as she has only been at the facility since November 2015, but will do everything in her power and authority to correct and resolve the deficiencies expediently. The Warden must make the resolution of these critical items a priority, holding the managers and supervisors responsible for managing the health care functions within this facility. The lack of commitment and follow through on the part of the supervisors and managers places doubt in the mind of CCHCS as to whether the facility can achieve and maintain the required standard and level of care. It must be pointed out the majority of the deficiencies mentioned in this report are easily correctable and are within the management's scope of control to ensure compliance.

PATIENT INTERVIEWS

The intent of this portion of the audit is to elicit substantive responses from the patient population, by utilizing each question as a springboard for discussion, with appropriate follow up to identify any areas where barriers to health care access may potentially exist. This is accomplished via interview of all the ADA patients housed at the facility, the Inmate Advisory Council (IAC) executive body and a random sampling of patients housed in general population (GP) and administrative segregation units. The results of the interviews conducted at DVMCCF are summarized in the table below.

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

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

Comments:

During the onsite visit in February 2016, the audit team interviewed seven IAC representatives, two GP patients and one DPP patient.

1. Regarding questions 1 through 4 – All interviewed patients were aware of the sick call process and had ready access to the forms, if needed. The patients claimed the RN picks up the CDCR Forms 7362 daily and sees the patients within one business day.

2. Regarding questions 5 through 8 – Of the nine patients interviewed, all were aware of the health care grievance/appeal process and some have even utilized the process in the past. One IAC representative expressed concern with the timeliness of facility's response to the patients' first level health care appeal. Review of the first level health care appeal log showed that the facility in fact does not respond to the patient's first level appeals within 30 working days. This issue was addressed with the HSA during the course of the audit and brought to the management's attention during the exit conference. Furthermore, following the onsite visit, the HPS I auditor sent the facility's HSA the *Health Care Appeals Operating Standards* document, that is being utilized by the Health Care Appeals Coordinators at CDCR institutions, for reference. The HPS I auditor also sent the contact information of the hub institution's Health Care Appeals Coordinator for those instances when the HSA has a question or needs to follow-up on the first level appeal forwarded to the hub institution for response.

3. Regarding questions 9 through 21 - At the time of the onsite audit, there was only one ADA patient housed at DVMCCF. There were no negative responses or issues expressed by this patient. On the contrary, the patient was quite pleased and content with the health care services that were provided to him by DVMCCF. The patient indicated he had all of his disability issues taken care of and that he has access to medical whenever he has any concerns regarding his disability.

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Private Prison Compliance and Monitoring Unit, Field Operations, Corrections Services
Matrix of Facility's Dispute of Case Review Findings and CCHCS's Disposition/Comments

Desert View Modified Community Correctional Facility (DVMCCF) Health Care Compliance and Monitoring Audit
Clinical Case Review Period: August 2015 through January 2016

Item #	Case # (MD/NCPR)	CCHCS Clinician Comment	DVMCCF Clinician Comment	Supporting Documentation Attached?	CCHCS Final Disposition/Comment
CR 1	DVMCCF-COMB2	08/04/15 - Patient submitted 7362 requesting refill of his fiber pills and tylenol. RN rec and rev the 7362 on 8/4/15. Documented request sent to LAC pharmacy. No documentation in eUHR of patient receiving medication.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	The 14 deficiencies (CR 1, 2, 3, 7, 10, 11, 12, 14, 15, 16, 17, 18, 19, and 20) are all related to the *Medication Management* quality indicator for which the facility received an overall rating of **Adequate**. Removing the disputed deficiencies will not change the overall indicator rating to *Proficient* since there are several remaining minor deficiencies outside the contested audit period. **No change to these findings nor the *Medication Management* quality indicator rating.**
CR 2	DVMCCF-COMB2	08/20/15 - Patient received omeprazole ordered on 8/19/2015. Delay in receiving requested medication. Med was requested on 8/12. Also, no nurse's name and signature or initial on the MAR.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 3	DVMCCF-COMB2	09/03/15 - Patient received acetaminophen, fiber pills, and selenium. No nurses' name, siganture or initial on the MAR.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 7	DVMCCF-COMB3	Patient received cetirizine. 3 day delay in patient receiving medication ordered on 9/17. No nurse's name and initial on the MAR.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 10	DVMCCF-ER6	Patient received 30-day supply of Lisinopril. Signed by patient but no signature of nurse dispensing meds. No name or signature/initial of nurse dispensing the medication.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 11	DVMCCF-ER6	Patient received 30-day supply of HCTZ. Signed by patient but no signature of nurse dispensing meds. No name or signature/initial of nurse dispensing the medication.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 12	DVMCCF-ER6	Patient received 30-day supply of Lisinopril timely. Signed by patient but no signature of nurse dispensing meds. No name or signature/initial of nurse dispensing the medication	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 14	DVMCCF-Hosp8	Patient receievd Chlorpheniramine Maleate for 30 day supply MAR does not have RN name and initial. The MAR does not have the name and initial of RN giving the medication.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 15	DVMCCF-CCC9	Pt received Propranolol. Fill and receipt date was 8/31. No Nurse's name and signature or initial. Pt received Naproxen 500 mg tab for 30 day supply. Filled on 9/10, given on 9/10. No Nurse's name and signature or initial on the MAR.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 16	DVMCCF-CCC9	Seen by MD who ordered to discontinue Naproxen and ordered Motrin 600 mg BID with meals. Patient receieved the med on 9/24/15. No nurses' name and initial on the MAR. No Nurse's name and signature or initial on the MAR.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 17	DVMCCF-CCC9	MD ordered Acetaminophen 325 mg. This medication was received late by patient on 8/20, six days after it was ordered. Acetaminophen was dispensed late on 8/20, six days after it was ordered. The MAR did not have nurse's name and signature or initial.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 18	DVMCCF-CCC10	MAR for Calcium Polycarbophil did not have nurse's name, signature and initial. The MAR did not have nurse's name, signature or initial.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	

Desert View Modified Community Correctional Facility (DVMCCF) Health Care Compliance and Monitoring Audit

Clinical Case Review Period: August 2015 through January 2016

Item #	Case # (MD/NCPR)	CCHCS Clinician Comment	DVMCCF Clinician Comment	Supporting Documentation Attached?	CCHCS Final Disposition/Comment
CR 19	DVMCCF-CCC10	MD ordered Atorvastatin, HCTZ, Levothyroxine, Lisinopril, and Dicyclomine. Meds were received late on 9/8/15. MAR also did not have nurse's name, signature or initial. MD ordered meds on 9/3/15 but patient received meds late on 9/8/15. The MAR also did not have nurse's name, signature, and initial	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	continued from previous page
CR 20	DVMCCF-CCC10	MD ordered Acetaminophen. This medication was received late by patient on 9/24/15, 20 days after it was ordered. MD ordered meds on 9/5/15 but patient received meds late on 9/24/15. The MAR also did not have nurse's name, signature, and initial.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 4	DVMCCF-COMB3	Patient submitted 7362 c/o pain in throat/neck area and swelling. RN rec and rev 7362 on 9/5/15. RN assessed patient using Upper Respiratory protocol. RN documented patient was receiving amoxicillin with swollen glands L side of neck and enlarge L tonsil. Plan gargle w salt water, Ib given and three day lay in. RN did not document patient had previously been dx on 6/30 with L otalgia and L otitis media and amoxicillin ordered 3 x day for 10 days. RN documented patient was still receiving abx 60 days after order. RN did not refer the patient to the PCP due to unresolved sx of infection.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	These five deficiencies (CR 4, 5, 9, 6, and 8) are related to *Access to Care* quality indicator. Three of the deficiencies (CR 4, 5, and 9) pertain to inappropriate nursing actions. Two deficiencies were due to RN's failure to notify the PCP of the patient's unresolved infection and medication side effects. This is a standard nursing practice and is not relevant to the contested audit period. The third deficiency was due to the nurse administering cough drops, which are not part of the nursing protocol based on the IMSP&P Nursing Protocol on Upper Respiratory Infections. This policy has been in effect since July 2011. The remaining two deficiencies (CR 6 and 8) pertain to the lack of focused nursing assessment related to the identified patient's medical complaint. This is a standard nursing practice and is not relevant to the contested audit period. **No change to these findings nor the *Access to Care* quality indicator rating.**
CR 5	DVMCCF-COMB3	Patient submitted 7362 stating he completed his cycle of amoxicillin but now has pressure in L ear and headaches. RN rec and rev 7362 9/14/16. RN assessed the patient on 9/14. L ear examined, VS WNL pain 7/10. Patient educated to return to medical is sx increased or persisted. RN did not refer the patient to PCP for f/u for c/o ear pressure following prolong tx of infection.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 9	DVMCCF-COMB4	Patient submitted 7362 for upper resp and fungal infection complaints. RN rec and rev 7362 9/21/15. RN assess patient using Upper Respiratory and Fungal infection protocol. VS WNL, pt requesting cough drops no c/o cough, lungs clear to auscultation. No other s/s of upper resp illness. Patient c/o itching between toes to heels for 2 months. RN noted lesions between toes and heels bilaterally. Plan issue cough drops, gargle w salt water and fungal cream. RN issued cough drops that are not part of the protocol plan.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 6	DVMCCF-COMB3	Patient submitted 7362 stating gums and cheek on R side of mouth are extremely swollen and c/o headache. RN rec and rev 7362 on 9/20. B/P 141/96, pain 6/10. RN scanned 7362 to LAC dental and advised patient to gargle with warm salt water. RN did not conduct a focused assessment of the patient.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 8	DVMCCF-COMB4	Patient seen by RN as f/u to PCP visit on 7/28 for c/o pain on urination. Pt was started on course of ABX on 7/28. RN assessed patient, no c/o pain on urination not other s/s. Education provided. No documentation of RN assessing patient to determine if completed course of Abx.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Private Prison Compliance and Monitoring Unit, Field Operations, Corrections Services
Matrix of Facility's Dispute of Case Review Findings and CCHCS's Disposition/Comments

Desert View Modified Community Correctional Facility (DVMCCF) Health Care Compliance and Monitoring Audit
Clinical Case Review Period: August 2015 through January 2016

Item #	Case # (MD/NCPR)	CCHCS Clinician Comment	DVMCCF Clinician Comment	Supporting Documentation Attached?	CCHCS Final Disposition/Comment
CR 13	DVMCCF-ER6	Chronic care follow up visit done, labs ordered: CBC, CMp, FLP, UA, PSA, Hep panel, HIV. Physician lab orders were not carried out until Oct 27, 2015. Routine lab orders should be done ithin 14 days of order.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	This deficiency pertains to a laboratory order not having been carried out timely. This nursing action was not in compliance with IMSP&P, Volume 4, Chapter 10, *Diagnostic Services* policy, with an effective date of January 2006. **No change to this finding nor the *Diagnostic Services* quality indicator rating.**
CR 21	DVMCCF-TRANS-OUT12	Patient was transferred to CSP-LAC for psychiatric care. Nursing did not complete a Health Care Transfer Information Summary. Nursing completed a Health Record Review documentation, which cannot replace the Health Transfer Information Summary.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	These deficiencies (CR 21, 22, 23) pertain to non-compliance with the IMSP&P, Volume 4, Chapter 3, *Health Care Transfer Process* , with an effective date of January 2010. One deficiency (CR 23) pertains to absence of nursing notes, specifically, completed Health Care Transfer Information form. This is not in compliance with IMSP&P's Health Care Tansfer Process, which requires the nurse to complete a Health Care Transfer Information form for every patient transferring out of the facility, except in cases of emergencies. Although the facility indicated that suporting documentation is attached for review, no documentation was provided disputing the finding. Furthermore, the removal of these deficiencies would not have resulted in an Adequate or Proficient overall rating for the *Health Appraisal/Health Care Transfer* quality indicator due to several remaining significant deficiencies outside the contested audit period. **No change to these findings nor the *Health Appraisal/Health Care Transfer* quality indicator rating.**
CR 22	DVMCCF-TRANS-IN13	DVMCCF receiving nurse did not countersign the Health Care Trasnfer Information completed by the sending institution. DVMCCF receiving nurse did not countersign the Health Care Trasnfer Information completed by the sending institution.	This finding is during the period between the last audit and the time the audit report was received. Respectfully requesting this finding be removed as the facility had no report to begin taking action to correct deficiencies.	No	
CR 23	DVMCCF-TRANS-IN12	No notes	Nothing on the case review finding to support an inadequate rating.	Yes	

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Private Prison Compliance and Monitoring Unit, Field Operations, Corrections Services
Matrix of Facility's Dispute of Quantitative Audit Findings and CCHCS's Disposition/Comments

Desert View Modified Community Correctional Facility (DVMCCF) Health Care Compliance and Monitoring Audit
Audit Review Period: August 2015 through January 2016
Onsite Audit: February 2-4, 2016

Item #	Question #	CCHCS Question	CCHCS Comment	DVMCCF's Dispute/Comments	Answers Changed as Result of Comment?	CCHCS's Final Disposition/Comment
1			The audit review period July 2015 - January 2016.	It was brought to the Warden's attention in January that a meeting had been hosted by PPCMU on October 1, 2015 was attended by the MCCF Wardens (previous Warden). At the time of the initial meeting a draft copy Private Prison Compliance and Health Care Monitoring Audit Instruction Guide was distributed and reviewed. A draft copy was sent and received October 5 by the facility, revisions continued until late November 2015. On January 22 a copy (Rev. November 2015) was provided in preparation for the audit scheduled February 2-4. The January 8, 2016 Audit Notification Letter indicated the review period would cover August 2015 through January 2016. It states that "The audit will rely upon the standardized audit methodology and will include an assessment of the facility's progress toward completion of any preexisting corrective action plan developed from the previous audit." The facility received the final audit report from the previous audit September 24, 2015. Corrective Actions Plan were required to be completed within 30-days of receiving the final audit report. Adequate time was not provided between the time of CAPs being implemented, support documentation being requested for the remote phase of the audit and when the actual audit took place for the required level of compliance in some areas to be achieved or maintained.	Yes	CCHCS realizes the facility could not start implementing the corrective actions until the final report was received identifying the deficiencies. As such, per management decision, the findings for the months of August and September 2015 were removed ONLY for those questions that were not based on IMSP&P or standards of nursing practice. The findings for questions and standards which are based on IMSP&P guidelines and nursing standards will remain the same as facility should have been following them regardless of the audit review period. **As a result, the ratings for the following questions were changed:** **- Question 2.4 - compliance rating changed from 86.7% to 88.1%.** **- Question 2.5 - compliance rating changed from 86.5% to 88.2%.** **- Question 2.6 - compliance rating changed from 85.0% to 85.7%.** **- Question 2.7 - compliance rating changed from 66.7% to 60.0%.** **- Question 2.8 - compliance rating changed from 94.6% to 94.4%.** **- Question 2.9 - compliance rating changed from 55.0% to 85.7%.**
2	1.2	Does the facility have written health care policies and/or procedures that are in compliance with Inmate Medical Services Policies and Procedures guidelines?	The facility does not have local operating procedures/policies that are in compliance with the Inmate Medical Services Policies and Procedures.	At the time of the review the local operating procedures were being updated to bring them in compliance with IMSP&P. Important to note that some of the updates required additional clarification. Some of the processes identified are not applicable to this facility specifically and/or require additional coordination due to Health Services being contracted out. The LOPs were revised with an effective date of February 15, 2016.	No	This is not a new CCHCS requirement. The facility was always expected to maintain local operating procedures in compliance with IMSP&P. **No change to the compliance rating of this question.**

Desert View Modified Community Correctional Facility (DVMCCF) Health Care Compliance and Monitoring Audit
Audit Review Period: August 2015 through January 2016
Onsite Audit: February 2-4, 2016

Item #	Question #	CCHCS Question	CCHCS Comment	DVMCCF's Dispute/Comments	Answers Changed as Result of Comment?	CCHCS's Final Disposition/Comment
3	1.4	Does the patient orientation handbook/manual or similar document explain the sick call and health care grievance/appeal processes?	The facility's patient orientation handbook/manual does not address sick call process.	The Inmate Handbook was updated in January 2016. The sick call process was already included but did not go into specific details. We believe the auditor meant to reference "Medical Appeals". The Appeals information was included but it did not specifically address the "Medical Appeals" process specifically in the Medical Section.	Yes	The patient orientation handbook/manual initially received by PPCMU prior to the onsite audit did not include and address the sick call process. Following the receipt of the facility's rebuttal, the auditor reviewed the submitted document again and noticed that the document was missing even numbered pages. Upon request, the facility submitted the missing pages from the handbook that addressed the sick call process. **As a result, the rating for this question changed from 50.0% to 100% compliance.**
4	3.2	Are health care and custody staff current with required medical emergency response certifications?	The facility's custody staff are not all current on their cardiopulmonary resuscitation certification.	This is a new requirement. At the time of the review we were aware that there were a few staff that required re-certification. One of the 4 staff had been out on leave and the others were part-time and recently moved to full-time. The Training Administrator was aware that several staff were due re-certification and they had been scheduled to attend the next scheduled training. This should not be applicable for this review as it was being addressed prior to the audit.	No	On November 25, 2015, DVMCCF received an addendum to the audit instrument via email from PPCMU that included this requirement. Although this is a new requirement for DVMCCF, the compliance for this question was not based on the August nor September 2015 data/information. The auditor utilized records/data from the month of February 2016. The auditor was informed during the onsite visit that the facility had two CPR training sessions already scheduled for custody staff for the 2nd and 3rd Friday of the month of February 2016. The facility was provided additional two weeks following the onsite audit to produce the documentation reflecting compliance with this requirement. The submitted documentation showed that four custody staff members did not complete the CPR training and were scheduled for the next first available CPR training session. **No change to the compliance rating for this question as the facility had enough time from November 2015 through February 2016 to provide the required training and ensure all custody and health care staff were current on their medical emergency certifications.**
5	9.9	Does the patient receive a complete health appraisal within seven calendar days of arrival?	The patients do not consistently receive a health appraisal within seven calendar days of their arrival at the facility.	This is a new requirement. The appraisals were consistently being done based on the 14-day requirement identified during the previous PPCMU audits and should not be applicable for this review.	No	This is not a new CCHCS requirement. During the previous onsite audits (February and August 2015), the facility was informed that the standard per IMSP&P for health appraisals was 7 days. However, since the audit methodology at that time had not been revised and the facility's contract referenced the 14 day requirement, the facility was scored based on the old audit methodology. The 7 day requirement for initial health appraisals has been in IMSP&P since October 2012. **No change to the compliance rating of this question.**

Desert View Modified Community Correctional Facility (DVMCCF) Health Care Compliance and Monitoring Audit
Audit Review Period: August 2015 through January 2016
Onsite Audit: February 2-4, 2016

Item #	Question #	CCHCS Question	CCHCS Comment	DVMCCF's Dispute/Comments	Answers Changed as Result of Comment?	CCHCS's Final Disposition/Comment
6	14.1	*Emergency Medical Response:* Does the facility conduct emergency medical response drills quarterly on each shift when medical staff is present?		This is a new requirement. At the time of the review response drills had been conducted in January (1st Quarter 2016). This should not be applicable for this review due to the timeframe of the audit. Drills were conducted in February and March to make sure all shifts participate and medical staff are included.	No	This is not a new CCHCS requirement. This requirement has been in the IMSP&P since July 2012. The MCCFs were always required to conduct emergency medical response drills quarterly and on each shift. However, CCHCS agrees with the facility that the findings for January 2016 should not be included due to the time frame of the audit review period. The facility had until March 2016 to comply with this requirement for the first quarter of 2016. Therefore, the auditor only assessed the third and fourth quarters of 2015 during which the facility conducted two emergency medical response drills out of the four required. **The change in the number of "Yes" and "No" answers did not affect the overall rating for this question, the facility's compliance remains 50.0%.**
7	14.5	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required documents?	The incident packages, submitted to EMRRC for review, do not include all required documents and forms. The is a new critical issue	This is a new requirement. During the previous PPCMU audits, it was not required to submit additional forms and documents. Any incidents that occurred prior to the final Audit Guide being received should not be applicable for this review.	No	This is not a new CCHCS requirement. Although during the previous audits the facility was not required to submit the forms to PPCMU, the facility was required to have them completed per IMSP&P. This requirement has been in the IMSP&P since July 2012. **No change to the compliance rating of this question.**
8	14.6	*Emergency Medical Equipment:* Is the facility's clinic Emergency Medical Response Bag secured with a seal?	The facility's emergency medical response bag is not inspected on each shift to ensure the bag is secured with a seal. This is a new critical issue.	At the time of the review this was being done. The staff consistently began documenting the seal number beginning in November 2015. The CAP was implemented and in compliance as noted in the auditor comments. The time frame prior to the end of October should not be applicable.	No	This question was assessed based on the January 2016 log/data. Based on the dates and nursing staff initials recorded on the log, it appears as though the bag was being checked two to three times daily; however, there were no seal numbers documented on the log. The IMSP&P states, in part, that *bags are to be inspected each watch (in which staff are posted) to ensure seals are intact* . As the seal numbers were missing from the documentation produced by the facility, the auditor was unable to confirm/validate that the EMR bag was in fact inspected on each shift. **No change to the compliance rating of this question.**
9	15.2	*Infection Control:* If autoclave sterilization is used, is there documentation showing weekly spore testing?	The facility has one autoclave and the review of the spore testing log for the month of January 2016 showed the testing was completed for the first three weeks of the month; however, for the week of January 25th, there was no documentation indicating the spore testing was completed that week. This equates to 0.0% compliance.	Spore testing completed on 1/27/16. Record attached.	Yes	The documentation submitted by the facility with the rebuttal reflects that the spore testing was completed on 1/27/16. **As a result, the rating for this question changed from 0.0% to 100% compliance.**