CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date : February 19, 2015

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

From : for
Don Meier, Deputy Director
Field Operations
Corrections Services

Subject : **FINDINGS OF THE CONTRACT FACILITY HEALTH CARE MONITORING AUDIT AT FLORENCE CORRECTIONAL CENTER**

The Private Prison Compliance and Monitoring Unit (PPCMU) of Field Operations, Corrections Services (FOCS), California Correctional Health Care Services (CCHCS) staff completed an on-site audit of Florence Correctional Center (FCC) on December 10 through 11, 2014. The purpose of this audit is to ensure that FCC is consistent in meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006 and the *TCCF Remedial Plan.*

Attached you will find the report in which FCC received an overall compliance rating of **92.5%.** This rating is a decrease of 3.9% percentage points from the overall compliance rating of 96.4% achieved during the May 8, 2014 audit. The report contains an executive summary, an explanation of the methodology behind the audit, findings detailed by chapters of the *Health Care Monitoring Instrument,* and a corrective action plan (CAP) request in accordance with the TCCF Remedial Plan. Please ensure that Corrections Corporation of America (CCA) submits a CAP, as detailed in the attached report, to Christopher Troughton, Health Program Specialist I, PPCMU, FOCS, CCHCS via e-mail at Christopher.Troughton@cdcr.ca.gov within 30 days of the date of this memorandum.

Although FCC achieved an overall passing score there were several deficient areas which are program critical in the delivery of constitutional health care to CDCR inmate-patients housed at this facility. The access and quality of medical care provided to the CDCR inmate-patient population at FCC is undesirable, creating grave concern for the inmate-patient population and their safety while being housed at FCC. The below areas will need immediate rectification in

order for CCA to maintain compliance as stated in the *Receiver's Turnaround Plan of Action and the TCCF Remedial Plan.*

- Chronic Care
- Continuous Quality Improvement **(repeat finding)**
- Medication Management
- Monitoring Logs
- Sick Call

These deficient areas can easily be corrected by the facility's strict adherence to the established policy and procedure as outlined in the contract.

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

Enclosures

cc: R. Steven Tharratt, M.D., M.P.V.M., F.A.C.P., Director, Health Care Operations, CCHCS
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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Contract Facility

Health Care Monitoring Audit

FLORENCE CORRECTIONAL CENTER

December 10 through 11, 2014

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DATE OF REPORT

February 19, 2015

INTRODUCTION

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

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

This report provides the findings associated with the audit conducted on December 10 through 11, 2014 at Florence Correctional Center (FCC) which is located in Florence, Arizona. At the time of the audit, CDCR's Weekly Population Count, dated December 5, 2014, indicated a budgeted bed capacity of 8,988 out-of-state beds. The FCC has a budgeted capacity of 600 general population beds, of which 599 are occupied with CDCR inmates. This facility has an American Correctional Association (ACA) Accreditation.

EXECUTIVE SUMMARY

From December 10 through 11, 2014, Field Operations staff conducted an onsite audit at FCC. The audit team consisted of the following personnel:

Grace Song, Medical Doctor (MD), Regional Physician Advisor
Greg Hughes, Nurse Consultant Program Review
Christopher Troughton, Health Program Specialist I (HPS I)
Kala Srinivasan, HPS I

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

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

Based on the quantitative portion of this audit, FCC achieved an overall compliance rating of **92.5%** with a rating of 90.7% in Administration, 91.4% in Delivery, and 97.0% in Operations. Comparatively speaking, during the previous audit (conducted May 8, 2014) the overall quantitative score for FCC was 96.4%, indicating a decline of 3.9 percentage points. Table 2 on the following page provides a comparative overview of facility's performance during the initial and follow-up audits, as well as a trend measurement to show improvement, decline or sustainability.

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

Table 1

Quantitative Compliance Ratings	Points Possible	Points Awarded	Score	CAP Required
Administration				
1. Administration	30.0	30.0	100.0%	No
2. Access to Health Care Information	40.0	40.0	100.0%	No
6. Continuous Quality Improvement (CQI)	60.0	50.0	83.3%	Yes
13. Licensure and Training	160.0	150.0	93.8%	No
15. Monitoring Logs	150.0	115.4	76.9%	Yes
20. Staffing	150.0	150.0	100.0%	No
Administration Sub Score:	**590.0**	**535.4**	**90.7%**	
Delivery				
5. Chronic Care	60.0	40.0	66.7%	Yes
7. Diagnostic Services	120.0	118.3	98.6%	No
8. Medical Emergency Services/Drills	270.0	266.7	98.8%	No
9. Medical Emergency Equipment	530.0	530.0	100.0%	No
14. Medication Management	300.0	240.0	80.0%	Yes
17. Patient Refusal of Medical Treatment	20.0	20.0	100.0%	No
18. Sick Call	300.0	242.1	80.7%	Yes
19. Specialty/Hospital Services	240.0	225.0	93.8%	No
Delivery Sub-Score:	**1,840.0**	**1,682.1**	**91.4%**	
Operations				
3. ADA Compliance	60.0	60.0	100.0%	No
4. Chemical Agent Exposure	N/A	N/A	N/A	N/A
10. Grievance/Appeal Procedure	50.0	50.0	100.0%	No
11. Infection Control	280.0	267.5	95.5%	No
12. Initial Intake Screening/Health Appraisal	240.0	232.5	96.9%	No
16. Observation Unit	30.0	30.0	100.0%	No
Operations Sub-Score:	**660.0**	**640.0**	**97.0%**	
21. Inmate Interviews (not rated)				
Final Score:	**3,090.0**	**2,857.5**	**92.5%**	

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

Table 2

Quantitative Performance Comparison	Audit I 05/2014	Audit II 12/2014	Variance Increase/(Decrease)
1. Administration	100.0%	100.0%	0.0%
2. Access to Health Care Information	100.0%	100.0%	0.0%
3. ADA Compliance	100.0%	100.0%	0.0%
4. Chemical Agent Exposure	N/A	N/A	N/A
5. Chronic Care	100.0%	66.7%	-33.3%
6. Continuous Quality Imprvement (CQI)	66.7%	83.3%	16.6%
7. Diagnostic Services	62.5%	98.6%	36.1%
8. Medical Emergency Services/Drills	100.0%	98.8%	-1.2%
9. Medical Emergency Equipment	100.0%	100.0%	0.0%
10. Grievance/Appeal Procedure	100.0%	100.0%	0.0%
11. Infection Control	100.0%	95.5%	-4.5%
12. Initial Intake Screening/Health Appraisal	97.8%	96.9%	-0.9%
13. Licensure and Training	100.0%	93.8%	-6.2%
14. Medication Management	98.6%	80.0%	-18.6%
15. Monitoring Logs	98.7%	76.9%	-21.8%
16. Observation Unit	100.0%	100.0%	0.0%
17. Patient Refusal of Health Care Treatment/ No Show	90.0%	100.0%	10.0%
18. Sick Call	92.2%	80.7%	-11.5%
19. Specialty/Hospital Services	93.8%	93.8%	0.0%
20. Staffing	100.0%	100.0%	0.0%
Overall Score:	96.4%	92.5%	-3.9%

METHODOLOGY

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

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

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

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

- 85% for each chapter within the audit instrument.

Compliance and non-compliance are defined as follows:

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

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

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

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

At the conclusion of the audit, a compliance value is assigned to each question based on the data gathered during the audit. That value is expressed as a percentage. The total points possible for a given

question is then multiplied by the percentage of compliance to yield the total points awarded. The final scores for each question and the compliance value percentages are rounded to the nearest tenth. For example, for a question valued at 50.0 total possible points, where the compliance rating is 96.0%, the resultant score for that question becomes 50.0 x 0.96 = 48.0 points.

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

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

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

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

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

CORRECTIVE ACTION PLAN REQUEST

The chart below reflects all quantitative analysis items where the facility was rated non-compliant, as well as any qualitative analysis items requiring a response from the facility. The audit results for FCC require the facility to develop a CAP for the following specific items. The facility's response must be received no later than 30 days from the date of this report; specifically **March 19, 2015.**

Corrective Action Items – Florence Correctional Center	
Chapter 5, Question 1	Inmate-patients chronic care follow-up visits are not consistently completed within the 90-day or less timeframe, or as ordered by the Licensed Independent Provider (LIP).
Chapter 5, Question 2	The LIP is not consistently providing health care education to inmate-patients regarding their chronic care condition during the last chronic care follow-up visit.
Chapter 6, Question 2	The facility Continuous Quality Improvement (CQI) Committee Meeting minutes do not establish whether a quorum was met per the approved CQI plan.
Chapter 14, Question 1	Inmate-patients are not consistently administered their medications as ordered by the LIP.
Chapter 14, Question 2	Documentation is not consistent in the medical record to support that the LIP explained newly prescribed medications to the inmate-patients. This CAP item remains unresolved from the previous audit.
Chapter 14, Question 8	Medication errors are not being documented on the Incident Report Medication Error Form.
Chapter 15, Question 1	The *Sick Call monitoring* log did not consistently document that the inmate-patients were seen in within the specified timeframes set forth in the Sick Call policy.
Chapter 15, Question 4	The facility submits chronic care monitoring logs with incomplete data.
Chapter 15, Question 5	The *Initial Health Appraisal Monitoring log* did not consistently document that the inmate-patients received an initial health appraisal within 14 calendar days of arrival.
Chapter 18, Question 2	Nursing staff is not consistently reviewing the sick call forms within one business day of receipt. This CAP item remains unresolved from the previous audit.
Chapter 18, Question 3	Inmate-patients submitting sick call requests with an emergent health care need are not consistently seen or evaluated face-to-face by a registered nurse (RN)/LIP.
Chapter 18, Question 4	Inmate-patients are not consistently being seen and evaluated by an RN/LIP within the specified timeframe when the sick call request indicates a non-emergent health care need.
Chapter 18, Question 5	RN/LIP's are not consistently following the Patient Care Protocol to address inmate-patient's chief complaints nor are they documenting the chief complaint in the Progress Note section of the sick call request form.

Chapter 18, Question 6	The facility RNs are not consistently completing the Subjective-Objective-Assessment-Plan-Education (S.O.A.P.E.) section of the Patient Care Protocol/Progress notes on inmate-patient sick call encounters.
Chapter 18, Question 8	When inmate-patients are referred for a follow-up appointment by the LIP, they are not consistently seen within the specified timeframe.
Chapter 18, Question 10	The Administrative Segregation Unit (ASU) does not have an area where inmate-patients can be medically evaluated with confidentiality.
*Qualitative Action Item 1 (Chapter 8, Question 8)	The Emergency Response Review Committee does not discuss or implement a quality improvement plan after they review the results from an emergency medical response/emergency medical response drill.
*Qualitative Action Item 2 (Chapter 11, Question 9)	The facility's medical staff do not have access to personal protective equipment in the ASU.
*Qualitative Action Item 3 (Chapter 11, Question 12)	Environmental cleaning of high touch surfaces are not being consistently documented in all medical clinics.
*Qualitative Action Item 4 (Chapter 12, Question 6)	During the Initial Intake Screening, RNs are not referring inmate-patients to the LIP for a follow-up chronic care appointment if the inmate-patients were previously enrolled in Chronic Care Clinic.
*Qualitative Action Item 5 (Chapter 13, Question 7)	The facility does not have a system in place ensuring that health care staff receive training for new or revised policies, which are based on Inmate Medical Services Policies and Procedures.
*Qualitative Action Item 6 (Chapter 19, Question 6)	The facility RNs are not notifying the LIP of the medication orders and follow-up instructions when inmate-patients return from a specialty care appointment.
Qualitative Action Item 7	FCC shall implement a contract with a local pharmacy to procure prescription medications for CDCR inmate-patients housed at their facility.

*Qualitative action items 1 through 6 are failed questions from passing (85% or higher) quantitative chapters.

QUANTITATIVE FINDINGS - DETAILED BY CHAPTER

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

CHAPTER 1 COMMENTS

None.

Chapter 2: Access to Health Care Information	Point Value	Points Awarded
1. Does the treating physician have access to the inmate-patient's CCHCS Electronic Unit Health Record (eUHR)?	10.0	10.0
2. Are loose documents filed and scanned into the health record daily?	10.0	10.0
3. Does the facility have and maintain a Release of Information (ROI) log?	10.0	10.0
4. Does the ROI log contain all required information?	10.0	10.0
5. Are all written inmate-patient requests for health care information documented on a *Patient Access to Medical Record Form* or similar form?	10.0	N/A
6. Are all written inmate-patient requests for health care information filed into the Medico-Legal or Miscellaneous section of the health record?	10.0	N/A
7. Are all written requests for release of health care information from a third party authorized by a current *Authorization for ROI Form* or similar form?	10.0	N/A
8. Are all written requests for release of health care information from a third party filed in the Medico-Legal or Miscellaneous section of the health record?	10.0	N/A
Point Totals:	80.0	40.0 (40.0)
Final Score:		**100%**

CHAPTER 2 COMMENTS

1. Questions 5 through 8 – Not applicable. There were no ROI or third party requests for medical records during the audit review period; therefore, these questions could not be evaluated.

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

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

CHAPTER 3 COMMENTS

1. Questions 1 through 6 – Although there are no inmate-patients with qualifying disabilities at this facility; the facility has policies and operational procedures addressing ADA requirements.

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

CHAPTER 4 COMMENTS

1. Questions 1 through 4 – Not applicable. During the audit review period there were no inmate-patients that were exposed to a chemical agent; therefore, these questions could not be evaluated.

Chapter 5: Chronic Care	**Point Value**	**Points Awarded**
1. Was the inmate-patient's chronic care follow-up visit completed within the 90-day or less timeframe, or as ordered by the LIP?	30.0	20.0
2. Did the LIP provide health care education to inmate-patients regarding their chronic care condition during the last Chronic Care Clinic (CCC) follow-up visit?	30.0	20.0
3. If an inmate-patient did not show or refused their chronic care medication half of the time or more in a one-week period during the audited month was a referral made to a LIP?	30.0	N/A
4. If an inmate-patient did not show or refused their chronic care medication half of the time or more in a one-week period during the audited month did the LIP see the inmate-patient within seven days of the referral?	30.0	N/A
Point Totals:	120.0	40.0 (60.0)
Final Score:		**66.7%**

CHAPTER 5 COMMENTS

1. Question 1 – Out of the 12 inmate-patient medical records reviewed, 8 inmate-patients had their chronic care follow-up visit completed within 90 days or less, or as ordered by the LIP. This equates to 66.7% compliance. This is a significant decline from the previous audit rating of 100% compliance.
2. Question 2 – Out of the 12 inmate-patient medical records reviewed, 8 included documentation that the LIP had provided health care education to the inmate-patients regarding their chronic care condition during the last Chronic Care Clinic follow-up visit. This equates to 66.7% compliance. This is a significant decline from the previous audit rating of 100% compliance.
3. Questions 3 through 4 – Not applicable. There were no inmate-patients who refused chronic care medications during the audit review period.

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

CHAPTER 6 COMMENTS

1. Question 2 – The FCC's CQI Plan does not identify the number of required committee members that are needed for a quorum. This equates to 0.0% compliance. This is a significant decline from the previous audit rating of 100% compliance.

Chapter 7: Diagnostic Services	**Point Value**	**Points Awarded**
1. Was the diagnostic test provided to the inmate-patient within the timeframe specified by the LIP?	30.0	28.3
2. Does an LIP review, initial, and date an inmate-patient's diagnostic reports within two days of receipt?	30.0	30.0
3. Was the inmate-patient seen by the LIP for a follow-up visit for a clinically significant diagnostic test result within 14 days, or as clinically indicated, from the date the test results were reviewed by the LIP?	30.0	30.0
4. Was the inmate-patient given written notification of the diagnostic test results within two days of receipt?	30.0	30.0
Point Totals:	120.0	118.3
Final Score:		**98.6%**

CHAPTER 7 COMMENTS

1. Question 1 – Out of the 18 inmate-patient medical records reviewed, 17 inmate-patients received a diagnostic test within the timeframe specified by the LIP. This equates to 94.4% compliance. This is a slight decline from the previous audit rating of 100% compliance.

Chapter 8: Medical Emergency Services/Drills	Point Value	Points Awarded
1. Does the facility have a current Medical Emergency Response procedure?	10.0	10.0
2. Does the facility's local operating procedure pertaining to medical emergencies/response contain instructions on how to communicate, respond, and transport inmate-patients during medical emergencies?	30.0	30.0
3. Does the facility's local operating procedure contain instructions on how to obtain Emergency Medical Services (EMS) transportation 24 hours a day, seven days a week?	30.0	30.0
4. When inmate-patients return from a community hospital emergency department, does an RN document their review of the inmate-patient's discharge plan?	30.0	30.0
5. When inmate-patients returns from a community hospital emergency department, does an RN document the completion of a face-to-face evaluation of the inmate-patient?	30.0	30.0
6. When an inmate-patient returns from a community hospital emergency department, does the inmate-patient receive a follow-up appointment with an LIP within five calendar days of discharge or sooner as clinically indicated from the day of discharge?	30.0	30.0
7. Is there documentation that the Emergency Response Review Committee has met at least once a month?	10.0	10.0
8. In the documentation of the Emergency Response Review Committee meetings, does the committee discuss and/or implement a quality improvement action after reviewing the results of an emergency medical response and/or emergency medical response drill?	10.0	6.7
9. Does the facility conduct quarterly emergency medical response (man-down) drills on each shift?	30.0	30.0
10. During emergency medical response and/or drills, is a Basic Life Support (BLS) certified staff member on-site within four minutes of the emergency medical alarm?	30.0	30.0
11. During emergency medical response and/or drills, is an Advanced Cardiac Life Support (ACLS) certified health care staff member providing treatment within eight minutes of the emergency medical alarm?	30.0	30.0
Point Totals:	270.0	266.7
Final Score:		**98.8%**

CHAPTER 8 COMMENTS

1. Question 8 – During the audit review period, two of the three Emergency Response Review Committee meeting minutes documented that the committee discussed and implemented a quality improvement plan/action after reviewing the results of the emergency medical response/emergency medical response drill. This equates to 66.7% compliance. This is a significant decline from the previous audit rating of 100% compliance.

Chapter 9: Medical Emergency Equipment	Point Value	Points Awarded
1. For each shift, do staff document that all Emergency Medical Response Bags in each clinic are secured with a seal?	30.0	30.0
2. Is there documentation, after each medical emergency, that all Emergency Medical Response Bags in each clinic are re-supplied and re-sealed?	30.0	30.0
3. Is there documentation, on each shift, that all Medical Emergency Crash Carts are secured with a seal?	50.0	50.0

4. Is there documentation, after each medical emergency, that all Medical Emergency Crash Carts are re-supplied and re-sealed?	30.0	N/A
5. Does the facility have a functional Defibrillator with Cardiac Monitor?	50.0	50.0
6. Is there documentation that the Defibrillator with Cardiac Monitor in each clinic is checked every shift for operational readiness?	30.0	30.0
7. Does the facility have a functional 12 Lead Electrocardiogram (EKG) machine with electrode pads?	50.0	50.0
8. Is there documentation that the 12 Lead EKG machine with electrode pads in each clinic is checked every shift for operational readiness?	30.0	30.0
9. Does the facility have functional Portable suction?	50.0	50.0
10. Is there documentation that the Portable suction in each clinic is checked every shift for operational readiness?	30.0	30.0
11. Does the facility have oxygen tanks?	50.0	50.0
12. Is there documentation that the oxygen tanks in each clinic is checked every shift for operational readiness (at least three-quarters full)?	30.0	30.0
13. Does the facility have a contract for routine oxygen tank maintenance service?	30.0	30.0
14. Is there documentation that the Automated External Defibrillator (AED) in each clinic is checked every shift for operational readiness?	30.0	30.0
15. Are first aid kits located in designated areas?	10.0	10.0
16. Do the first aid kits contain all required items?	10.0	10.0
17. Are spill kits located in the designated areas?	10.0	10.0
18. Do the spill kits contain all required items?	10.0	10.0
Point Totals:	560.0	530.0 (530.0)
Final Score:		**100%**

CHAPTER 9 COMMENTS

1. Question 4 – Not applicable. Although FCC had three medical emergency drills during the last quarter, the medical emergencies did not warrant the use of the medical emergency crash cart; therefore, this question could not be evaluated.

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

CHAPTER 10 COMMENTS

None.

Chapter 11: Infection Control	Point Value	Points Awarded
1. Does the facility have an Infection Control Plan that meets CCHCS guidelines?	30.0	30.0
2. Does the facility have a Bloodborne Pathogen Exposure Control Plan?	30.0	30.0
3. Are packaged sterilized reusable instruments within the expiration date?	10.0	10.0
4. When autoclave sterilization is used, is there documentation showing weekly spore testing?	30.0	30.0
5. Are disposable instruments discarded after one use?	10.0	N/A
6. Are inmate-patients who come to the clinic with a potential communicable disease isolated from the rest of the inmate-patients in the clinic area?	10.0	10.0
7. Does the staff practice hand hygiene?	30.0	30.0
8. Does the facility have hand sanitizers which are maintained and available for staff use?	10.0	10.0
9. Is personal protective equipment (PPE) (i.e. gloves, masks, face shields, gowns, etc.) available for staff use?	10.0	7.5
10. Is healthcare staff following Universal Precaution measures during inmate-patient contact?	30.0	30.0
11. Is the inmate-patient clinic area cleaned after each inmate-patient use?	10.0	10.0
12. Is environmental cleaning of "high touch surfaces" completed within the medical clinic at least once a day?	10.0	0.0
13. Are biohazard materials placed in biohazard material labeled containers?	10.0	10.0
14. Are the central storage biohazard material containers emptied on a regularly scheduled basis?	10.0	10.0
15. Is the central storage area for biohazard materials labeled and locked?	10.0	10.0
16. Are sharps placed into a puncture resistant, leak-proof container that is closeable, locked, and labeled with the biohazard symbol?	10.0	10.0
17. Does the facility account for all sharps (needles, scalpels, etc.) by documenting the number at the end of each shift?	10.0	10.0
18. Does the facility have a process to reconcile the sharp count if needed?	10.0	10.0
19. Does the facility secure sharps?	10.0	10.0
Point Totals:	290.0	267.5 (280.0)
Final Score:		**95.5%**

CHAPTER 11 COMMENTS

1. Question 5 – Not applicable. During the onsite audit, this process was not observed; therefore, this question could not be evaluated.
2. Question 9 – Out of four exam rooms at FCC, three exam rooms had PPE available for staff use. The RNs assessing the inmate-patients in the ASU do not have access to the PPE. This equates to 75.0% compliance. This is a significant decline from the previous audit rating of 100% compliance.
3. Question 12 – Out of the two clinics at FCC, neither clinic maintains a log documenting the clinic's high touch surfaces are cleaned at least once a day. This equates to 0.0% compliance. This is a significant decline from the previous audit rating of 100% compliance.

Chapter 12: Initial Intake Screening/ Health Appraisal	Point Value	Points Awarded
1. *Did the inmate-patient receive an Initial Intake Screening upon arrival at the* facility by licensed health care staff?	30.0	30.0
2. If an inmate-patient was referred to a LIP by nursing staff during the Initial Intake Screening, was the inmate-patient seen in the specified time frame? (Immediately, within 24 hours, or within 72 hours)	30.0	30.0

3. If the inmate-patient had an existing medication order upon arrival at the facility, was the inmate-patient seen by a LIP or had their medications ordered within 8 hours of arrival?	30.0	30.0
4. If the inmate-patient was referred for a follow-up medical, dental or mental health appointment, was the appointment completed within the time frame specified by the LIP?	30.0	30.0
5. Did the inmate-patient receive a complete Health Appraisal by the LIP ≤ 14 calendar days of arrival at the facility?	30.0	30.0
6. If the inmate-patient was enrolled in a Chronic Care Clinic at a previous facility, did the RN refer the patient to LIP or Primary Care Primary Care Physician (PCP) for CCC follow-up?	30.0	22.5
7. Did the inmate-patient receive a complete screening for the signs and symptoms of Tuberculosis (TB) upon arrival?	30.0	30.0
8. Did the inmate-patient receive a Tuberculin Skin Test (TS) evaluation upon arrival?	30.0	N/A
9. Does the initial intake screening take place in a manner that ensures inmate-patient confidentiality both visually and orally?	30.0	30.0
Point Totals:	270.0	232.5 (240.0)
Final Score:		**96.9%**

CHAPTER 12 COMMENTS

1. Question 6 – Out of the 18 inmate-patient medical records reviewed, 4 inmate-patients had been enrolled in a Chronic Care Clinic at a previous facility. Out of these four, only three inmate-patients were referred to a LIP by an RN for a follow-up appointment. This equated to 75.0% compliance. This is a significant decline from the previous audit rating of 92.3% compliance.

2. Question 8 – Not applicable. Due to a change in departmental policy, inmate-patients are not required to receive a Tuberculin (TB) skin test evaluation upon arrival. Inmate-patients receive a TB skin test upon arrival at the CDCR Reception Center and then annually thereafter.

Chapter 13: Licensure and Training	**Point Value**	**Points Awarded**
1. Are copies of current licenses maintained for all health care staff?	30.0	30.0
2. Is there a centralized system for tracking expiration of license for all health care staff?	30.0	30.0
3. Are the ACLS certifications current for the Physician, Nurse Practitioner (NP), Physician Assistant (PA) and RN?	30.0	30.0
4. Are the BLS certifications current for the LPN/Custody Staff?	30.0	30.0
5. Is there a method in place to address expired certifications/licenses?	10.0	10.0
6. Is there a centralized system in place to track training provided to health care staff?	10.0	10.0
7. Is there a system in place to ensure that health care staff receives training for new or revised policies that are based on Inmate Medical Services Policy and Procedures (IMSP&P) requirements?	10.0	0.0
8. Did the CCA Management (on-site supervisors) receive training for new or revised policies that are based on IMSP & P requirements?	10.0	10.0
Point Totals:	160.0	150.0
Final Score:		**93.8%**

CHAPTER 13 COMMENTS

1. Question 7 – The facility does not have a system in place to ensure that health care staff receives training on new or revised policies based on IMSP&P. FCC has eight health care employees that have not received training on various policies. This equates to 0.0% compliance. This is a significant decline from the previous audit rating of 100% compliance.

Chapter 14: Medication Management	Point Value	Points Awarded
1. Was the medication administered to the inmate-patient as ordered by the LIP?	30.0	15.0
2. Did the prescribing LIP document that they explained the medication to the inmate-patient?	30.0	15.0
3. If a patient did not show or refused their prescribed medication 50% of the time or more during the audit period was a referral made to an LIP?	30.0	30.0
4. If a patient did not show or refused their prescribed medication 50% of the time or more during the audit period did the LIP see the patient within 7 days of the referral?	30.0	30.0
5. Does the same LPN/RN who prepares the inmate-patient medication also administer the medication?	30.0	30.0
6. Are inmate-patient medications administered on the same day that the medications are prepared?	30.0	30.0
7. Does the LPN/RN document the medication is administered on the Medication Administration Record (MAR) once the medication is given to the inmate-patient?	30.0	30.0
8. Are medication errors documented on the Incident Report-Medication Error Form?	30.0	0.0
9. Does the LPN/RN directly observe an inmate-patient taking DOT medication?	30.0	30.0
10. Does the LPN/RN check every inmate-patient's mouth, hands and cup after administering DOT medications?	30.0	30.0
11. Does the inmate-patient take all Keep on Person (KOP) medications to the designated LPN/RN prior to transfer?	30.0	N/A
12. Does the LPN/RN verify the KOP medications against the current pharmacy medication profile prior to transfer?	30.0	N/A
13. Does the transfer envelope contain a current pharmacy medication profile?	30.0	N/A
14. Does the transfer envelope contain a sufficient supply of prescription medications to cover the period of the inmate-patient transport?	30.0	N/A
Point Totals:	420.0	240.0 (300.0)
Final Score:		**80.0%**

CHAPTER 14 COMMENTS

1. Question 1 – Out of the 12 inmate-patient medical records reviewed, 6 inmate-patients received their medications as ordered by the LIP. This equates to 50.0% compliance. This is a significant decline from the previous audit rating of 100% compliance.
2. Question 2 – Out of the 12 inmate-patient records reviewed, 6 records had documentation that the LIP explained the medication to the inmate-patient. This equates to 50.0% compliance. This is a significant decline from the previous audit rating of 83.3% compliance. This remains an unresolved CAP item from the previous audit.
3. Question 8 – The facility does not utilize an Incident Report-Medication Error form to document medication errors. This equates to 0.0% compliance. This is a significant decline from the previous audit rating of 100% compliance.
4. Questions 11 through 14 – Not applicable. During the onsite audit there were no inmate-patient transfers; therefore, these questions could not be evaluated.

Chapter 15: Monitoring Log	Point Value	Points Awarded
1. Are inmate-patients seen within timeframes set forth in the sick call policy?	30.0	26.9
2. Are inmate-patients seen within the timeframes set forth in the specialty care policy?	30.0	30.0

3. Are inmate-patients seen within the timeframes set forth in the emergency/hospital services policy?	30.0	30.0
4. Are inmate-patients seen within timeframes as it relates to chronic care policy?	30.0	0.0
5. Are inmate-patients seen within timeframes set forth in the initial intake screening/health appraisal policy?	30.0	28.5
Point Totals:	150.0	115.4
Final Score:		**76.9%**

CHAPTER 15 COMMENTS

1. Question 1 – Out of 87 sick call appointment requests, 78 inmate-patients were seen within the specified timeframe. This equates to 89.7% compliance. This is a slight decline from the previous audit rating of 94.6% compliance.

Routine		Urgent		Emergent		Totals	
# of requests reviewed	# within timeframe	# of requests reviewed	# within timeframe	# of requests reviewed	# within timeframe	# of requests reviewed	# within timeframe
84	75	2	2	1	1	**87**	**78**

2. Question 4 – The auditors reviewed the chronic care log for the audit review period of July through September 2014 and found incomplete documentation, specifically incorrect dates in several columns. Based on this information it could not be ascertained if inmate-patients were seen by the PCP within the specified timeframe. This equates to 0.0% compliance. This is a significant decline from the previous audit rating of 98.6% compliance.

3. Question 5 – Of the 20 inmate-patients identified to have received an initial health screening during the audit review period, 19 were seen within the specified timeframe. This equates to 95.0% compliance. This is a slight decline from the previous audits rating of 100% compliance.

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

CHAPTER 16 COMMENTS

1. Questions 1 through 2 – Not applicable. During the audit review period no inmate-patients were housed in medical observation; therefore, these questions could not be evaluated.

Chapter 17: Patient Refusal of Health Care Treatment/No Show	**Point Value**	**Points Awarded**
1. If an inmate-patient refuses a health care appointment/treatment, did an RN/LIP complete the CDCR Form 7225, *Refusal of Examination and/or Treatment* Form?	10.0	10.0
2. If an inmate-patient refuses a health care appointment/treatment, did an RN/LIP document their discussion of risk and benefits of refusing the appointment/treatment in the inmate-patient's Progress Notes section of the Electronic Medical Record?	10.0	10.0

3. If an inmate-patient did not show for their medical appointment, did the RN/LIP contact the housing unit supervisor to have the inmate-patient escorted to medical to speak with health care staff?	10.0	N/A
4. If an inmate-patient was a no show for a medical appointment/treatment, did the RN contact the LIP to determine if/when the inmate-patient should be rescheduled?	10.0	N/A
Point Totals:	40.0	20.0 (20.0)
Final Score:		**100%**

CHAPTER 17 COMMENTS

1. Questions 3 through 4 – Not applicable. There were no inmate-patient "no-shows" during the audit review period; therefore, these questions could not be evaluated.

Chapter 18: Sick Call	**Point Value**	**Points Awarded**
1. Does the inmate-patient handbook or similar document explain the sick call process?	10.0	10.0
2. Is an RN reviewing all sick call request forms within one day of receipt?	30.0	26.9
3. Are inmate-patients seen and evaluated face-to-face by an RN/LIP if the sick call request form indicates an emergent health care need?	30.0	0.0
4. Are inmate-patients seen and evaluated by an RN/LIP within the next business day if the sick call request indicated a non-emergent health care need?	30.0	29.3
5. Does an RN/LIP follow the Patient Care Protocol to address an inmate-patient's chief complaint, and is the chief complaint documented in the Progress Note on the sick call request form?	30.0	28.8
6. Is the Subjective-Objective-Assessment-Plan-Education (S.O.A.P.E) section of the Patient Care Protocol/Progress Note completed by an LPN/RN?	30.0	23.8
7. If an inmate-patient was referred for follow-up to the LIP by the RN, was the inmate-patient seen within the specified timeframe?	30.0	30.0
8. If an inmate-patient was referred for follow-up by the LIP, was the inmate-patient seen within the ordered timeframe?	30.0	27.0
9. Are all inmate-patients referred to an LIP by an RN if they presented to sick call three or more times in a month for the same complaint?	30.0	N/A
10. Do the sick call visit locations provide for inmate-patient confidentiality both visually and orally in General Population (GP), Administrative Segregation (Ad Seg), and Lockdown?	30.0	20.0
11. Does nursing staff conduct daily rounds in Administrative Segregation Housing Units?	30.0	30.0
12. Are the sick call request forms readily available to inmate-patients in all housing units?	10.0	10.0
13. Are inmate-patients able to submit sick call request forms on a daily basis in secured/locked boxes in all housing units?	10.0	10.0
Point Totals:	330.0	245.8 (300.0)
Final Score:		**81.9%**

CHAPTER 18 COMMENTS

1. Question 2 – Out of the 48 inmate-patient sick call requests submitted during the audit review period, 43 were reviewed by an RN within one day of receipt. This equates to 89.6% compliance. This is a significant decline from the previous audit score of 100% compliance.
2. Question 3 – Out of the 48 inmate-patient sick call requests submitted during the audit review period, 6 inmate-patient sick call requests reflected an emergent health care need; none of which were seen and evaluated face-to-face by an RN/LIP. This equates to 0.0% compliance.

3. Question 4 – Out of the 42 inmate-patient sick call requests submitted during the audit review period reflecting a non-emergent health care need, 41 inmate-patients were seen and evaluated by an RN/LIP within the next business day. This equates to 97.6% compliance. This is an improvement from the previous audit rating of 85.7% compliance.

4. Question 5 – Out of the 48 inmate-patient charts reviewed, 46 charts reflected documentation that the RN/LIP followed the Patient Care Protocol to address the inmate-patient's chief complaint. This equates to 95.8% compliance. This is a slight decline from the previous audit rating of 97.9% compliance.

5. Question 6 – Out of the 48 inmate-patient S.O.A.P.E. notes reviewed, 38 were completed by the LPN/RN. This equates to 79.2% compliance. This is a slight decline from the previous audit rating of 85.4% compliance.

6. Question 8 – Out of the 10 inmate-patient medical records reviewed, nine received a follow-up within the ordered timeframe. This equates to 90.0% compliance. This is a significant improvement from the previous audit rating of 66.7% compliance.

7. Question 9 – Not applicable. There were no inmate-patients that presented to sick call three or more times in a month for the same complaint during the audit review period. Therefore this question could not be evaluated.

8. Question 10 – The facility has three areas where sick call appointments are conducted; Main medical, Short Hall Clinic, and ASU. Main medical and Short Hall Clinic's inmate-patients receive medical examinations in a confidential location. The RNs are required to conduct face-to-face sick call assessments for ASU Inmate-patients on the tier in the ASU building. All face to face encounters between the RN and the inmate-patient is conducted inside the inmate-patients cell. If an inmate-patient has a cellmate, the cellmate is taken out of the cell and placed in a secured location. The inmate-patients' being seen by the RN are not consistently placed in mechanical restraints prior to the RN entering the cell. This practice is a clear violation of the *CDCR IMSP&P Volume 4, Chapter 4, Section 3A.5*, which clearly states that, "Each inmate-patient ducated for primary health care services shall be seen for his/her scheduled appointment in the clinic by the appropriate discipline." This equates to 66.7% compliance. This is a significant decline from the previous audit rating of 100% compliance.

Chapter 19: Specialty/Hospital Services	**Point Value**	**Points Awarded**
1. Are LIP requests for urgent specialty services approved or denied within 72 hours of being requested?	30.0	30.0
2. Are LIP requests for routine specialty services approved or denied within seven days of being requested?	30.0	30.0
3. Are LIPs evaluating an inmate-patient every 30 days or as specified until the routine specialty appointment occurs?	30.0	30.0
4. Are inmate-patients seen by a specialist within the timeframe specified by an LIP? (Emergent=immediately, Urgent < 14 days or Routine < 90 days)	30.0	30.0
5. Upon return from a specialty consult appointment, does an RN/LIP complete a face-to-face evaluation prior to the inmate-patient returning to their assigned housing unit?	30.0	30.0
6. When and inmate-patient returns from a specialty consult appointment, does an RN notify an LIP of any immediate medication orders or follow-up instructions provided by the specialty consultant?	30.0	15.0
7. Does an LIP review the consultant's report and see the inmate-patient for a follow-up appointment within the specified timeframe? (≤ 3 days for emergent/urgent and ≤ 14 days for routine)	30.0	30.0
8. Does all pertinent health care information accompany the inmate-patient to their specialty consult appointment?	30.0	30.0

9. When an inmate-patient is discharged from a community hospital, does an RN document their review of the inmate-patient's discharge plan?	30.0	N/A
10. When an inmate-patient is discharged from a community hospital, does the RN document their face to face evaluation of the inmate-patient prior to the inmate-patient being re-housed?	30.0	N/A
11. When an inmate-patient is discharged from a community hospital, does the inmate-patient receive a follow-up appointment with an LIP within five calendar days from the day discharged or sooner as clinically indicated?	30.0	N/A
Point Totals:	330.0	225.0 (240.0)
Final Score:		**93.8%**

CHAPTER 19 COMMENTS

1. Question 6 – Out of the 10 medical records reviewed for inmate-patients who were sent out for a specialty care appointment, 2 inmate-patients returned with immediate medication orders. The LIP was notified by nursing staff of only one medication order, this resulted in the delay of care for one of the two inmate-patients. The effected inmate-patient was delayed in receiving prescribed antibiotics for a three week period. This equates to 50.0% compliance. This is a significant decline from the previous audit rating of 100% compliance.
2. Questions 9 through 11 – Not applicable. During the audit review period there were no inmate-patients that were admitted to a community hospital; therefore, these questions could not be evaluated.

Chapter 20: Staffing	**Point Value**	**Points Awarded**
1. Does the facility have the required LIP staffing complement?	30.0	30.0
2. Does the facility have the required management staffing complement?	30.0	30.0
3. Does the facility have the required RN staffing complement?	30.0	30.0
4. Does the facility have the required LPNS staffing complement?	30.0	30.0
5. Does the facility have the required Certified Medical Assistant (CMA) staffing complement?	30.0	30.0
Point Totals:	150.0	150.0
Final Score:		**100%**

CHAPTER 20 COMMENTS

None.

QUALITATIVE FINDINGS

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

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

Brian Koehn – Warden
William Crane – Regional Medical Director
Anne Diggs – Regional Nursing Director (RND), Health Services
Scott Smith – Quality Assurance Manager (QAM)
Boru Nale – Facility Physician
Katherine Hakeman – Nurse Practitioner (NP)
Michael Reingold – Health Services Administrator (HSA)
Lea Ann Hayes – RN, Clinical Nursing Supervisor
Heather Presson – RN, CQI
Norma Bravo – Consults / Medical Records Clerk
Jean Byers – Administrative Clerk

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

SUMMARY OF QUALITATIVE FINDINGS

Since the completion of the previous audit in May 2014, there have been several changes in FCC's medical management staffing and the incoming staff have received what appears to be minimal training on medical processes. CCA's failure in monitoring and providing adequate training to the facility's new and existing medical staff has resulted in the facility's poor performance in key areas, such as chronic care, medication management and sick call which has adversely affected the overall score of this audit.

During the onsite audit the physician-auditor observed clinical encounters, conducted interviews and reviewed several charts of both the facility physician and nurse practitioners. Below is a summary of the physician-auditor's observations.

The physician-auditor observed the facility physician in his clinic conducting inmate-patient medical appointments. The facility physician administered good bedside manner when conducting his medical appointments and he has an established rapport with his CDCR inmate-patients. He was observed

educating inmate-patients on his treatment plans. The facility physician informed the physician-auditor that he has been utilizing older CCHCS care guidelines when treating CDCR inmate-patients. The physician-auditor provided the facility physician with the location of the correct CCHCS care guidelines on the CCHCS website; http://www.cphcs.ca.gov/, which he was able to navigate in the presence of the physician-auditor. The facility physician will make use of the new care guidelines immediately when treating the CDCR inmate-patient population.

The physician auditor had a one-on-one discussion with the facility physician in regards to; access to medical care, emergency services, and specialty care and medication management to gauge whether FCC has any barriers to care. The facility physician stated that the sick call clinics work well at FCC and custody staff works diligently with the challenging task of moving inmate-patients to the clinics on CDCR clinic days. FCC has four different jurisdictions at their facility, California, Vermont, US Marshals and Immigration and Customs Enforcement (ICE) inmates; California inmate-patients are scheduled in the main medical clinic on Monday and Wednesdays. The facility physician stated that access to emergency services is adequate with no delays internally nor are there any delays externally with the ambulance transport. FCC maintains a good working relationship with the outside local hospitals. The facility physician stated that FCC specialty care schedulers do not have any problems scheduling specialty care appointments with the outside vendors and that FCC is able to meet the CCHCS compliance guidelines. The facility physician also stated that he does not perceive any problems with the pharmacy or medication management.

At the exit conference, the physician-auditor voiced extreme concern with FCC's lack of follow through with medication management. During the physician-auditors EMR review, it was discovered that an inmate-patient who returned from a specialty care (urology) appointment was prescribed an antibiotic as treatment for his diagnose of chronic prostatitis. On September 17, 2014 this inmate-patient returned to FCC, nursing staff assessed the inmate-patient; however, there was no documentation notating this inmate-patient had a medication order nor was the facility physician notified that he was to see this inmate-patient. The facility physician did not review the specialist notes until September 22, 2014 and subsequently put in the order of Levaquin on September 23, 2014. There was no record of antibiotics on this inmate-patient's MAR until October 8, 2014, which indicates that this inmate-patient had a three week delay in receiving his medication. The physician-auditor made the recommendation that a regular review be conducted of the pharmacy medication administration process at FCC. Additionally, the physician-auditor advised the HSA to ensure that the facility RNs review and notify the facility physician of the specialists' plan and prescription orders for all inmate-patients returning from offsite specialty appointments. The process should include the time of ordering, procurement and delivery of medications to the inmate-patients. The HSA stated that he would work with his nursing staff on a plan of action for improving the medication management process.

The physician-auditor and the facility physician discussed inmate-patients who suffer from a visual acuity of 20/200 bilaterally and do not have immediate access to eyeglasses. The facility physician stated that the facility has vision vests available for inmate-patients to wear, however, the inmate-patients express dislike in wearing the vest as they can potentially become the target for other inmates. The physician-auditor advised the facility physician to prescribe corrective eyeglasses for inmate-patients with visual acuity of the 20/200 bilaterally. Until such time the eyeglasses are obtained the physician-auditor suggested that the facility physician designate these inmate-patients as Permanent Vision Impairment (DPV) status and discontinue their status once the eyeglasses are provided. The physician-auditor reiterated the importance of providing corrective eyeglasses to these inmate-patients in order for them to navigate the facility in a safe manner.

During this conversation the physician-auditor also discussed the tracer audit case that she conducted prior to the audit. This inmate-patient had been subjected to a chemical in his eye. The physician-auditor did not find any irregularities with this inmate-patient's medical care but did make the recommendation that medical staff perform visual acuity exams on inmate-patients post eye injuries to monitor their progress. The physician-auditor also made the recommendation that the nursing staff consider using a different form other than the *"Emergency anatomical form"* to document patient's return from outside facility and return to housing. During the exit conference, the HSA stated that he would work with the nursing staff on their documentation when inmate-patient return from outside medical encounters.

The physician-auditor also interviewed and observed the nurse practitioner conducting routine encounters. The nurse practitioner states that she sees CDCR inmate-patients on an "as needed" basis. The physician-auditor observed the nurse practitioner conduct two medical encounters; she has a good rapport with the inmate-patients and strives to follow policy. The nurse practitioners attitude toward treating inmate-patients is fair, firm and consistent; she has no problem telling an inmate-patient "no" when there is no medical basis for granting a request.

The nurse practitioner did have a concern with the pharmacy that FCC uses, Diamond Pharmacy, which is located on the east coast. At times medications are delayed which impacts the treatment of inmate-patients. This issue was discussed at the exit conference and the RND stated that the facility maintains a supply of "stock" medications, such as over the counter medications and some prescription medications such as antibiotics. However the RND agreed to review alternate solutions to remedy the identified issue.

Health Services Administrator (HSA): At the conclusion of the entrance conference, the HPS-I conducted an interview with the HSA. The HSA was newly hired in October 2014 and has received approximately three to four hours of training from his Regional Nursing Director (RND). As a result, the HSA is not yet wholly familiar with FCC operational procedures and CDCR IMSP&P. In attempt to be pro-active, the HSA reached out to his peer at another CCA facility housing CDCR inmates. This resulted in their sister facility sending their CQI nurse to FCC to provided training.

The HSA was observed to be working collaboratively with both medical and custody staff. He expressed his willingness to learn IMSP&P and FCC's corporate and local operating policies and procedures. He reached out to appropriate staff when he did not have an answer to a specific question; he was open to constructive criticisms and was willing to take action to correct any discrepancies or issues that the audit team observed.

The HSA's role and responsibility is to provide guidance and leadership to the medical staff and ensure all medical staff follow the appropriate treatment protocols outlined in the IMSP&P when providing medical care to CDCR inmate-patients. The HSA also functions as the ADA coordinator, however at this time the facility does not house any ADA inmate-patients. The HPS I-auditor explained to the HSA that even though FCC does not currently house inmate-patients with ADA needs, FCC is still required to have the resources available for accommodating such inmate-patients if such needs arise. Failure to understand ADA requirements will result in failure to identify and accommodate disabled inmate-patients, such as the case of the inmate-patient identified to have poor visual acuity.

The HSA is also the designated health care appeals coordinator responsible for responding to all first level health care appeals received from CDCR inmate-patients. The HSA stated that he responds to all health care appeals within the specified timeframe. At the request of the auditor, the HSA could not produce the health care appeals log nor was he aware that he had to maintain a log. He stated that the Grievance/Appeal coordinator for the institution maintains an appeals log. The HPS I-auditor informed the HSA that he is required to maintain a separate log to track all health care appeals received from CDCR inmate-patients, regardless of the Grievance/Appeal coordinator maintaining her own log. During the course of the audit, the HSA was successful in locating the first level appeals log that had been maintained by the prior HSA. Upon finding the log it was also learned that the log had not been updated since March 2014. This incident further emphasized the CCA management's failure to provide sufficient training to the newly appointed staff and the lack of cross training between existing staff on facility's various medical and administrative processes. The HPS I-auditor advised the HSA to update this log to include all health care appeals received since last entry on the log and maintain the log current at all times. The HSA understood this requirement and provided the audit team a completed and up-to-date copy of the log prior to the exit conference.

The auditors observed that the facility staff had minimal knowledge about facility's operational procedures and this was confirmed by the following example. When the physician-auditor had a discussion with the HSA regarding the facility's Workers Compensation process (based on her tracer audit on an inmate-patient who was a kitchen worker and was accidently sprayed with a chemical in his eye while he was cleaning), the HSA stated that he was not familiar with the facility's Workers Compensation process. The HSA agreed to work with the Quality Assurance officer to understand the process. However, when the Quality Assurance officer was interviewed, he stated that he was not aware of the process either.

It warrants mentioning that during the course of the initial HSA interview, the RND came into the HSA's office, interrupted the interview and made a disparaging comment regarding the audit process. The HPS I-auditor felt uncomfortable by the remark and concluded the interview. The HSP I-auditor continued to engage the HSA throughout the remainder of the audit. Whether meant in jest, or as intent to divert the audit process, the RND's remark was inappropriate. This issue has been elevated and addressed through the Chief Medical Officer within CCA.

Grievance/Appeal Coordinator: The HPS I-auditors met with the Grievance/Appeal coordinator to discuss the appeals process. The grievance/appeal coordinator collects and logs all appeals on a daily basis. Both the medical and non-medical appeals are recorded on the same log. Health care appeals received from CDCR inmate-patients are sorted out and routed to the HSA for his review and response within one day of receipt. The Grievance/Appeal coordinator stated that she allows the HSA 15 calendar days to respond to the health care appeals. This allows her the time to review the HSA's response and inform the inmate-patient of their decision within the appropriate time frame.

The auditors made the recommendation to the Grievance/Appeal coordinator that they maintain a separate log to document CDCR inmate-patients' appeals. Currently, the Grievance/Appeal coordinator is utilizing the same log to track appeals of inmate-patients from all four jurisdictions; ICE, US Marshals, Vermont and CDCR. The Grievance/Appeal coordinator agreed to maintain a separate log for CDCR inmate-patient appeals.

FCC Health Care Staff: In general FCC's medical staff demonstrated marginal knowledge of the IMSP&P, CCA's local and corporate policies and procedures. Although the staff could demonstrate to the auditors where and how they access all the policies and procedures, they lacked the fundamental working knowledge of these policies and procedures.

Prior to the onsite audit, the HPS I-auditor reviewed the monitoring logs and came to the conclusion that the Chronic Care monitoring log was inaccurate. While onsite the HPS I-auditors met with the medical staff who were responsible to complete the monitoring logs. The staff was confused as to how to complete the chronic care monitoring log which resulted in providing incorrect and incomplete data to PPCMU. The staff was not aware of the facility having received the updated monitoring logs and the monitoring log user guide that was sent via email by CCHCS staff on July 1, 2014. It was learned that none of this information had been disseminated to the FCC medical staff for their use. The current HSA had no knowledge of the updated monitoring log and the information was subsequently provided to the HSA via email during the audit. The HSA agreed to review the monitoring logs and user guide and conduct training for all medical staff that are responsible to input information into the monitoring logs.

The HPS I-auditors found 8 health care employees that had not been trained on IMSP&P guidelines. The administrative clerk is responsible for tracking and documenting training information for all medical staff. But when the auditor requested the administrative clerk to provide the log for review, she was unable to produce any log or documentation associated with licensing or training of medical staff and stated that the facility training coordinator was responsible for tracking medical staff training. When the training coordinator was interviewed by the auditors, she stated that she was responsible only for providing and tracking training for custody staff. When apprised, the HSA and the Quality Assurance officer informed the auditor that the administrative clerk was in fact responsible for tracking all medical staffs' licensure and training. This further reinforced the auditors' observations regarding the facility's failure to train staff on their assigned job duties. The HPS I-auditor discussed this discrepancy with the HSA and the Quality Assurance officer. Both of them agreed to educate the assigned staff regarding their responsibilities to document and track training for all medical staff. There appears to be a complete breakdown in job duty definitions in all classifications.

Because FCC has undergone frequent changes in medical staffing during the past several months, the auditors recommended to the HSA and RND that the appeals log, license and training and monitoring logs be placed on the facility's shared drive for easy access. The audit team also recommended to the RND that she provide cross training to all existing medical and administrative staff on tracking and maintenance of all logs. The RND stated that this will be made an immediate priority and will ensure that these logs are saved in the shared drive for easy accessibility.

The nurse auditor observed several inmate-patient sick call appointments, observed medication pill passes and interviewed various medical staff. Below are the nurse auditor's observations:

While conducting the onsite audit, the nurse-auditor verified that FCC's medical clinics had all the required medical equipment and that the medical staff were checking all the equipment for operational readiness. All logs were complete and all equipment is being checked on all shifts. The nurse-auditor found the emergency response bag was missing one item; the missing item was ammonia ampoules. Overall, the nurse-auditor was very impressed with the organization of the emergency response bag at FCC, she recommended the CQI nurse go to other CCA facilities and train their nurse on how to properly organize the emergency response bags.

The nurse auditor reviewed the CQI meeting minutes from the previous quarter and concluded that the meeting minutes included a detailed analysis of opportunities for improvement, including a thorough analysis of each identified problem. The CQI meeting minutes included corrective actions plans, the completion date and assigned the staff responsible for implementing the corrective action plan. The nurse-auditor did find that the CQI meeting minutes failed to establish a quorum. The HSA stated that this would be corrected at the next CQI meeting.

During the onsite audit the nurse-auditor was unable to see any inmate-patient encounters that related to off-site specialty care or initial intake. However, she did observe nursing staff conducting sick call appointments in the medical clinics. Sick call appointments were conducted efficiently and effectively and all nursing protocols were adhered to. The nurse-auditor did express concern for the nursing staff conducting sick call in the ASU. As previously stated in the quantitative section, inmate-patients who are housed in ASU, that require sick call services are assessed inside their cells. This is a clear violation of CCHCS guideline as stated in the quantitative section under *Chapter 18: Sick Call*. Not only is this a violation of CCHCS policy, it is a recipe for disaster. CCA must reexamine their policy/practice of allowing RN's to enter the cell of an unrestrained inmate-patient for the purpose of a face to face assessment. While in the ASU the nurse-auditor observed the ASU inmate-patients being escorted to the medical clinic to be assessed by the facility physician and Nurse Practitioner. It was clearly stated at the exit conference that there should not be delineation between a nurse's role and physician/nurse practitioner's role, as they are all providing medical care to the inmate-patient population. The nurse-auditor expressed her disapproval about the RNs being required to conduct face to face in cell assessments in the ASU. There appears to be a double standard as the ASU inmate-patients were brought to the medical clinic for physician and NP appointments. The facility management could not provide an explanation to justify this requirement. However, the Quality Assessment officer stated that he would look at the schematics of the ASU and see if a medical clinic could be built. While this may be a long term solution, it does address the imminent requirement to halt to this unsafe practice. CCA must provide the appropriate clinical space creating a safe environment for the RN to conduct their face to face triaging of ASU inmate-patients.

The nurse-auditor discovered that personal protective equipment (PPE) is not available for use in the ASU unit. The HSA stated that he would order the appropriate PPE equipment for the ASU unit. While in the clinics, the nurse-auditor observed the medical staff to be practicing universal/standard precautions for hand hygiene between each inmate-patient encounter. However, the nurse- auditor found no clinics logs for cleaning of "high touch surfaces." The Main clinic is operational seven days a week; there is no documentation of the clinic being cleaned. The nurse-auditor did observe an inmate-porter cleaning the high traffic areas on the days the audit team were onsite. FCC staff stated that since FCC has inmates from multiple agencies, they cannot have other inmates be in contact with a CDCR inmate while cleaning the clinic. The HSA stated that he would ensure logs are created in all medical clinics.

The nurse-auditor observed two medication pill passes. She observed nursing staff preparing the medication to administer to the inmate-patient on the same day. During the medication pass the nurse-auditor observed the nurses placing medication directly into the inmate-patients hand, subsequently she observed on three instances the medication rolling out of the inmate-patients hand and fall to the floor. The nurse-auditor indicated to the local staff that this is not a standard practice for administration of medication and proceeded to educate the nurses that medication should be given to the inmate-patients in a medication cup. The nurse-auditor observed the nurses documenting all medication encounters on the inmate-patients medication administration record (MAR). When the nurse-auditor inquired about how FCC documents medication errors, nursing staff stated that they were using an

Incident report to document all errors. The nurse-auditor advised the HSA that he should implement the use of a Medication Error reporting system, which he agreed to implement immediately.

During the pill call line the nurse-auditor observed Licensed Practical Nurse (LPN) dispensing multiple over-the-counter (OTC) medications to inmate-patients, who had a physician's order for the medication. The LPNs are labeling the OTC medication bubble cards with the inmate-patient's name, name of medication, dosage and frequency. This practice is outside the scope of LPN. Upon advisement the HSA stated that he would look into this issue and make the appropriate adjustments.

Emergency Response: The audit team reviewed Emergency Response Review Committee (EMRRC) minutes for the previous quarter, October, November and December. The meeting minutes indicates all response times were within policy. Upon review of the EMRRC supporting documents for the emergency drill dated October 9, 2014, it revealed a 40 minute delay in transporting the patient from FCC to a community hospital emergency room. The delay was not identified and a corrective action plan was not initiated. The nurse-auditor discussed this delay with the HSA and the CQI nurse and advised them to document any corrective actions taken and submit the corrective action plan to the EMRRC at the January meeting. The CQI nurse acknowledged this recommendation and she would make the correction. In addition, current EMRCC minutes reflect the same scenarios are emulated on a monthly basis. To avoid over-familiarization and complacency the nurse auditor recommended varying the scenarios and conduct future emergency response drills in various locations at the facility. The CQI nurse agreed to start varying the scenarios.

While interviewing the Nurse Practitioner the physician-auditor observed officers and nursing staff running past the clinic door. The physician-auditor stepped outside of the clinic to find a drill taking place. It took staff 2 minutes and 11 seconds to assemble at the housing unit. The drill was called off after officers went inside the housing area. It was the observation of the physician-advisor that FCC Staff are accustomed to the same reoccurring emergency situations and therefore demonstrate a lack of realism.

Prior CAP Resolution:

Although the majority of the CAP items from the previous audit we found resolved, some items were not. The facility will take ownership in resolving these items and continue to monitor their progress toward improvement. The facilities advancement toward resolution of the previous audit's CAP items are summarized below:

1. *The facility does not perform a comprehensive analysis for each identified "opportunity for improvement" as listed in the Aspects of Care Monitoring form or similar form.* During the May 2014 audit, auditors found 0.0% compliance. The facility's CAP indicated that the HSA would provide training to the CQI nurse on how to properly complete the comprehensive analysis for each "opportunity for improvement" as listed in the Aspects of Care Monitoring form. The audit team found that the corrective action taken by FCC to resolve this issue has had the desired affect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.

2. *The documented action and follow-up plan for each identified "opportunity for Improvement" does not describe the plan in detail.* During the May 2014 audit, auditors found 0.0% compliance. The facility's CAP indicated that the Clinical Nurse Supervisor will conduct training with the CQI nurse on how to properly complete the Aspects of Care report. The audit team found that the corrective action taken by FCC to resolve this issue has had the desired affect and

the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.

3. *The LIP(s) do not review, initial and date inmate-patients diagnostic reports within 2 days of receipt.* During the May 2014 audit, auditors found 50.0% compliance. This facility's CAP indicated that all providers will receive training on the initialing and dating of diagnostic service reports. The CQI nurse will receive all copies of labs and verify that all labs have been signed and reviewed by a provider. The audit team found that the corrective action taken by FCC to resolve this issue has had the desired affect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.

4. *Inmate-patients are not given written notification of diagnostic report within 2 days of receipt.* During the May 2014 audit, auditors found 0.0% compliance. The facility's CAP indicated that all providers will receive training on reviewing diagnostic reports and provide written notification to inmate-patients within two days. The audit team found that the corrective action taken by FCC to this issue has had the desired affect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.

5. *The LIP did not document that they explained the newly prescribed medication to the inmate-patient.* During the May 2014 audit, auditors found 83.3% compliance. The facility's CAP indicated that all LIP's would be trained on how to properly document all newly prescribed medications to inmate-patients. The CQI nurse will review 100% of new medication orders to ensure that the new medication orders have been documented. In addition, the HSA will meet with the CQI nurse monthly to report on the compliance rate. The audit team found that the corrective action taken by FCC to remedy this issue has not had the desired affect and the facility's compliance fell drastically 23.3% compliance. This corrective item is unresolved and will continue to be the subject of monitoring during subsequent audits.

6. *If an inmate-patient refused a health care appointment/treatment, the RN/LIP did not document their discussion with the inmate about the risk and benefits of refusing the appointment/treatment, in the Progress Notes section of the inmate-patient's Electronic Medical Record.* During the May 2014 audit, auditors found 80.0% compliance. The facility's CAP indicated that the Clinical Nurse Supervisor would conduct training with all RN/LIP's on the process of documentation on the discussions about the risks of refusing appointments/treatment. The CQI nurse will be given 100% of all refusals daily for review of RN signature and documentation on the refusal form and progress notes, if risk and benefits are not documented on the progress note the CQI nurse will schedule that inmate-patient for a sick call appointment. The audit team found that the correction action taken by FCC to this issue has had the desired affect and the facility has improved in this area and received 100% compliance. This corrective action is considered to have been effective and this issue is resolved.

7. *Inmate-patients were not seen within the ordered timeframe when referred for follow-up by the LIP.* During the May 2014 audit, auditors found 66.7% compliance. The facility's CAP indicated that all providers and nursing staff would be instructed on how to enter referrals and follow-up in the Allscripts. Also, an RN will go through the work list of inmate-patient requiring a follow-up appointment and have appointments scheduled within the specified timeframe. The audit team found that the corrective action taken by FCC to remedy this issue has improved in this area and

received 90.0% compliance. Even though this action item had improved, it remains a CAP item since the Chapter has failed.

8. *The RN did not document their review of the inmate-patient discharge plan when the inmate-patient was discharged from a community hospital.* During the May 2014 audit, auditors found 50.0% compliance. The facility's CAP indicated that all RN's will received training on reviewing the inmate-patients discharge plan when inmate-patients are discharged from a community hospital. The CQI nurse will also review 100% of inmate-patients discharge plans and chart in the progress notes. The audit team could not close this corrective action as there were no inmate-patients that were admitted to a community hospital as a result of a specialty care appointment. Therefore, this issue is unresolved and will continue to be subject to monitoring during subsequent audits.

9. *A multidisciplinary review (medical and pharmacy) shall be completed to ensure current practices of pill pass during facility lockdowns and the policies and procedures meet the required Patient Bill of Rights for medical administration.* During the May 2014 auditor, the nurse-auditor found that the pill pass took over three hours to conduct when the facility was on lockdown. The facility's CAP indicated that the facility pill pass has been moved to 0800 and 2000 hours. The nurse-auditor observed pill passes and found that the facility has improved in this area. This corrective is considered to have been effective and this issue is considered resolved.

New CAP Issues:

New quantitative and qualitative CAP items are fully discussed where necessary in the comments section of the relevant section(s) of this report. There is one new qualitative CAP item that requires further detail:

1. *FCC shall implement a contract with a local pharmacy to procure prescription medications for CDCR inmate-patients housed at their facility.* During the December 2014, the auditors discovered that FCC utilizes Diamond pharmacy for their medication orders, which delays inmate-patients from receiving medications. However, FCC stated that they have "stock" medications for inmate-patients. FCC is required to administer prescription medications to inmate-patients in a timely manner. Therefore, FCC shall enter into a contract with a local pharmacy to remedy this CAP item. This is a new CAP item, Qualitative Action Item #7.

Conclusion: The audit revealed that FCC is struggling to provide constitutional health care as it relates to chronic care, medication management and sick call for CDCR inmate-patients that are housed at this facility. Since the previous audit in May 2014, the overall compliance score decreased from 96.4% to 92.5%. Poor performance scores in several areas is a direct result of incomplete documentation; where as in other areas, lack of training and knowledge of IMSP&P and FCC policy and procedures specific to the delivery of medical services is the driving force and requires immediate improvement.

FCC's inability to meet the CCHCS guidelines for accessible constitutional health care for inmate-patients, which is outlined in Volume IV and VII of the Inmate Medical Services Policies and Procedures, requires immediate attention.

> *"Each CDCR Form 7362 requesting medical services for symptoms shall be reviewed each day by the RN. The RN shall establish medical priorities on an emergent or non-emergent basis. If there is no RN in the clinic, the Director of Nursing, or designee, shall be notified to provide direction.*

i. *Inmate-patients with emergent health care needs shall be seen by an RN, mental health clinician, and/or dentist immediately to establish disposition.*
ii. *Inmate-patients with non-emergent medical needs shall be seen by an RN on the following business day for a face-to-face RN triage.*
iii. *Inmate-patients with non-emergent mental health or dental* needs shall be seen in a time frame consistent with established program guidelines."

"Medications *prescribed shall be available the next business day unless otherwise ordered (e.g., order specifies medication to start today). Providers may order medications STAT or order them to begin at a specified future date as appropriate."*

"Patients arriving in the Receiving and Release (R&R) area from a site other than a CDCR institution who are on essential prescription medications shall be seen by a Primary Care Provider (PCP) AND Psychiatrist when indicated, or have their prescription medications ordered within eight (8) hours of arrival to prevent any interruption in treatment. The goal is to administer the medication by the next dosing interval so to avoid a missed dose. (For many, the next scheduled dose may not be until the next day.)"

The current audit reveals that FCC is currently not meeting any of the requirements stated above and the documentation to support proof of practice is inconsistent and inadequate. The audit team explained the importance of staff training, scheduling inmate-patients for sick call appointments and to implement an efficient system for the tracking of medication orders.

FCC must continue to work conscientiously to improve the identified deficiencies. FCC must improve on the quality of medical services being provided to the CDCR inmate-patient population housed at this facility.

STAFFING UTILIZATION

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

A review of the health care staff positions for the week of the audit, December 8, 2014 through December 12, 2014, revealed no vacancies during this audit period. The following table is a summary of the staffing and findings of the review.

Florence, AZ/CDCR Total Population: 599

Primary Care	Original Contract FTE	Current Required FTE	Variance
Senior Physician	0.0	0.0	-
Physician	1.0	1.0	-
ARNP/PA	1.0	1.0	
ARNP/PA (contract)	0.0	0.0	-
Total Primary Care	**2.0**	**2.0**	**0.0**
CCA Management			
Deputy Director / Senior Health Services Administrator	0.0	0.0	-
Health Services Administrator	1.0	1.0	-
Clinical Supervisor	1.0	1.0	-
Total CCA Management	**2.0**	**2.0**	**0.0**
Nursing Services			
Staff RN (7 day)	4.0	10.0	6.0
Staff RN (5day)	0.0	0.0	-
RN-CQI	0.0	0.0	-
Coordinator, Infectious Disease	0.0	0.0	-
RN Total	**4.0**	**10.0**	**6.0**
LPN's			
Staff LPN/LVN (5 day)	0.0	0.0	
Staff LPN/LVN (7 day)	16.0	16.0	-
Pharmacy Tech/LPN	[1.0]	[1.0]	-
LPN Health Information Specialist	[1.0]	[1.0]	-
Phlebotomist	[1.0]	[1.0]	-
CMA	3.0	3.0	-
LPN Total	**16.0**	**16.0**	**0.0**
Total Nursing	**20.0**	**26.0**	**6.0**

INMATE INTERVIEWS

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

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

Chapter 21: Inmate Interviews (not rated)

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

COMMENTS

CCHCS staff interviewed four randomly selected inmate-patients during this onsite audit.

1. Questions 1 through 8 - No negative responses.
2. Questions 9 through 24 – Not applicable. There were no inmate-patients with qualifying disabilities at FCC during the audit review period.

Florence Correctional Center
Health Care Monitoring Audit - Corrective Action Plan
Audit Dates: December 10-11, 2014
CAP Date: March 19, 2015

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Reference Chap/Q		Specific Nature of Non-Compliance	Facility's Proposed Action Plan	Anticipated Completion Date	Assigned Personnel	Action Plan Status
5	1	Inmate-patients chronic care follow-up visits are not consistently completed within the 90-day or less timeframe, or as ordered by the Licensed Independent Provider (LIP).				Not Completed / In Progress / Completed [DATE]
5	2	The LIP is not consistently providing health care education to inmate-patients regarding their chronic care condition during the last chronic care follow-up visit.				Not Completed / In Progress / Completed [DATE]
6	2	The facility Continuous Quality Improvement (CQI) Committee Meeting minutes do not establish whether a quorum was met per the approved CQI plan.				Not Completed / In Progress / Completed [DATE]
14	1	Inmate-patients are not consistently administered their medications as ordered by the LIP.				Not Completed / In Progress / Completed [DATE]
14	2	Documentation is not consistent in the medical record to support that the LIP explained newly prescribed medications to the inmate-patients.				Not Completed / In Progress / Completed [DATE]
14	8	Medication errors are not being documented on the Incident Report Medication Error Form.				Not Completed / In Progress / Completed [DATE]
15	1	The *Sick Call monitoring* log did not consistently document that the inmate-patients were seen in within the specified timeframes set forth in the Sick Call policy.				Not Completed / In Progress / Completed [DATE]

Reference Chap/Q		Specific Nature of Non-Compliance	Facility's Proposed Action Plan	Anticipated Completion Date	Assigned Personnel	Action Plan Status
15	4	The facility submits chronic care monitoring logs with incomplete data.				Not Completed / In Progress / Completed [DATE]
15	5	The *Initial Health Appraisal Monitoring log* did not consistently document that the inmate-patients received an initial health appraisal within 14 calendar days of arrival.				Not Completed / In Progress / Completed [DATE]
18	2	Nursing staff is not consistently reviewing the sick call forms within one business day of receipt. This CAP item remains unresolved from the previous audit.				Not Completed / In Progress / Completed [DATE]
18	3	Inmate-patients submitting sick call requests with an emergent health care need are not consistently seen or evaluated face-to-face by a registered nurse (RN)/LIP.				Not Completed / In Progress / Completed [DATE]
18	4	Inmate-patients are not consistently being seen and evaluated by an RN/LIP within the specified timeframe when the sick call request indicates a non-emergent health care need.				Not Completed / In Progress / Completed [DATE]
18	5	RN/LIP's are not consistently following the Patient Care Protocol to address inmate-patient's chief complaints nor are they documenting the chief complaint in the Progress Note section of the sick call request form.				Not Completed / In Progress / Completed [DATE]
18	6	The facility RNs are not consistently completing the Subjective- Objective-Assessment-Plan-Education (S.O.A.P.E.) section of the Patient Care Protocol/Progress notes on inmate-patient sick call encounters.				Not Completed / In Progress / Completed [DATE]
18	8	When inmate-patients are referred for a follow-up appointment by the LIP, they are not consistently seen within the specified timeframe.				Not Completed / In Progress / Completed [DATE]

Reference Chap/Q		Specific Nature of Non-Compliance	Facility's Proposed Action Plan	Anticipated Completion Date	Assigned Personnel	Action Plan Status
18	10	The Administrative Segregation Unit (ASU) does not have an area where inmate-patients can be medically evaluated with confidentiality.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #1		The Emergency Response Review Committee does not discuss or implement a quality improvement plan after they review the results from an emergency medical response/emergency medical response drill.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #2		The facility's medical staff do not have access to personal protective equipment in the ASU.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #3		Environmental cleaning of high touch surfaces are not being consistently documented in all medical clinics.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #4		During the Initial Intake Screening, RNs are not referring inmate-patients to the LIP for a follow-up chronic care appointment if the inmate-patients were previously enrolled in Chronic Care Clinic.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #5		The facility does not have a system in place ensuring that health care staff receive training for new or revised policies, which are based on Inmate Medical Services Policies and Procedures.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #6		The facility RNs are not notifying the LIP of the medication orders and follow-up instructions when inmate-patients return from a specialty care appointment.				Not Completed / In Progress / Completed [DATE]
Qualitative Action Item #7		FCC shall implement a contract with a local pharmacy to procure prescription medications for CDCR inmate-patients housed at their facility.				Not Completed / In Progress / Completed [DATE]

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