September 7, 2016

Minga Wofford
McFarland Female Community Re-entry Facility
120 Taylor Street
McFarland, CA 93250

Dear Warden Wofford,

The staff from California Correctional Health Care Services (CCHCS) completed an onsite health care monitoring audit McFarland Female Community Re-entry Facility (FCRF) from June 7 through 9, 2016. The purpose of this audit was to ensure that FCRF is meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006.

On August 24, 2016, a draft report was sent to you providing the opportunity to review and dispute any findings presented in the draft report. On September 1, 2016, your facility submitted a response accepting the findings in the report.

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

The audit findings reveal that during the audit review period, FCRF failed to provide adequate health care to CDCR patients housed at the facility. The facility's continued struggle with internal monitoring, specifically as it relates to the completion of the weekly and monthly monitoring logs, maintenance of local operating policies and procedures, patient's access to care, chronic care management, diagnostic services, emergency services, medication management, infection control and facility's failure in conducting routine emergency medical response training drills and poor maintenance of the emergency medical response equipment, has resulted in impediments that prevented patients from receiving adequate level of care.

Additionally, the care provided by the facility's clinicians, namely the nursing staff and physician, was identified to be below the required standards due to the following deficiencies:

- Nursing staff's failure to follow Standard Nursing Protocols while rendering care to patients;
- Nursing staff's failure to effectively communicate with patients regarding their treatments;
- Incomplete nursing assessments of patients' symptoms;
- Incomplete and/or missing nursing documentation related to initial health screening, diagnostic tests, blood pressure checks, specialty care referrals, health care transfers, Tuberculosis symptom screening and administration of prescribed medications to the patients;

- Provider's failure in making accurate diagnoses of the patients' symptoms;
- Provider's practice of prescribing unnecessary tests and/or cultures without adequate clinical evidence to justify the need;
- Provider's injudicious practice of prescribing excessive medications and/or antibiotics for the patients in the absence of clinical symptoms to warrant such treatment;
- Provider's failure in effectively communicating with the patients regarding their clinical symptoms;
- Provider's failure to follow best practices and manufacturer's recommendations when ordering medications;

The abovementioned issues create major barriers in providing continuous and quality care to the patient population. These deficiencies require the facility's immediate attention and resolution and can be brought to compliance by the facility's strict adherence to the established policies and procedures outlined in the *Inmate Medical Services Policies and Procedures*, contract, and the standard nursing and physician practice.

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

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

Enclosure

cc: John Dovey, Director, Corrections Services, CCHCS
Joseph W. Moss, Chief, Contract Beds Unit (CBU), California Out of State Correctional Facility (COCF), Division of Adult Institutions (DAI), California Department of Corrections and Rehabilitation (CDCR)
Michael J. Williams, Chief Deputy Administrator, CBU, COCF, DAI, CDCR
Kerry Oglesby, Chief Executive Officer, Central California Women's Facility, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT

Female Community Re-entry Facility, McFarland

June 7 – 9, 2016

TABLE OF CONTENTS

DATE OF REPORT

September 7, 2016

INTRODUCTION

As a result of an increasing patient population and a limited capacity to house patients, the California Department of Corrections and Rehabilitation (CDCR) entered into contractual agreements with private prison vendors to house California patients. Although these patients are housed in a contracted facility, either in or out-of-state, the Private Prison Compliance and Monitoring Unit (PPCMU) within 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, PPCMU staff developed a tool to evaluate the effectiveness, efficiency and compliance of the health care processes implemented at each contracted facility to facilitate patient access to health care. This audit instrument is intended to measure the facility's compliance with various elements of patient access to health care and to assess the quality of health care services provided to the patient population housed in these facilities.

This report provides the findings associated with the onsite audit conducted between June 7 and 9, 2016, at the Female Community Re-entry Facility (FCRF), located in McFarland, California, as well as findings associated with the review of various documents and patient medical records for the review period of November 2015 through April 2016. At the time of the audit, CDCR's *Weekly Population Count*, dated June 3, 2016, indicated a budgeted bed capacity of 300 beds, of which 214 were occupied with CDCR patients.

EXECUTIVE SUMMARY

From June 7 through 9, 2016, the CCHCS audit team conducted an onsite health care monitoring audit at FCRF. The audit team consisted of the following personnel:

Bruce Barnett, MD, JD, MBA, CCHP, Chief Medical Consultant
Luzviminda Pareja, Nurse Consultant, Program Review
Kala Srinivasan, Health Program Specialist I

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

PPCMU rates each of the operational areas based on case reviews conducted by CCHCS physicians and registered nurses, medical record reviews conducted by registered nurses, and onsite reviews conducted by CCHCS physician, registered nurse, and Health Program Specialist I auditors. The ratings

for every applicable indicator may be derived from the clinical case review results alone, the medical record and/or onsite audit results alone, or a combination of both of these information sources (as shown in the *Executive Summary Table* below).

Based on the quantitative reviews and clinical case reviews completed for the 15 operational areas/quality indicators during the audit, FCRF achieved an overall point value of ***0.5*** which resulted in an overall audit rating of ***inadequate***.

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

Executive Summary Table

Operational Area/Quality Indicator	Case Review Rating	Quantitative Review Score	Quantitative Review Rating	Overall Indicator Rating	Points Scored
1. Administrative Operations	N/A	79.3%	Inadequate	Inadequate	0
2. Internal Monitoring & QM	N/A	85.5%	Adequate	Adequate	1
3. Licensing/Certification, Training & Staffing	N/A	100.0%	Proficient	Proficient	2
4. Access to Care	Inadequate	95.4%	Proficient	Inadequate	0
5. Chronic Care Management	Adequate	93.8%	Proficient	Adequate	1
6. Community Hospital Discharge	N/A	N/A	N/A	N/A	N/A
7. Diagnostic Services	Inadequate	95.8%	Proficient	Adequate	1
8. Emergency Services	Adequate	N/A	N/A	Adequate	1
9. Health Appraisal/Health Care Transfer	Inadequate	85.7%	Adequate	Inadequate	0
10. Medication Management	Inadequate	93.8%	Proficient	Inadequate	0
11. Observation Cells	N/A	N/A	N/A	N/A	N/A
12. Specialty Services	Adequate	100.0%	Proficient	Adequate	1
13. Preventive Services	N/A	66.7%	Inadequate	Inadequate	0
14. Emergency Medical Response/Drills & Equipment	N/A	61.7%	Inadequate	Inadequate	0
15. Clinical Environment	N/A	85.9%	Adequate	Adequate	1
16. Quality of Nursing Performance	Inadequate	N/A	N/A	Inadequate	0
17. Quality of Provider Performance	Inadequate	N/A	N/A	Inadequate	0
				Average	0.5
				Overall Audit Rating	Inadequate

NOTE: For specific information regarding any non-compliance findings indicated in the tables above, please refer to the Identification of Critical Issues (located on page 11 of this report), or to the detailed audit findings by quality indicator (located on pages 13 through 60) sections of this report.

BACKGROUND AND PROCESS CHANGES

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

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

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

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

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

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

Additionally, a clinical case review section has been added to the audit process. This will help PPCMU to better assess and evaluate the timeliness and quality of care provided by nurses and physicians at the

contract facilities. The ratings obtained from these reviews will be utilized to determine the facility's overall performance for all *medical quality indicators* section. The resulting quality ratings from the case reviews will be incorporated with the quantitative review ratings to arrive at the overall audit rating and will serve as the sole decisive factor for determining compliance for some of the operational areas whereas for some of the other operational areas, case review ratings will play a dominant role in determining the overall compliance.

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

Quantitative Review

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

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

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

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

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

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

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

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

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

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

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

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

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

Qualitative Review

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

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

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

1. *Nurse Case Review*
   The CCHCS registered nurses perform two types of case reviews:

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

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

2. *Physician Case Review*
   The CCHCS physician completes a detailed retrospective review of 15 patient health records in order to evaluate the quality and timeliness of care provided to the patient population housed at that facility.

Overall Quality Indicator Rating

The overall quality of care provided in each health care operational area (or chapter) is determined by reviewing the rating obtained from clinical case reviews and the ratings obtained from quantitative

review. The final outcome for each operational area is based on the critical nature of the deficiencies identified during the case reviews and the standards that were identified deficient in the quantitative review. For all those chapters under the *Medical Quality Indicator* section, whose compliance is evaluated utilizing both quantitative and clinical case reviews, more weight is assigned to the rating results from the clinical case reviews, as it directly relates to the health care provided to patients. However, the overall quality rating for each operational area is not determined by clinical case reviews alone. This is determined on a case by case basis by evaluating the deficiencies identified and their direct impact on the overall health care delivery at the facility. The physician and nurse auditors discuss the ratings obtained as a result of their case reviews and ratings obtained from quantitative review to arrive at the overall rating for each operational area.

Based on the collective results of the case reviews and quantitative reviews, each quality indicator is rated as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*.

Overall Audit Rating

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

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

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

- **Proficient** - Since the cut-off value for a proficient rating in the quantitative review is 90.0% and the highest available point value for quality rating is 2.0, the threshold value range is calculated by multiplying the highest available points by 90.0%, which is: 2.0 X 90.0% = 1.8. This value is a *constant* and has been determined to be the minimum value required to achieve a rating of *proficient.* Therefore, any overall score/value of 1.8 or higher will be rated as *proficient*. This is designed to mirror the performance standard established in the quantitative review (i.e., 90.0% of the maximum available point value of 2.0).

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

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

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

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

Scoring for Non-Applicable Questions and Double-Failures:

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

Resolution of Critical Issues

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

IDENTIFICATION OF CRITICAL ISSUES

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

Critical Issues – McFarland Female Community Re-entry Facility	
Question 1.2	The facility's local operating procedures/policies are not all in compliance with the *Inmate Medical Services Policies and Procedures*.
Question 1.4	The facility's patient orientation handbook does not provide all details on the health care grievance/appeal process.
Question 1.5	The facility's health care staff do not log-on to the CDCR's electronic Unit Health Record once every 30 days to maintain their access current.
Question 2.1	The facility does not consistently hold a Quality Management Committee meeting a minimum of once per month.
Question 2.4	The facility does not consistently submit the weekly and monthly monitoring logs by the required scheduled dates.
Question 2.5	The facility does not accurately document all the dates on the sick call monitoring log.
Question 2.6	The facility does not accurately document all the dates on the specialty care monitoring log.
Question 2.8	The facility does not accurately document all the dates on the chronic care monitoring log.
Question 2.9	The facility does not accurately document all the dates on the initial intake screening monitoring log.
Question 4.5	The registered nurses (RN) do not consistently complete a focused subjective/objective assessment based on the patient's chief complaint.
Question 4.8	The registered nurses do not consistently document that effective communication was established and education was provided to the patient related to the treatment plan.
Question 5.2	The patient's chronic care medications are not consistently received by the patient without interruption.
Question 9.2	The registered nurses do not consistently document an assessment of the patient if the patient answered "yes" to any of the medical problems listed on the *Initial Health Screening* form.
Question 9.10	The patients arriving at the facility with existing medication orders do not consistently receive their prescribed medications timely.
Question 10.5	The medication nurse does not consistently perform a "cup check" when administering Directly Observed Therapy (DOT) medications to the patients.
Question 13.3	The facility does not monitor the patient monthly while the patient is on the anti-Tuberculosis medication.

Question 14.1	The facility does not conduct emergency medical response drills quarterly on each shift.
Question 14.4	The facility does not consistently hold an Emergency Medical Response Review Committee (EMRRC) meeting a minimum of once per month.
Question 14.5	The incident packages, submitted to EMRRC for review, do not include all the required documents and forms.
Question 14.7	The facility's emergency medical response bag is not consistently re-supplied and re-sealed before the end of the shift, if the emergency medical response and/or drill warranted an opening of the bag.
Question 14.8	The facility's emergency medical response bag is not consistently inventoried monthly if it has not been used for emergency medical response and/or drill.
Question 14.9	The facility's emergency medical response bag did not include the items as listed on the facility's Emergency Medical Response Bag Checklist.
Question 15.8	The facility does not consistently complete environmental cleaning of common clinic areas with high foot traffic at least once a day.
Question 15.10	The facility clinic's biohazard waste is not stored securely in the centralized location and the storage area is not labeled as a "biohazard" area.
Question 15.13	The facility's health care staff do not consistently account for and reconcile all sharps at the beginning and end of each shift.
Question 15.16	One of the facility clinic's exam rooms does not have essential core medical equipment.

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

AUDIT FINDINGS – DETAILED BY QUALITY INDICATOR

1. ADMINISTRATIVE OPERATIONS

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
79.3% [*Inadequate*]
Overall Rating:
Inadequate

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

The facility received a compliance score of 79.3% in the *Administrative Operations* indicator, equating to the overall rating of *inadequate*. Ten out of fifteen of the facility's policies and LOPs were not in compliance with IMSP&P guidelines. The facility failed to update their policies to meet the current requirements stated in the IMSP&P even though they had been notified about the revisions during the meeting between Field Operations and facility management held on October 1, 2015. It should be noted that one of the facility's LOPs, *901b- Aids to Impairment,* was copied directly from the IMSP&P and many areas were not specifically related to FCRF's actual operating procedures. This issue was addressed during the audit and the auditors admonished the facility staff due to their failure in updating their local operating procedures; the auditors informed the facility management that their current practices were unacceptable and it is mandatory that they update FCRF's policies to make them specific to the facility's local operating procedures, while at the same time ensuring they are in compliance with IMSP&P guidelines and requirements. The facility's inmate handbook does not state all details regarding the health grievance and appeal process. First identified as a critical issue during the February 2015 audit, the facility continued to be non-compliant with this requirement during the Corrective Action Plan Review that was conducted on November 4, 2015. During the current audit, it was identified that two out of five registered nurses (RNs) had failed to access the CDCR's Electronic Unit Health Record (eUHR) during the audit review period. As a result, those RNs lost their access to the eUHR potentially impacting care provided to patients. Currently all staff have access to the eUHR and Electronic Health Record System (EHRS), CDCR's new electronic medical record system, which is being utilized by the facility's hub, Central California Women's Facility (CCWF), since October 2015.

Quantitative Review Results

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

Administrative Operations		Yes	No	Compliance
1.1	Does health care staff have access to the facility's health care policies and procedures and know how to access them?	7	0	100%
1.2	Does the facility have written health care policies and/or procedures that are in compliance with *Inmate Medical Services Policies and Procedures* guidelines?	5	10	33.3%
1.3	Does the facility have current contracts/agreements for routine oxygen tank maintenance service, hazardous waste removal, and repair, maintenance, inspection, and testing of biomedical equipment?	3	0	100%
1.4	Does the patient orientation handbook/manual or similar document explain the sick call and health care grievance/appeal processes?	1	1	50.0%
1.5	Does the facility's health care staff access the California Correctional Health Care Services patient's electronic medical record?	5	2	71.4%
1.6	Does the facility maintain a Release of Information log that contains all the required data fields?	1	0	100%
1.7	Are all patients' written requests for health care information documented on a CDCR Form 7385, *Authorization for Release of Information*, and scanned/filed into the patient's medical record?	20	0	100%
1.8	Are all written requests from third parties for release of patient medical information accompanied by a CDCR Form 7385, *Authorization for Release of Information*, from the patient and scanned/filed into the patient's medical record?	Not Applicable		
	Overall Quantitative Review Score:			**79.3%**

Comments:

1. Question 1.2 – Of the 15 LOPs reviewed, 10 were found not in compliance with IMSP&P guidelines. Specifically, policies related to *Maintenance/Management of Patient Medical Records, Release of Medical Information, Access to Care, Chronic Care, Emergency Medical Response & Drills, Health Appraisal / Health Care Transfer Process, Infection Control Plan, Medication Management, Specialty Services and Quality Management Program.* This equates to 33.3% compliance. The following deficiencies were identified within the aforementioned policies:

   - *Maintenance/Management of Patient Medical Records* – The LOP does not address if the treating physician will have access to the patient's Electronic Health Records System (EHRS) and if the facility sends the originals of all documents generated at the facility to the hub (CCWF) to be scanned into the EHRS. Additionally, the LOP does not state if the health care staff signs into the EHRS system a minimum of once monthly in order to maintain their access to their accounts.
   - *Release of Medical Information* – The facility's LOP states that the Unit Health Record is maintained at the facility. This is not accurate, since the current process requires all modified community correctional facilities to maintain shadow files for all patients, sending the original documents generated at the facility to the hub institution for scanning into the eUHR/EHRS within 2-3 days from the date documents were created.
   - *Access to Care* – FCRF's LOP does not describe the daily process for collection of sick call requests. Additionally, the policy states that the RN conducts a paper triage within 24 hours or the next business day after the sick call slips are collected, which is contrary to the IMSP&P that requires the sick call slips to be triaged by the RN on the same day they are collected.
   - *Chronic Care Program* – The policy states that Health Services Administrator (HSA) is responsible for administering chronic care services instead of stating the Primary Care Provider (PCP) is responsible

for administering chronic care services. Additionally, there are no details regarding the facility's process for administration of chronic care medications; the LOP only states that "medications are monitored every 90 days or less".

- *Health Appraisal / Health Care Transfer Process* – The facility's LOP does not address any details regarding the Initial Intake Screening or Health Appraisal processes. Additionally, the LOP states that HSA will determine if a patient is to be transferred out of the facility, which is contrary to the IMSP&P that requires the PCP to determine all transfers.
- *Medication Management* – The LOP does not state the time frames for administration of non-urgent new prescription medications or non-urgent renewed prescription medications. The current LOP also does not address the details regarding the facility's process for distribution of Keep on Person (KOP) medications, administration of Directly Observed Therapy (DOT) medications and documentation in the Medication Administration Record (MAR).
- *Specialty Services* – FCRF's LOP states the patient will complete a CDCR 7219, *Request for Health Services* Form. The identified CDCR form number documented in the LOP is incorrect. The patient is required to fill out a CDCR 7362 form; CDCR 7219 is *Medical Report of Injury or Unusual Occurrence form*. Additionally, the LOP does not state the PCP is required to conduct a face-to-face (FTF) appointment with the patient and review the consultant's report upon the patient's return from the specialty services appointment.
- *Emergency Medical Response & Drills* – FCRF's LOP does not mention the mode of communication used by the facility during emergencies and methods employed by the facility to obtain emergency medical services transportation. The facility also fails to state in their LOP that the PCP is required to have a current Advanced Cardiac Life Support (ACLS) certification and all the other health care staff and custody staff are required to have a current Basic Life Support (BLS) certification.
- *Infection Control Plan* – The LOP does not state if sterilized re-usable instruments are packaged with the expiration date on the packaging.
- *Quality Management Program* – The FCRF's LOP states the Quality Management Committee (QMC) meetings are to be held "once per quarter", which is contrary to the IMSP&P that requires the facility to hold QMC meetings monthly. Additionally, although the LOP addresses the Emergency Medical Response Review Committee (EMRRC) meetings and states that all emergency forms are to be completed by staff following an emergency response, it does not specify that these documents are to be submitted to the EMRRC for review.

2. Question 1.4 – The facility's patient orientation handbook/manual does not provide a complete overview regarding the health care grievance/appeal process such as descriptions of the second level and the third level stages of the health care grievance/appeal process, the mailing addresses for submitting second and third level appeals and the processing times for the first, second and third level health care appeals. This equates to 50.0% compliance.
3. Question 1.5 – Based on the review of the *Contractor's Log-on Report* provided to PPCMU by CCHCS Information Technology staff, a total of five medical staff who had been provided access to the electronic Unit Health Record (eUHR) system, two RNs did not log-on or access the eUHR system at least once a month. One of the RN's eUHR accounts was created on October 16, 2015 and the staff member last logged in to eUHR on November 11, 2015. The other RN's eUHR account was created on April 22, 2016 and the staff member never logged in to eUHR until June 1, 2016. This equates to 71.4% compliance. It should be noted that all health care staff were provided access to the EHRS system during the time period of April-June 2016 and when requested by the auditor, all staff were able to log-on to the EHRS system.
4. Question 1.8 – Not Applicable. There were no third party requests for release of patient health care information received during the audit review period; therefore, this question could not be evaluated.

2. INTERNAL MONITORING & QUALITY MANAGEMENT

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
85.5% [*Adequate*]
Overall Rating:
Adequate

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

FCRF received a compliance score of 85.5% in the *Internal Monitoring and Quality Management* indicator, equating to an overall quality rating of ***adequate***. Seven of the thirteen questions assessed in this component scored in the *proficient* range (90% and above) and six questions scored in the *inadequate* range (below 85.0% compliance). Refer to the *Comments* section, following the table below, for additional details related to the deficiencies identified in this area.

Quantitative Review Results

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

Internal Monitoring & Quality Management		**Yes**	**No**	**Compliance**
2.1	Does the facility hold a Quality Management Committee a minimum of once per month?	5	1	83.3%
2.2	Does the Quality Management Committee's review process include documented corrective action plan for the identified opportunities for improvement?	5	0	100%
2.3	Does the Quality Management Committee's review process include monitoring of defined aspects of care?	5	0	100%
2.4	Does the facility submit all monitoring logs (sick call, specialty care, hospital stay/emergency department, chronic care and initial intake screening) by the scheduled date per Private Prison Compliance and Monitoring Unit program standards?	66	24	73.3%
2.5	Are the dates documented on the sick call monitoring log accurate?	32	20	61.5%
2.6	Are the dates documented on the specialty care monitoring log accurate?	23	10	69.7%

2.7	Are the dates documented on the hospital stay/emergency department monitoring log accurate?	14	0	100%
2.8	Are the dates documented on the chronic care monitoring log accurate?	37	23	61.7%
2.9	Are the dates documented on the initial intake screening monitoring log accurate?	37	23	61.7%
2.10	Are the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* readily available to patients in all housing units?	4	0	100%
2.11	Are patients able to submit the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* on a daily basis in all housing units?	4	0	100%
2.12	Does the facility maintain a CCHCS Health Care Appeals log and does the log contain all the required information?	1	0	100%
2.13	Are the first level health care appeals being processed within specified time frames?	18	0	100%
	Overall Quantitative Review Score:			**85.5%**

Comments:

1. Question 2.1 – Of the six QMC meetings required to be completed within the audit review period, the facility completed five meetings. The QMC meeting was not held in the month of November 2015. This equates to 83.3% compliance.
2. Question 2.4 – During the audit review period of November 2015 through April 2016, 90 submissions of monitoring logs were required. Of the 90 monitoring logs submitted, 66 were submitted on time. The weekly monitoring logs were not submitted on November 3, 10, 17 and December 8, 2015, February 16 & 23, March 15 and April 26, 2016. This equates to 73.3% compliance. See table below for additional information and details.

Type of Monitoring Log	Required Frequency of Submission	Number of Required Submissions for the Audit Review Period	Number of Timely Submissions	Number of Late Submissions
Sick Call	weekly	26	18	8
Specialty Care	weekly	26	18	8
Hospital Stay/Emergency Department	weekly	26	18	8
Chronic Care	monthly	6	6	0
Initial Intake Screening	monthly	6	6	0
	Totals:	**90**	**66**	**24**

3. Question 2.5 – A total of 52 entries were randomly selected from the weekly sick call monitoring logs to assess the accuracy of the dates reported on the log. Of the 52 entries reviewed, 32 were found to be accurate with dates matching the dates of service reflected in the patients' medical records. This equates to 61.5% compliance. Discrepancies identified within the remaining 20 entries were due to:
   - ❖ incorrect date of when the sick call request was received and reviewed (4 entries);
   - ❖ incorrect date documented of when the patient had a FTF appointment with the RN (3 entries);
   - ❖ incorrect date documented of when the patient had a FTF appointment with the PCP (3 entries);
   - ❖ PCP appointment recorded on the log although no documentation exists in patients' medical records (5 entries);

- RN's referral to the PCP documented on the log although there is no documentation of a referral in the patient's medical record (1 entry);
- documentation of the patient's refusal of appointment on the log although documentation in the medical record showed that appointment was completed (1 entry);
- incorrect name of the patient (1 entry);
- incorrect CDCR number for the patient documented on the log (2 entries);
- missing CDCR Form 7362 and documentation reflecting the patient was seen by RN for FTF evaluation (4 entries).

4. Question 2.6 – A total of 33 entries were randomly selected from the weekly specialty care monitoring logs to assess the accuracy of the dates reported on the log. Of the 33 entries reviewed, 23 were found to be accurate with dates matching the dates of service reflected in the patients' medical record. This equates to 69.7% compliance. Discrepancies identified within the remaining 10 entries were due to:

   - Incorrect PCP referral date (1 entry);
   - missing date of specialist appointment (2 entries);
   - missing date of PCP FTF assessment following the specialist appointment (1 entry);
   - missing date of RN FTF assessment following the specialist appointment (2 entries);
   - date of RN FTF assessment documented in the log although no documentation found in the medical record (1 entry);
   - incorrect date of approval for specialty services appointment (6 entries);
   - date of approval for specialty services appointment documented in the log although no documentation found in the medical record (1 entry);
   - missing specialty appointment disposition (2 entries).

5. Question 2.8 – A total of 60 entries were randomly selected from the monthly chronic care monitoring logs to assess the accuracy of the dates reported on the log. Of the 60 entries reviewed, 37 were found to be accurate with dates matching the dates of service reflected in the patients' medical records. This equates to 78.0% compliance. Discrepancies identified within the remaining 23 entries were due to:

   - incorrect date of last PCP assessment (2 entries);
   - incorrect date of actual PCP assessment (4 entries);
   - missing documentation reflecting the PCP's last assessment date and actual assessment date (2 entries);
   - last PCP assessment date not documented on the log although documentation exists in the patient's medical record (3 entries);
   - incorrect CDCR number for the patient documented on the log (2 entries);
   - patient's name incorrectly documented on the log (1 entry).

6. Question 2.9 – A total of 60 entries were selected from the monthly initial intake screening monitoring logs to assess the accuracy of the dates reported on the log. Of the 60 entries reviewed, 37 were found to be accurate with dates matching the dates of service reflected in the patients' medical records. This equates to 61.7% compliance. Discrepancies identified within the remaining 23 entries were due to:

   - missing CDCR Form 7277 *Initial Health Screening* in the patient's medical record; therefore, unable to validate the date of initial health screening (3 entries);
   - incorrect documentation of referral of the patient to the PCP; CDCR Form 7277 showed that the patient had not been referred to the PCP but to the Licensed Clinical Social Worker (14 entries);
   - missing CDCR Form 196-B *Intake History and Physical* from the patient's medical record; therefore, unable to validate the date of health appraisal (2 entries);
   - incorrect date of patient's arrival and initial health screening documented on the log (1 entry);
   - incorrect date of health appraisal documented on the log (4 entries).

3. LICENSING/CERTIFICATIONS, TRAINING, & STAFFING

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
100% [*Proficient*]
Overall Rating:
Proficient

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

FCRF received a compliance score of 100% in the *Licensing/Certifications, Training & Staffing* indicator, resulting in an overall rating of *proficient*.

Quantitative Review Results

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

Licensing/Certifications, Training, & Staffing		Yes	No	Compliance
3.1	Are all health care staff licenses current?	7	0	100%
3.2	Are health care and custody staff current with required medical emergency response certifications?	72	0	100%
3.3	Did all health care staff receive training on the facility's policies based on Inmate Medical Services Policies and Procedures requirements?	7	0	100%
3.4	Is there a centralized system for tracking licenses, certifications, and training for all health care staff?	1	0	100%
3.5	Does the facility have the required provider staffing complement per contractual requirement?	1.0	0.0	100%
3.6	Does the facility have the required nurse staffing complement per contractual requirement?	5.2	0.0	100%
3.7	Does the facility have the required clinical support staffing complement per contractual requirement? (COCF Only)?	Not Applicable		
3.8	Does the facility have the required management staffing complement per contractual requirement? (COCF Only)	Not Applicable		
3.9	Are the peer reviews of the facility's providers completed within the required time frames?	1	0	100%
	Overall Quantitative Review Score:			**100%**

Comments:

1. Questions 3.7 and 3.8 – These questions are not applicable to in-state modified community correctional facilities.

4. ACCESS TO CARE

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

Case Review Rating:
Inadequate
Quantitative Review Score [Rating]:
95.4% [Proficient]
Overall Rating:
Inadequate

For *Access to Care* indicator, the case review and quantitative review processes yielded different results. The case review received an *inadequate* rating while the quantitative review resulted in overall score of 95.4% compliance, equating to a quality rating of *proficient*. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the magnitude of all deficiencies identified in both processes and their potential impact on the patient's health care condition. The case review identified multiple deficiencies related to access to medical care which the CCHCS physician determined could have potentially had an adverse effect. Therefore, the case review's *inadequate* rating was deemed a more accurate reflection of the appropriate overall rating.

Case Review Results

The CCHCS clinicians reviewed 108 provider and nursing encounters related to *Access to Care* – 66 nursing encounters and 42 provider encounters. Out of 108 total encounters, 38 deficiencies were found, of which 11 were related to nursing performance and 24 were related to provider's performance. Specific examples of deficiencies and areas of concern identified by CCHCS nurse consultant are as follows:

- In Cases # 2, 3 and 4, the nursing staff did not follow IMSP&P Standard Nursing Protocols by prescribing cough drops or throat lozenges, senna tablets for constipation, etc. which are not a part of Standard Nursing Protocol.
- In Case # 3, a 23 year old patient submitted a sick call form on December 20, 2015 complaining of scratchy throat and sensitive left ear. Nurse completed an assessment and advised the patient to gargle with warm salt water and provided throat lozenges and acetaminophen. The Nursing staff did not follow IMSP&P Standard Nursing Protocols related to upper respiratory infection because throat lozenges are not part of the Nursing Protocol. The same patient

submitted a CDCR Form 7362 *Health Care Service Request* form complaining of a bad chest pain on January 15, 2016. Nursing staff completed an assessment and administered aspirin 81 milligram (mg). Nursing referred the patient to the PCP and EKG was performed which was determined to be normal. However, once again nursing staff was not in compliance with the IMSP&P Nursing Protocol for chest pain which requires 325 mg of aspirin to be administered for chest pains and not 81 mg.

- In Case # 4, a 42-year old patient submitted a CDCR Form 7362 *Health Care Service Request* form on November 7, 2015, complaining of difficulty in getting up and down off the top bunk due to pain. Although the nursing diagnosis was alteration in comfort related to pain, nursing staff did not document pain scale. On another occasion when this patient complained of burning rash spreading across chest area with some large swollen bumps, the nursing assessment was determined as inadequate because nursing failed to investigate the reason for the rash by inquiring if the rash had been caused by food, medications or if the patient had been exposed to any irritants, etc. Nursing also did not document the time period when the rash broke out and failed to note the size, distribution and pattern of the rash. In addition, the nursing staff failed to follow the IMSP&P Nursing Protocols on two different occasions. First this patient complained of sinus pain and nasal stuffiness was diagnosed as having altered comfort due to allergies. The patient was given Chlorpheniramine Maleate and cough drops, which are not part of the Nursing Protocol. Second the patient submitted a sick call request complaining of painful bowel movement and was diagnosed as having constipation, the nursing staff provided senna tablets, which are not part of the Nursing Protocol.
- In Case # 5, a 41-year old patient complaining of blurry vision refused an optometry consult. The nursing staff did not obtain a signed refusal form from the patient in a timely manner. The refusal form was obtained three days after the patient had refused the specialty service; additionally the nursing staff did not document the date of receipt of the CDCR Form 7362 *Health Care Service Request* form requesting Clotrimazole drops.
- In Case # 6, a 31-year old patient complained of dizziness and palpitations. Although nursing conducted an assessment, nursing staff did not document a nursing plan of action and diagnosis related to the patient's chief complaint. Additionally, a CDCR Form 7362 *Health Care Service Request* form was not completed for the appointment.

Out of 42 total provider encounters reviewed, 24 were found deficient/inadequate. Most of the cases reviewed showed that the provider prescribed multiple medications (polypharmacy) contrary to best practices for the diagnoses and/or prescribed medications in response to the complaints without making accurate diagnoses. The provider consistently failed to provide adequate education to the patients regarding effective weight management, dietary modifications, weight control strategies, and non-pharmacological management of symptoms. Specific examples of deficiencies and areas of concern identified by CCHCS physician are as follows:

- In Case # 1, the PCP prescribed Avelox, a non-formulary drug, to treat the patient’s persistent vaginal discharge without any indication that justified use of this antibiotic. This medication did not prove to be effective. When the symptoms did not improve, the PCP determined the patient had urinary tract infection (UTI) and candidal vaginosis and prescribed another antibiotic, Diflucan, to be taken along with Avelox. Due to the injudicious and repeatedly unnecessary antibiotics prescribed, the patient continued to suffer from recurrent yeast

infections. During the subsequent visit, a vaginal culture was ordered by the PCP instead of emphasizing the importance of hygiene to the patient. Vaginal cultures provide no clinically significant information and should not be ordered. When the patient returned to the clinic after a week complaining of moderate vaginal discharge, the PCP examined the patient and assessed the yellowish green discharge to be due to ureaplasma vaginitis resistant to Tetracycline and Avelox. The PCP once again prescribed one dose of antibiotic Azithromax and ordered the patient to return to the clinic in a weeks' time to repeat the vaginal culture. Repeated oral antibiotic courses were determined to be inappropriate since ureaplasma and mycoplasma are found in asymptomatic women and considered as normal flora. The best practice should have been not treating vaginal discharge solely on the basis of vaginal cultures. During the onsite audit, the CCHCS physician discussed the case with the PCP and followed up with the patient; the patient stated that her vaginitis was resolved. CCHCS physician determined that patient would have improved to have identical outcome and earlier symptom resolution without repeated antibiotic course.

- In Case # 2, the patient complained of tiredness but the lab test results were found to be normal. The PCP ordered benzoyl peroxide for patient's mild acne although prescription of benzoyl peroxide is not appropriate pursuant to Title 15 that directs physicians to only provide medically necessary services. There was no evidence that patient's mild acne interfered with her activities of daily living or posed a risk for premature death. However, patient's obesity, anxiety and situational depression, did deserve treatment that was not provided by facility PCP. When the same patient complained of sore throat and vesicular rash in the genitalia, the PCP prescribed Amoxicillin and Acyclovir. Treatment with Amoxicillin was inappropriate because there was no indication of strep throat and/or bacterial sinusitis. The prescribed dose also was determined to be too high. The PCP also failed to describe the patient's vesicular rash in the progress note with sufficient details such as, if the rash was painful, recurrent, etc. A complete description of the rash is necessary to make an accurate diagnosis.
- In Case # 3, the patient complained of abdominal pain, palpitations on exertion, constipation and vaginal discharge. The PCP's exam did not reveal anything abnormal. However, the PCP prescribed multiple medications: Simethicone, Ranitidine, Atenolol, Lactulose, and ordered a vaginal culture without documenting the differential diagnosis under consideration that justified these medications and the vaginal culture. As described above, vaginal cultures are virtually worthless tests. CCHCS physician auditor found that prescriptions by PCP in this case were not justified. The polypharmacy engaged by PCP could lead to adverse consequences from drug side effects. The vaginal culture was of no value.
- In Case # 5, a morbidly obese patient with monilial rashes under the breasts in skin folds was diagnosed as suffering from tinea infection despite the overwhelming likelihood that the rash was due to yeast or moniliasis. The PCP prescription of multiple medications (Nystatin, hydrocortisone and Bacitracin ointment) is not best practice. The PCP failed to educate the patient on improving hygiene, making serious dietary changes and did not recommend weekly weigh-ins in order to monitor weight loss. The PCP also did not order any laboratory test to diagnose glucose intolerance. The patient returned to the clinic with the same rash since the symptoms had not improved with medications. Once again, the PCP failed to implement steps for intensive weight management. CCHCS physician auditor determined that the PCP should have prescribed Metformin as a first line treatment for pre-diabetics and to assist in weight loss. During another visit, when the patient complained of redness and tenderness of the second toe, the PCP diagnosed the redness to be an infection and prescribed multiple medications, Bactrim

and Doxycycline, even though Bactrim alone would have sufficed. The PCP failed to educate the patient on non-pharmacological measures to manage foot irritation such as elevation of the affected foot and use of foot soaks; the PCP also failed to schedule a follow-up with the patient within two days. The patient was seen for a follow-up only after five days.

- In Case # 7, due to the PCP prescribing excessive blood pressure (BP) medications namely Lisinopril and Atenolol, the patient was experiencing dizziness. The PCP did not consider reducing the BP medications or educate the patient on the need to intensify weight loss efforts in order to manage dizziness. When the patient complained of diarrhea, the PCP diagnosed the condition to be caused by Clostridium difficile (C. difficile) and prescribed Flagyl. There was no clinical basis upon which to diagnose clostridium infection. The patient was not ill. The PCP did not document that patient suffered any dehydration or other indications of a serious diarrhea condition. A more appropriate treatment would have been to advise the patient to be on clear liquids for one day, avoid dairy for the next week, and return for re-evaluation. There was insufficient evidence to support diagnosis of C. difficile and/or treatment with Flagyl. The PCP prescribed unnecessary medications without making a proper diagnosis.
- In Case # 10, when the patient complained of runny nose, the PCP diagnosed the condition to be allergic rhinitis and prescribed Zyrtec. The medical record did not document any direct examination of the nares that showed inflammation consistent with allergic rhinitis. CCHCS physician determined transient runny nose did not require prescription medications and did not find any basis to justify the PCP's diagnosis. The physician also noted that the PCP did not focus on the patient's increasing body weight and failed to reduce the dosage of Lisinopril (which had been prescribed at the highest possible dose with no apparent need). The CCHCS physician auditor determined that the patient's obesity deserved the PCP's attention.
- In Case # 13, the patient was prescribed anti-thyroid drug just based on low Thyroid Stimulating Hormone (TSH) levels even though other clinical symptoms related to hyperthyroidism was absent. According to the CCHCS physician auditor, the PCP should have considered other reasons for the low TSH levels like Acquired Immune Deficiency Syndrome (AIDS), Hepatitis, effects of the drugs the patient was taking at the time and even the possibility of an erroneous lab result instead of presuming hyperthyroidism solely based on a single reading of low TSH levels. Additionally, the anti-thyroid drug, Methimazole can be toxic and cause adverse side-effects in patients without thyroid disease. The same patient complained of decreased urine frequency and the PCP diagnosed the condition as UTI and prescribed Bactrim. Since the patient has some vaginal discharge, it would have been difficult to assess or obtain a clean catch urine sample at the time of exam, in order to justify treatment with antibiotic. Under such circumstances, the CCHCS physician considered treatment with Bactrim to be excessive. When the patient complained of nausea and pelvic pain, the PCP diagnosed the condition as Helicobacter pylori (H. pylori) gastritis and prescribed multiple medications for treating the symptoms. The physician auditor noted that there was no clinical evidence to justify the therapy. The physician determined that the significant side-effects of the medications could likely be more harmful than beneficial.
- In Case # 15, the patient presented with diarrhea and vomiting for one day without any weight loss or signs of dehydration. However, the PCP diagnosed the condition to be "acute gastroenteritis" and ordered Flagyl and Reglan. The diagnosis of "acute gastroenteritis" includes a wide range of conditions including food poisoning, viral infection and bacterial infection. There was no reason to presume that Flagyl (an antibiotic) would be helpful. Reglan is not an appropriate or effective treatment of acute gastroenteritis. The prescribed drugs were not

helpful and could have caused harmful side effects. During another visit, when the patient complained of headaches and heartburn, the PCP diagnosed the condition as "headaches" and started the patient on Nortriptyline. The CCHCS physician auditor concluded that "headache" is just a symptom and cannot be a diagnosis. The physician also deemed the treatment with an anti-depressant to be inappropriate absent evidence of depression or chronic pain that might be treated with that drug. Furthermore, it appeared the Nortriptyline was prescribed as a KOP medication. Dispensing psychoactive Central Nervous System depressants as KOP medication is exceptionally dangerous for the patient's health. The PCP also prescribed antibiotic for patient's complaint of in-grown hair instead of educating the patient on local hygiene and advising hot soaks. The treatment with antibiotics was inappropriate and it could have adverse side-effects such as monilial vaginitis.

CCHCS clinicians determined the overall clinical case review rating for *Access to Care* indicator as *inadequate* due to the following deficiencies that were identified in majority of cases that were reviewed:

- Nursing staff's failure to follow Standard Nursing Protocols and inadequate nursing assessments and documentation of nursing diagnoses;
- provider's failure to make accurate diagnoses of the patient's symptoms and/or failure to consider other contributing factors while making diagnoses;
- PCP's injudicious practice of prescribing excessive medications and/or antibiotics for the patients in the absence of clinical evidence to justify such treatment;
- PCP's failure in effectively communicating with the patients regarding their clinical symptoms; and
- PCP not educating the patients on personal hygiene, weight management and non-pharmacological methods to alleviate symptoms.

Quantitative Review Results

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

Access to Care		**Yes**	**No**	**Compliance**
4.1	Does the registered nurse review the CDCR Form 7362, *Health Care Services Request*, or similar form on the day it is received?	21	1	95.5%
4.2	Following the review of the CDCR Form 7362, or similar form, does the registered nurse complete a face-to-face evaluation of a patient within the specified time frame?	23	0	100%
4.3	Does the registered nurse document the patient's chief complaint in the patient's own words?	23	0	100%
4.4	Does the registered nurse document the face-to-face encounter in Subjective, Objective, Assessment, Plan, and Education (SOAPE) format?	23	1	95.8%
4.5	Is the focused subjective/objective assessment conducted based upon the patient's chief complaint?	19	4	82.6%
4.6	Does the registered nurse document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data?	22	2	91.7%

4.7	Does the registered nurse implement a plan based upon the documented subjective/objective assessment data that is within the nurse's scope of practice or supported by the nursing sick call protocols?	22	0	100%
4.8	Did the registered nurse document that effective communication was established and that education was provided to the patient related to the treatment plan?	19	5	79.2%
4.9	If the registered nurse determines a referral to the primary care provider is necessary, is the patient seen within the specified time frame?	23	1	95.8%
4.10	If the registered nurse determines the patient's health care needs are beyond the level of care available at the facility, does the nurse contact or refer the patient to the hub institution? (MCCF Only)	6	0	100%
4.11	If the patient presented to sick call three or more time for the same medical complaint, does the registered nurse refer the patient to the primary care provider?	5	0	100%
4.12	Does nursing staff conduct daily rounds in segregated housing units? (COCF only)	Not Applicable		
4.13	Does nursing staff conduct daily rounds in segregated housing units to collect CDCR Forms 7362, *Health Care Services Request*, or similar forms? (COCF only)	Not applicable		
4.14	Are CDCR Forms 7362, *Health Care Services Request*, or similar forms readily accessible to patients in all housing units?	4	0	100%
4.15	Are patients in all housing units able to submit the CDCR Forms 7362, *Health Care Services Request*, or similar forms on a daily basis?	4	0	100%
	Overall Quantitative Review Score:			**95.4%**

Comments:

For questions 4.1 through 4.11, a random sample of 24 patient medical records was reviewed for the audit review period of November 2015 through April 2016.

1. Question 4.1 – Two of the 24 records reviewed were found to be non-applicable since one of the patients was brought to medical after the patient lost consciousness. For the other patient, the RN was called to Receiving and Release area (R&R) to evaluate a patient who was suicidal. There was no CDCR Form 7362 *Health Care Service Request* forms filled out in either case since they were emergencies. Of the remaining 22 records reviewed, 21 records had documentation that the RN reviewed the CDCR Form 7362, *Health Care Services Request* form on the day it was received. The remaining one record was found non-compliant since the date and time of receipt was not documented on the CDCR Form 7362. This equates to 95.5% compliance.
2. Question 4.4 – Twenty-three medical records reviewed reflected that the RN documented the FTF encounters in Subjective, Objective, Assessment, Plan, and Education (SOAPE) format. The remaining one record was non-compliant because the nurse documentation was not in SOAPE format. This equates to 95.8% compliance.
3. Question 4.5 – One of the 24 medical records reviewed was found not applicable as the patient had refused to be seen and did not permit the RN to conduct an assessment. Of the remaining 23 patient medical records reviewed, 19 records showed that the RN conducted a focused subjective/objective assessment based on the patient's chief complaint. The remaining four records were found non-compliant; one had incomplete documentation of vital signs and medications/allergies, one was missing documentation of patient's history of asthma and medication/allergies, one was missing documentation of medications/allergies and a burn on patient's finger and the fourth was missing documentation of medications/allergies. This equates to 82.6% compliance.

4. Question 4.6 – Twenty-two medical records reviewed included documentation of a nursing diagnosis related to subjective/objective assessment data. The two non-compliant cases did not include documentation of a nursing diagnosis. This equates to 91.7% compliance.

5. Question 4.7 – Only 22 medical records, that were compliant of question 4.6, were reviewed for this question because the criteria measured in this question can be evaluated only if the records are compliant with the requirement measured in question 4.6. Therefore, the remaining two records were deemed non-applicable since they were non-compliant for 4.6. All 22 records were found to be compliant with this requirement. This equates to 100% compliance.

6. Question 4.8 – Nineteen patient medical records reflected that effective communication was established and education related to the treatment plan was provided to the patient. The remaining five cases were missing nurse's documentation to support effective communication had been established. This equates to 79.2% compliance.

7. Question 4.9 –Twenty-three patient medical records included documentation that following the RN's referral, the patient was seen by a PCP within the required time frame. For the remaining one record, the referral was identified as a routine referral to the PCP for history of headaches; however, the patient was not seen by the PCP within 14 days. This equates to 95.8% compliance.

8. Questions 4.12 & 4.13 – Not applicable. These questions do not apply to in-state modified correctional facilities.

5. CHRONIC CARE MANAGEMENT

Case Review Rating:
Adequate

Quantitative Review Score [Rating]:
93.8% [*Proficient*]

Overall Rating:
Adequate

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

The case review and quantitative review processes yielded different results. Although the quantitative review resulted in a score of 93.8% compliance, equating to a quality rating of *proficient,* the case review received only an *adequate* rating. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the magnitude of all deficiencies identified in both processes and their potential impact on the patient's health care condition. Since most of the deficiencies identified in the case reviews were minor in nature and were determined not to have an adverse effect on patient's health, the overall rating for chronic care management was determined to be *adequate*.

Case Review Results

The CCHCS clinicians reviewed 30 encounters related to *Chronic Care Management* – 7 nursing encounters and 23 provider encounters. Out of 30 total encounters, 10 deficiencies were found, of which only one was related to nursing performance and the remaining 9 were related to provider's performance. The only nursing deficiency identified in one case was due to the unavailability of documentation showing the patient's blood pressure was monitored as ordered by the PCP.

Most of the deficiencies identified by the CCHCS physician were mainly related to the patients being overmedicated for their chronic care conditions, PCP's failure to consider other contributing factors when treating the patients for their chronic care conditions, poor patient education regarding weight control, and the PCP not following best practices when providing treatment to the patients. Specific deficiencies and areas of concern identified by CCHCS physician are as follows:

- In Case # 1, the patient had been clinically diagnosed with bacterial vaginosis. In spite of this, the PCP ordered a vaginal culture results of which indicated the presence of mycoplasma and ureaplasma. The PCP prescribed Doxycycline for 10 days. There was no need for a vaginal culture to be done because vaginal cultures are worthless for diagnostic purposes in any immuno competent patient and prescribing Doxycycline was a poor choice of treatment since this antibiotic could, most likely, aggravate the yeast infection. Patients sexually inactive do not need any pharmacological treatment for bacterial vaginosis as that condition usually improves/resolves spontaneously. The infection also could have been properly treated with Metronidazole instead of Doxycycline.
- In Case # 5, a morbidly obese patient with pre-diabetes was not adequately treated and monitored to promote weight loss. The patient had a chronic care appointment for Hepatitis C and iron deficiency anemia. The PCP ordered a 90 day follow-up, which, according to CCHCS physician, was insufficient. Since the patient was morbidly obese and had an elevated Basic Metabolic Index (BMI) of 44, the PCP should have taken into consideration these risk factors and provided more intensive therapy since these factors pose a risk for development of fatty liver. Additionally, a BMI of 41 and above shortens the life span and therefore meets Title 15 criteria for more intensive therapy.
- In Case # 7, the patient was treated for hypertension (HTN) with moderate doses of Lisinopril and Atenolol even though the patient's blood pressure was normal or possibly too low (100/74). The patient was overmedicated. During subsequent visit, the patient's BP was measured and was read as 140/64. The PCP determined the BP was "uncontrolled" and increased the dosage of the medications. This was not an appropriate diagnosis. A single reading of 140 systolic does not indicate uncontrolled BP.
- In Case # 8, the patient was in the chronic care program for HTN. During the chronic follow-up visit, the BP was 167/103 and the patient's BMI was 45. The PCP ordered the patient to be weighed regularly but did not order a dietary consultation for the patient; the PCP also did not regard the patient's obesity as a relevant factor in the management of the patient's chronic care condition. The dosage of the BP medication was doubled and the PCP discontinued the beta blocker. The PCP failed to consult with the mentor/leadership for effective management of the patient's BP. The PCP appeared ignorant of the pharmacology for the drug she prescribed. The maximum effective dose of Lisinopril is, in nearly all cases, 40 mg per the manufacturer's recommendations (Lisinopril doses higher than 40 mg is known to be ineffective in African-American patients and this patient was African-American). The PCP did not follow best practices for effective management of the patient's chronic care condition.
- In Case # 10, the patient was seen for a chronic care follow-up for HTN. The BP reading was 131/80 which the PCP deemed to be at goal and the patient was on Lisinopril 40 mg. The patient's BMI was 34. The PCP did not focus on advising the patient on lifestyle changes and did not order for regular weight measurements. The PCP failed to effectively communicate with the patient regarding weight control and there was no proper follow up regarding this issue. The

patient was ordered for follow-up when necessary (PRN) which was not appropriate. During subsequent follow-up appointment, the BP reading was 143/84 and the patient was continued on 40 mg Lisinopril and PCP ordered Simvastatin 20 mg to manage high LDL of 165. Once again, the PCP failed to address the major factor that contributed to the patient's chronic care conditions, namely, patient's body weight. The PCP ordered a follow up in 30 days which is not adequate to manage the patient's chronic care condition.

- In Case # 11, the patient's diabetic condition required more aggressive management and intense monitoring of the patient's diet was also required. The patient's diabetic medication doses also needed to be increased (such as more Metformin, sulfonylurea, or insulin) for effective management of the patient's diabetes.

In review of all the chronic care encounters and the identified deficiencies, patients did not appear to have suffered any adverse outcomes. However, much room for improvements was noted, as described above. As a result, the CCHCS clinicians determined the quality of physician and nursing care in chronic care as *adequate*.

Quantitative Review Results

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

Chronic Care Management		**Yes**	**No**	**Compliance**
5.1	Is the patient's chronic care follow-up visit completed as ordered?	26	4	86.7%
5.2	Are the patient's chronic care medications received by the patient without interruption within the required time frame?	23	5	82.1%
5.3	If a patient refuses his/her chronic care keep-on-person medications, is the refusal documented on the CDCR Form 7225, *Refusal of Examination and/or Treatment*, or similar form?	3	0	100%
5.4	If a patient does not show or refuses the nurse administered/direct observation therapy chronic care medication for three consecutive days or 50 percent or more doses in a week, is the patient referred to a primary care provider?	1	0	100%
5.5	If a patient does not show or refuses the nurse administered/direct observation therapy chronic care medication for three consecutive days or 50 percent or more doses in a week, is the patient seen by a primary care provider within seven calendar days of the referral?	1	0	100%
5.6	If a patient does not show or refuses his/her insulin, is the patient referred to a primary care provider for medication non-compliance?	Not applicable		
	Overall Quantitative Review Score:			**93.8%**

Comments:

For questions 5.1 through 5.6, a random sample of 30 patient medical records was reviewed for the audit review period of November 2015 through April 2016.

1. Question 5.1– Twenty six medical records reviewed had documentation that the patients' chronic care appointments were completed as ordered. The remaining four non-compliant records showed that the patients were not seen by the PCP within the ordered timeframes. This equates to 86.7% compliance.

2. Question 5.2 – Two of the 30 medical records reviewed were found not applicable as the one patient was not on any chronic care medications at the time and the other patient was on a rescue inhaler which did not have to be refilled on a monthly basis. Twenty-three patient medical records showed that the patient received his chronic care medication without interruption and five were non-compliant with this requirement. This equates to 82.1% compliance. See below for additional information regarding the nine non-compliant record reviews:

    - Record 1 – The patient did not receive refills for her Lisinopril consistently;
    - Record 2 – No indication the patient received her Lisinopril for October and November 2015;
    - Record 3 – No indication the patient received her Lisinopril for November and December 2015;
    - Record 4 – No indication the patient received her Hydrochlorothiazide for HTN for February and March 2016.
    - Record 5 – The patient did not receive her refills for Lisinopril and Simvastatin consistently.

3. Question 5.6 – Not Applicable. There were no patients on insulin at FCRF during the audit review period; therefore, compliance with this requirement could not be evaluated at this time.

6. COMMUNITY HOSPITAL DISCHARGE

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

Case Review Rating:
Not Applicable

Quantitative Review Score [Rating]:
Not Applicable

Overall Rating:
Not Applicable

During the audit review period of November 2015 through April 2016, a total of 13 patients were sent to a community hospital emergency department (ED). Ten of these patients returned to FCRF on the same day. Three were admitted to the community hospital and permanently transferred to the hub following their discharge. As there were no valid cases available to assess the facility clinical staff's performance in this area during the current audit, this indicator was *not rated*.

7. DIAGNOSTIC SERVICES

For this indicator, the CCHCS clinicians assess several types of diagnostic services such as radiology, laboratory, and pathology. The auditors review the patient medical records to determine whether radiology and laboratory services were provided timely, whether the primary care provider completed a timely review of the results, and whether the results were communicated to the patient within the

required time frame. The case reviews also evaluate the appropriateness, accuracy, and quality of the diagnostic tests ordered and the clinical response to the results.

The case review and quantitative review processes yielded different results. The quantitative review resulted in overall score of 95.8% compliance, equating to a quality rating of *proficient*. However, the case review received an *inadequate* rating. In order to determine the overall rating for this indicator, the CCHCS clinicians evaluated the magnitude of all deficiencies identified in both processes and their potential impact on the patient's health care condition.

Case Review Rating:
Inadequate

Quantitative Review Score [Rating]:
95.8% [*Proficient*]

Overall Rating:
Adequate

Case Review Results

CCHCS clinicians reviewed 25 encounters related to *Diagnostic Services,* which consisted of 20 nursing encounters and 5 physician encounters. The clinicians identified 10 deficiencies, 5 related to nursing care and 5 related to provider care. All five deficiencies identified by the CCHCS nurse consultant were related to absence of laboratory reports and lack of nursing documentation showing the patients' laboratory tests were carried out per the PCP's orders. All five encounters reviewed by CCHCS physician were deemed to be deficient/ inadequate; however most of the deficiencies were due to the PCP ordering unnecessary vaginal cultures for patients without a valid reason for the test. Specific examples of the deficiencies identified by CCHCS physician are listed below:

- In Case # 1, when the patient initially complained of vaginal discharge, a culture was ordered by the PCP. During the follow-up appointment, the PCP did not document conducting a vaginal exam and the test result of the culture was still pending. CCHCS physician determined the vaginal culture to be an essentially worthless test since there was no indication of any concern about the vaginal flora. During subsequent visit, the patient's urine was analyzed and a vaginal culture was ordered for vaginal candidiasis. The vaginal cultures were deemed as unnecessary and the CCHCS physician concluded that the PCP had initially misdiagnosed the vaginal discharge to be bacterial vaginosis and the patient was treated with tetracycline; this inappropriate treatment resulted in vaginal candidiasis.
- In Case # 7, a morbidly obese patient complained of dyspnea, back ache and vaginal discharge. The PCP ordered a vaginal culture which has no value. The PCP did not propose a treatment for the obesity and did not consider the possibility of diabetes.
- In Case # 13, the PCP did not order a mammogram for the patient during a history and physical exam although the patient had a strong family history of breast cancer that calls for high vigilance to detect breast cancer in its earliest stages. The PCP recommended the patient conduct "self exams" and ordered an exam to be completed during subsequent visit. The same patient was seen by the PCP for complaints of vaginal discharge. The PCP once again ordered a vaginal culture which was worthless. The PCP also ordered the patient's intra uterine device (IUD) to be removed. The removal of the IUD was reasonable and appropriate.

The deficiencies identified by the clinicians mostly involved the unavailability of laboratory reports, lack of nursing documentation and unnecessary laboratory examinations which did not adversely impact

patients' health conditions. The potential harm from lack of attention to obesity and family history of breast cancer was brought to the attention of provider and nursing staff. Overall, the case review rating for diagnostic services was determined as *adequate*.

Quantitative Review Results

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

Diagnostic Services		Yes	No	Compliance
7.1	Is the diagnostic test completed within the time frame specified by the primary care provider?	16	2	88.9%
7.2	Does the primary care provider review, sign, and date all patients' diagnostic test report(s) within two business days of receipt of results?	18	0	100%
7.3	Is the patient given written notification of the diagnostic test results within two business days of receipt of results?	18	0	100%
7.4	Is the patient seen by the primary care provider for clinically significant/abnormal diagnostic test results within 14 days of the provider's review of the test results?	17	1	94.4%
	Overall Quantitative Review Score:			**95.8%**

Comments:

For questions 7.1 through 7.4, a random sample of 18 patient medical records was reviewed for the audit review period of November 2015 through April 2016.

1. Question 7.1 – Sixteen patient medical records included documentation that the diagnostic test was completed within the time frame specified by the PCP and two were non-compliant with this requirement. The two records were non-compliant due to the PCP not having specified the time frame for the lab draw and the labs were not drawn within 14 days of the order. This equates to 88.9% compliance.
2. Question 7.4 – Seventeen patient medical records included documentation that the patient was seen by the PCP for clinically significant/abnormal diagnostic test results within 14 days and one record was found non-compliant with this requirement. This equates to 94.4% compliance.

8. EMERGENCY SERVICES

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

This quality indicator is evaluated by CCHCS clinicians entirely through the review of patient medical records and facility's documentation of the emergency medical response process. No quantitative results are conducted for this indicator and therefore, the overall rating is based on the results of the clinical case reviews.

Case Review Rating:
Adequate

Quantitative Review Score [Rating]:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The CCHCS nurse consultant reviewed 11 emergency services encounters and, did not identify any deficiency; therefore, nurse case review was deemed proficient. On the other hand, of the 10 encounters reviewed by CCHCS physician auditor for *Emergency Services*, the physician identified 4 deficiencies related to provider care. The deficiencies were mainly due to the PCP not meeting standards of care by exhibiting poor judgment when providing treatment for a serious infection and the PCP's lack of communication with the Emergency Department (ED) physicians and hub providers to discuss the patient's health condition. The identified deficiencies are detailed below:

- In Case # 6, the patient complained of worsening right lateral quadrant pain and was brought to the facility clinic on February 23, 2016 as an emergency. Following evaluation, the PCP prescribed ibuprofen. Since the medication proved to be ineffective, the patient returned to the clinic on the following day with worsening symptoms suggestive of gallbladder disease (Cholecystitis) and patient's liver function test showed elevated liver enzymes. The PCP prescribed triple antibiotics and referred the patient for routine surgical evaluation and returned the patient to housing. When the patient became increasingly febrile and her condition appeared to worsen, the PCP ordered the patient be transferred to the community hospital ED on February 25, 2016. The patient returned from hospital on February 26, 2016 and the facility PCP determined the patient's condition to be unstable following an evaluation; however, the PCP failed to conduct daily follow-ups with the patient. The PCP re-evaluated the patient only after seven days from the date of initial follow-up. CCHCS physician determined that this patient had exhibited near classic symptoms and findings of Cholecystitis. The PCP failed to provide the appropriate treatment in an efficient manner. The patient was unnecessarily shuttled back and forth from the hospital and underwent risky treatments as an outpatient. Even though the patient's Cholecystitis condition was resolved following the ED visit, the PCP had failed to promptly refer the patient for surgical evaluation and cholecystectomy procedure on an emergent basis thus failing to provide timely medical care to the patient. CCHCS physician summarized that the patient had been extremely fortunate to have undergone laparoscopic gallbladder removal just in time before becoming morbidly ill.
- In Case # 9, the patient was sent to the hospital ED for nausea and headache. Upon the patient's return from the ED, the PCP completed a follow-up appointment with the patient and ordered Omeprazole, Simethicone and Colace for the patient although there was no diagnosis made to support the treatment provided. The PCP also conducted a breath test for H. pylori which was determined to be unnecessary.

Since the CCHCS physician's review found the patients' conditions to have resolved successfully in spite of the delayed treatment provided by the PCP, the overall rating for this indicator was determined to be

adequate. CCHCS physician discussed this case with the facility PCP and advised the PCP to consult with the hub providers in resolving complex cases such as this in order to provide patients with the adequate care in a timely manner, which in turn, will help avoid placing the patients' health and well being in jeopardy.

9. HEALTH APPRAISAL/HEALTH CARE TRANSFER

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

Case Review Rating:
Inadequate

Quantitative Review Score [Rating]:
85.7% [*Adequate*]

Overall Rating:
Inadequate

The case review and quantitative review processes yielded different results. The quantitative review resulted in overall score of 85.7% compliance, equating to a quality rating of *adequate*. However, the case review received an *inadequate* rating. In order to determine the overall rating for this indicator, the CCHCS clinicians evaluated the magnitude of all deficiencies identified in both processes and their potential impact on the patient's health care condition. Based on the clinical case review and quantitative findings, FCRF received an *inadequate* rating in the *Health Appraisal/Health Care Transfer* indicator. The deficiencies were mainly due to the nursing staff not completing initial health screening and Tuberculosis (TB) screening of patients upon their arrival at the facility and nursing staff's failure to complete the CDCR Form 7371, *Health Care Transfer* form when patient was transferred out of the facility.

Case Review Results

The CCHCS physician, within the clinical cases reviewed, did not identify any encounters related to Health Care Appraisal/Health Care Transfer process, therefore, the case review rating was based solely on the CCHCS nurse consultant's findings. CCHCS nurse consultant reviewed a total of 12 nursing encounters for the *Health Care Appraisal/Health Care Transfer* indicator and determined 7 out of 12 encounters as deficient. Specific examples of deficiencies and areas of concern identified by CCHCS nurse consultant are as follows:

- In Cases 10, 11, 12 and 13, the CDCR Form 7277, *Initial Health Screening* form, CDCR Form 7277-A, *Initial Health Screening (supplemental) - Female Inmates* form and CDCR Form 7331 *Tuberculin Testing/Evaluation Report* were missing in the EHRS. Due to absence of these forms in the EHRS, the CCHCS nurse consultant was unable to determine if appropriate screening and evaluations were completed by the nursing staff for the newly arrived patients.

- In Cases 8, 14 and 15, CDCR Form 7371, *Health Care Transfer* form was missing in the EHRS and for Case # 14, there was no nursing progress note or transfer note indicating the reason for the patient's transfer.

It is imperative that the nursing staff complete the *CDCR Form 7277, Initial Health Screening* form and *CDCR Form 7331 Tuberculin Testing/Evaluation Report* for newly arrived patients and/or the CDCR Form 7371, *Health Care Transfer* form for patients transferring out of the facility in order to maintain continuity of care and ensure medically necessary health care is received by the patient in a timely manner.

Quantitative Review Results

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

Health Appraisal/Health Care Transfer		**Yes**	**No**	**Compliance**
9.1	Does the patient receive an initial health screening upon arrival at the receiving facility by licensed health care staff?	18	0	100%
9.2	If "YES" is answered to any of the medical problems on the *Initial Health Screening* form (CDCR 7277/7277A or similar form), does the registered nurse document an assessment of the patient?	6	5	54.5%
9.3	If a patient presents with emergent or urgent symptoms during the initial health screening, does the registered nurse refer the patient to the appropriate provider?	Not Applicable		
9.4	If a patient is not enrolled in the chronic care program but during the initial health screening was identified as having a chronic disease/illness, does the registered nurse refer the patient to the primary care provider to be seen within the required time frame??	Not Applicable		
9.5	If a patient was referred to an appropriate provider during the initial health screening, was the patient seen within the required time frame?	7	0	100%
9.6	If a patient was enrolled in a chronic care program at a previous facility, is the patient scheduled and seen by the receiving facility's primary care provider within the time frame ordered by the sending facility's chronic care provider?	10	0	100%
9.7	If a patient was referred by the sending facility's provider for a medical, dental, or a mental health appointment, is the patient seen within the time frame specified by the provider?	3	0	100%
9.8	Does the patient receive a complete screening for the signs and symptoms of tuberculosis upon arrival?	18	0	100%
9.9	Does the patient receive a complete health appraisal within seven calendar days of arrival?	17	1	94.4%
9.10	If a patient had an existing medication order upon arrival at the facility, were the nurse administered medications administered without interruption and keep-on-person medications received within one calendar day of arrival?	1	11	8.3%
9.11	When a patient transfers out of the facility, are the scheduled specialty services appointments that were not completed, documented on a Health Care Transfer Information Form (CDCR 7371) or a similar form?	8	0	100%

9.12	Does the Inter-Facility Transfer Envelope contain all the patient's medications, current Medication Administration Record and Medication Profile?	1	0	100%
			Overall Quantitative Review Score:	**85.7%**

Comments:

For questions 9.1 through 9.12, a random sample of 18 patient medical records were reviewed for the audit review period of November 2015 through April 2016.

1. Question 9.2 – Seven patient medical records were found not applicable to this question. Of the remaining eleven patient medical records reviewed, six included documentation that the RN assessed the patient if the patient answered 'yes' to any of the medical problems listed on the CDCR Form 7277, *Initial Health Screening* form. Of the five records that were non-compliant, the screening nurse indicated on the CDCR Form 7277 that one patient had thyroid issues and the patient was being treated for mental illness, however the RN did not complete an assessment. For the second patient, the RN did not document the patient's history of asthma or list the medications the patient arrived with. The third patient's record did not have RN's documentation of the patient being in the chronic care program at the previous facility for type II diabetes. The fourth patient's hypothyroid condition was not documented by the RN on the CDCR Form 7277. The fifth patient's CDCR Form 7277 did not have documentation that the patient had hypothyroidism and was on Levothyroxin. This equates to 54.5% compliance.
2. Questions 9.3 and 9.4 – Non-applicable. None of the patients within the selected sample met the criteria for these questions; therefore, compliance with these requirements could not be evaluated at this time.
3. Question 9.9 – Seventeen patient medical records included documentation that the patient received a complete health appraisal within seven calendar days of arrival at FCRF. One patients' medical record documentation reflected that the health appraisal was not completed within seven days. This equates to 94.4% compliance.
4. Question 9.10 – A total of 12 patient medical records out of 18 reviewed were found applicable to this question. Of the 12 patient medical records reviewed, only 1 record included documentation that the patient, upon arrival at the facility, received her existing medications without interruption. One patient had to submit a CDCR Form 7362 in order to request a medication refill. Eleven records were missing documentation of the patients having received their medications upon arrival at the FCRF. This equates to 8.3% compliance.

10. MEDICATION MANAGEMENT

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

Case Review Rating:
Inadequate
Quantitative Review Score [Rating]:
93.8% [*Proficient*]
Overall Rating:
Inadequate

For *Medication Management* indicator, the case review and quantitative review processes yielded different results. Although the quantitative review resulted in an overall score of 93.8%, equating to a quality rating of *proficient*, the case review resulted in an *inadequate* rating. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the critical nature of the deficiencies identified during the medical record and clinical case reviews for their potential impact on the patient's health care condition. The case review resulted in several deficiencies of which the nursing deficiencies were significant in nature mainly related to the nursing staff not documenting in the MAR if the prescribed medications were administered to the patients within the specified time frames and failure to administer the medications and/or provide medication refills to the patients in a timely manner. The physician deficiencies were also critical in nature and mainly related to PCP prescribing unnecessary antibiotics and medications to patients without making a clear diagnosis of the patient's condition, a practice which could potentially lead to side-effects and likely result in adverse effects on patient's health including gastrointestinal distress and yeast vaginitis. As a result, the CCHCS clinicians determined the appropriate overall rating for *Medication Management* indicator was ***inadequate***.

Case Review Results

The CCHCS clinicians reviewed a total of 114 encounters related to medication management and found 41 deficiencies, 31 in nursing performance and 10 in provider's performance. Twenty-eight of the nursing deficiencies were related to lack of documentation in the MAR of patients receiving their prescribed medications (Cases 1, 2, 3, 4, 5, 7, 8, 9 and 10). The remaining three nursing deficiencies were a result of the patients receiving their prescribed medications and/or medication refills late and the nursing staff not following IMSP&P Standard Nursing Protocols when administering certain medications. Specific examples of deficiencies identified are stated below:

- In Case # 1, the patient with diagnoses of vaginitis due to mycoplasma and ureaplasma was prescribed Doxycycline. There was no documentation in MAR to show that Doxycycline was administered as ordered on March 23, 2016. At the time of follow-up on March 25, 2016 for vaginal mycoplasma and diarrhea, the PCP ordered to discontinue Doxycycline and prescribed Avelox and Imodium to be administered immediately. There was no documentation in the MAR that Doxycycline was discontinued as ordered. In addition, the MAR was also lacking documentation of Imodium being administered to the patient. Furthermore, the patient received medication, Avelox, late on April 1, 2016. Per policy, newly ordered medications received by pharmacy on any business day must be available to the patient no later than 3 business days unless otherwise ordered.
- In Case # 2, the patient was on KOP medications Fiberlax and Ferrous Sulfate but the March 2016 MAR showed that these medications were not refilled since January 21, 2016. These medications were to be refilled on a monthly basis and the patient should have received a refill on or before February 21, 2016. The patient had also been on Amoxicillin, and Acyclovir and the MAR did not have documentation to show that patient received her last dose of these medications on March 9, 2016. The patient was prescribed Topamax for migraine and neck pain on April 8, 2016. The MAR did not have documentation the medication was administered as ordered.
- In Case # 3, the patient was prescribed Amitriptyline. The MAR showed that medication was started on November 1, 2015. However, the medication was originally prescribed on September 30, 2015. The MAR for September and October 2015 did not show that this medication was administered; this indicated that the medication was not administered as ordered. The same

patient was prescribed Ranitidine and Tums on January 29, 2016; however, the MAR for February 2016 did not list these medications. The patient was ordered Amitriptyline again on March 18, 2016. There was no documentation in the MAR to show that this medication was administered to the patient. On March 31, 2016, the PCP ordered Benadryl and Prednisone to be administered as STAT (immediately) for allergies; however, the nurse consultant reviewer could not find a MAR in the EHRS indicating the STAT doses were given. The PCP also ordered Prednisone and Chlorpheniramine Maleate (CTM) the following day. However, these medications were also not documented on the MAR to indicate they were administered to the patient as ordered. The nursing also failed to follow IMSP&P Standard Nursing Protocols on three different occasions; once when the patient complained of diarrhea, nursing staff administered Pepto bismuth instead of Loperamide which is the approved drug for diarrhea in the Nursing Protocol; a second time, when the patient complained of chest pains, nursing administered 81 mg Aspirin, instead of 325 mg Aspirin as indicated in the Nursing Protocol and for a third time, when nursing staff provided throat lozenges for scratchy throat which is not indicated in the Standard Nursing Protocols.

- In Case # 4, the patient complained of headache and nursing staff tried to administer Ibuprofen as part of the nursing protocol for headache. But the patient declined. A signed refusal of treatment form was not found in the medical record. The patient was prescribed Nortriptyline for headache along with Ibuprofen to be administered immediately. There was no documentation in the MAR to indicate Ibuprofen was administered per the PCP's orders. The same patient was ordered Loratadine and the MAR did not show that this medication was administered either. The PCP ordered hydrocortisone cream to be applied twice a day for a month for rashes, but there was no MAR indicating this order was carried out. The nursing staff also did not follow Standard Nursing Protocols when prescribing Bacitracin ointment for patient's rashes which is not part of the Nursing Protocols and also not indicated for possible allergic reaction.
- In Case # 5, the patient's second dose of Hepatitis B vaccine originally ordered as STAT on December 4, 2015 was administered late on December 16, 2015. The MAR posted on March 1, 2016 did not show that Simvastatin was administered as ordered. The patient was ordered Bisacodyl and this medication was listed on the patient's MAR. However, there was no nurse's signature to indicate that the medication was administered.
- In Case # 7, there was no MAR indicating Omeprazole or Ranitidine was administered as ordered. The PCP ordered Pneumovaccine and Hepatitis A & B vaccines for the patient. However, there was documentation in the MAR to indicate only the Hepatitis A and B vaccines were administered. The nursing staff failed to follow Standard Nursing Protocols for diarrhea by administering Pepto bismuth instead of Loperamide.
- In Case # 8, there was no MAR showing Flagyl and Cipro medications were administered as ordered. This patient also was administered an incorrect dosage of the medication, namely 25 mg of Lisinopril instead of 5 mg Lisinopril. The same patient was prescribed Nystatin cream for fungal infection but the MAR did not indicate that this medication was administered to the patient.
- In Case # 9, the patient was ordered Bactrim DS for UTI. The MAR did not have documentation to indicate this medication was provided. The patient was also prescribed Ranitidine, Loratadine and Lisinopril. There was no documentation in the MAR to indicate any of these medications were administered as ordered.

- In Case # 10, the patient was initially prescribed Vitamin D and Lisinopril on October 27, 2015. It was not clear if the patient received the medications during the month of December 2015 since the MAR was not available for review. The PCP renewed the prescription for these medications on January 18, 2016 and the patient received Vitamin D and Lisinopril on January 20, 2016.

CCHCS physician reviewed a total of 13 encounters for *Medication Management* indicator of which 10 encounters were deemed to be inadequate/deficient. The deficiencies identified were mainly related to the PCP prescribing too many medications and antibiotics for the patients without valid clinical diagnoses to support the treatments chosen. Examples of specific deficiencies identified by the CCHCS physician are described below:

- In Case # 2, the PCP prescribed Amoxicillin for patient's sore throat although there was no clinical indication of strep throat and the dose prescribed was too high.
- In Case # 3, during a follow up appointment with the PCP, when the patient's temperature measured 99.6 ^{0} F, the PCP determined the patient had fever and prescribed high doses of Doxycycline and Amoxicillin after making a presumptive diagnosis of pneumonia. There was insufficient evidence available to justify antibiotic treatment and the dosage was very high. CCHCS physician determined that pneumonia was highly unlikely with patient's respiratory rate of 18 breaths per minute. There was also no likelihood of patient having a fever and this could have been verified by repeating the vital signs. The patient returned to the clinic after two weeks complaining of recurrent cough. The PCP misdiagnosed the condition as pneumonia and continued to treat the patient with Amoxicillin and also ordered a new medication Biaxin without clinical evidence or X-ray evidence to support the treatment. Subsequently, the patient returned to the clinic complaining of diarrhea, a possible side effect of taking excessive antibiotics. CCHCS physician concluded that unnecessary treatment with antibiotics would potentially lead to vaginitis and possibly other side-effects such as the one noted above. The use of antibiotics may also place the patient at risk of developing enterocolitis.
- In Case # 7, the PCP ordered Nortriptyline for the patient without documenting a clear reason for the prescription. The documentation suggested that this medication was prescribed for "foot pain". There was no diagnosis documented for the foot pain. The patient was also prescribed Lisinopril and Atenolol for diagnosis of HTN; however the patient's BP was normal without medication.
- In Case # 8, the patient complained of right ear pain with discharge. The PCP diagnosed the condition as Otitis Externa without considering the possibility of Diabetes Mellitus which is known to predispose adults to otitis externa. The CCHCS physician noted that the PCP did not focus on advising the patient of a focused weight control plan in spite of patient's BMI of 45 and PCP ordered Cortisporin otic solution to be administered twice a day (BID) instead of four times a day (QID) which is the recommended dose for effective treatment of Otitis Externa. The PCP also prescribed amoxicillin which was unnecessary. The patient was followed up by the PCP a week later. The patient should have been followed up sooner.
- In Case # 9, the patient reported fever and complained of sore throat and cough. Her temperature measured 99.3 ^{0} F and exam showed the tonsils to be swollen without exudates. The PCP diagnosed the condition as pharyngitis and prescribed Amoxicillin for the patient. CCHCS physician auditor determined the diagnosis of pharyngitis did not justify treatment with Amoxicillin since antibiotic treatment is not indicated for viral pharyngitis. The physician auditor also noted that the ordered dose was incorrect despite the type of medication prescribed. The

patient returned to the clinic two months later complaining of nausea and vomiting for a day along with migraine. The exam was normal and PCP's diagnosis was "nausea and vomiting". The patient was prescribed Benadryl, Reglan and electrolytes pack. "Nausea and vomiting" is not a diagnosis, but a reiteration of the symptoms. The treatment provided was not according to best practices. There was no clinical indication for prescribing Benadryl, Reglan or electrolyte solution. The PCP should have advised the patient to take clear liquids and return to the clinic the following day.

- In Case # 13, during a follow-up appointment for abdominal pain, the patient complained of heaviness in both breasts. Upon examination, the breasts were found diffusely tender to palpation. The PCP did not make a diagnosis to explain breast tenderness and ordered Naprosyn BID.
- In Case # 14, the patient was on high dose of Metoprolol to treat palpitations. However, the PCP failed to establish a diagnosis to justify pharmacological treatment of "palpitations". There was no follow-up completed for diet and weight management. CCHCS physician auditor determined that beneficial weight loss was impaired by the drugs.
- In Case # 15, the patient was prescribed Nortriptyline and the dosage was increased due to continued headaches. The PCP also ordered Tylenol and ibuprofen for the patient without making a diagnosis for the headaches. The medications provided were determined to be inappropriate.

Quantitative Review Results

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

Medication Management		**Yes**	**No**	**Compliance**
10.1	Does the prescribing primary care provider document that the patient was provided education on the newly prescribed medications?	18	0	100%
10.2	Is the initial dose of the newly prescribed medication administered to the patient as ordered by the provider?	17	1	94.4%
10.3	Does the nursing staff confirm the identity of a patient prior to the delivery and/or administration of medications?	2	0	100%
10.4	Does the same medication nurse who administers the nurse administered/direct observation therapy medication prepare the medication just prior to administration?	2	0	100%
10.5	Does the medication nurse directly observe a patient taking direct observation therapy medication?	1	1	50.0%
10.6	Does the medication nurse document the administration of nurse administered/direct observation therapy medications on the Medication Administration Record once the medication is given to the patient?	2	0	100%
10.7	Are medication errors documented on the Medication Error Report form?	2	0	100%
10.8	Are refrigerated drugs and vaccines stored in a separate refrigerator that does not contain food and/or laboratory specimens?	1	0	100%

10.9	Does the health care staff monitor and maintain the appropriate temperature of the refrigerators used to store drugs and vaccines twice daily?	62	0	100%
10.10	Does the facility employ medication security controls over narcotic medications assigned to its clinic areas?	Not Applicable		
10.11	Are the narcotics inventoried at the beginning and end of each shift by licensed health care staff?	Not Applicable		
10.12	Do patients, housed in Administrative Segregation Unit, have immediate access to the Short Acting Beta agonist inhalers and/or nitroglycerine tablets? (COCF only)	Not Applicable		
	Overall Quantitative Review Score:	**93.8%**		

Comments:

For questions 10.1 through 10.10, a random sample of 18 patient medical records was reviewed for the audit review period of November 2015 through April 2016.

1. Question 10.2 – Seventeen patient medical records reviewed included documentation reflecting the initial dose of the newly prescribed medications was administered to the patients as ordered by the PCP. One record was found to be non-compliant due to missing documentation of the patient receiving the newly prescribed medication as ordered by PCP. This equates 94.4% compliance.
2. Question 10.5 – Of the two nurses observed administering the DOT medications during the onsite audit, one nurse did not consistently conduct a "cup check" after administering the medications to the patients. This equates to 50.0% compliance.
3. Questions 10.10 and 10.11 – Not applicable. FCRF does not store narcotic medications at the facility; therefore, these questions could not be evaluated.
4. Question 10.12 – Not applicable. This question does not apply to the in-state correctional facilities.

11. OBSERVATION CELLS

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

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

Case Review Rating:
Not Applicable

Quantitative Review Score [Rating]:
Not Applicable

Overall Rating:
Not Applicable

12. SPECIALTY SERVICES

Case Review Rating:
Adequate

Quantitative Review Score [Rating]:
100% [Proficient]

Overall Rating:
Adequate

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

For *Specialty Services* indicator, the case review and quantitative review processes yielded similar results. The quantitative review resulted in overall score of 100%, equating to a quality rating of *proficient*, while the case review resulted in an *adequate* rating. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the magnitude of the deficiencies identified during case reviews and their potential impact on patient's health care condition. The case review results revealed four deficiencies which did not impact the patient's access to health care. As a result, the CCHCS clinicians determined the appropriate overall rating for this indicator was ***adequate***.

Case Review Results

The CCHCS clinicians reviewed a total of 18 encounters related to specialty services and found 7 deficiencies, 1 in nursing performance and 6 in provider's performance. The nursing deficiency involved the CCHCS nurse auditor not being able to locate documentation indicating the patient's gynecology appointment was completed. The identified deficiency is as stated below:

- In Case # 2, a 29-year old patient complained of a heavy menstrual period and abdominal cramps. She was referred to a gynecologist for an evaluation of her symptoms. However, there was no documentation available in the EHRS to confirm that this appointment was completed as ordered.

CCHCS physician reviewed ten encounters and identified six deficiencies. The deficiencies identified by the CCHCS physician are described below:

- In Case # 6, the PCP did not expedite the request for a surgical evaluation of the patient who exhibited near classic symptoms and findings of gallbladder disease. The delay in evaluation put the patient at risk of death from Cholecystitis. However, the patient underwent laparoscopic gallbladder removal before becoming deathly ill.
- In Case # 13, the PCP did not order a mammogram for the patient in spite of the patient having a family history of breast cancer. The patient was prescribed anti-thyroid drugs without a clinical diagnosis of hyperthyroidism. The patient's endocrinology appointment was pending at the time of review. The PCP did not consult with peers by phone or otherwise to discuss the case. The patient was diagnosed with a 0.4 cm nodule on the thyroid gland but there was no follow-up done or diagnosis made. CCHCS physician met with the PCP during the onsite audit and discussed this case. The CCHCS physician came to understand that the PCP had no plans to refer the patient to specialty services to address the breast cancer risks and for evaluation of the

nodule. The apparent delay in providing the necessary medical services suggests PCP's lack of familiarity with women's important health care issues. Federal United States Preventive Services Task Force standards and best practices promulgated by American Academy of Family Physicians and American Congress of Obstetricians and Gynecologists recommend annual mammogram and BRCA (breast cancer gene) testing.

- In Case # 14, the PCP prescribed Metoprolol and Methimazole for patient's complaints of palpitation without any clinical or laboratory findings to support the treatment. The PCP presumed the patient's palpitations were caused by hyperthyroidism. The PCP did not refer the patient to specialty services for an evaluation of the symptoms.

Quantitative Review Results

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

Specialty Services		**Yes**	**No**	**Compliance**
12.1	Is the primary care provider's request for specialty services approved or denied within the specified time frame? (COCF Only)	Not Applicable		
12.2	Is the patient seen by the specialist for a specialty services referral within the specified time frame? (COCF Only)	Not Applicable		
12.3	Upon return from the hub, a specialty consult appointment or community emergency department visit, does a registered nurse complete a face-to-face assessment prior to the patient's return to the assigned housing unit?	15	0	100%
12.4	Upon return from the hub, a specialty consult appointment or community emergency department visit, does a registered nurse notify the primary care provider of any immediate orders or follow-up instructions provided by the hub, a specialty consultant, or emergency department physician?	1	0	100%
12.5	Does the primary care provider review the specialty consultant's report, hub provider's report or the community emergency department provider's discharge summary and complete a follow-up appointment with the patient within the required time frame?	15	0	100%
	Overall Quantitative Review Score:			**100%**

Comments:

1. Questions 12.1 and 12.2 – Not applicable. These questions do not apply to in-state correctional facilities.

13. PREVENTIVE SERVICES

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

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

The facility received a compliance score of 66.7% in *Preventive Services* indicator, which equates to an overall rating of *inadequate*. It should be noted that out of nine compliance tests conducted, seven were found not applicable. Refer to the *Comments* section, following the table below, for additional information and details.

Case Review Rating:
Not Applicable

Quantitative Review Score [Rating]:
66.7% [Inadequate]

Overall Rating:
Inadequate

Quantitative Review Results

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

Preventive Services		Yes	No	Compliance
13.1	*For patients prescribed anti-Tuberculosis medication(s):* Does the facility administer the medication(s) to the patient as prescribed?	6	0	100%
13.2	*For patients prescribed anti-Tuberculosis medication(s):* Does the nursing staff notify the primary care provider or a public health nurse when the patient misses or refuses anti-TB medication?	Not applicable		
13.3	*For patients prescribed anti-Tuberculosis medication(s):* Does the facility monitor the patient monthly while he/she is on the medication(s)?	2	4	33.3%
13.4	Do patients receive a Tuberculin Skin Test annually?	Not applicable		
13.5	Are the patients screened annually for signs and symptoms of tuberculosis?	Not applicable		
13.6	*For all patients:* Were the patients offered an influenza vaccination for the most recent influenza season?	Not applicable		
13.7	*For all patients 50 to 75 years of age:* Are the patients offered colorectal cancer screening?	Not applicable		
13.8	*For female patients 50 to 74 years of age:* Is the patient offered a mammography at least every two years?	Not applicable		
13.9	*For female patients 21 to 65 years of age:* Is the patient offered a Papanicolaou test at least every three years?	Not applicable		
	Overall Quantitative Review Score:			**66.7%**

Comments:

1. Question 13.2 – Not applicable. There is no indication that the six patients who were on anti-TB medications during the review period, missed or refused their prescribed anti-TB medications. Therefore, this question could not be evaluated.

2. Question 13.3 – Of the six medical records reviewed, two records had documentation showing the patients were monitored on a monthly basis while they were on anti-TB medications. The remaining four records did not have any such documentation. This equates to 33.3% compliance.

3. Questions 13.4 and 13.5 – Non applicable. Per the methodology, these questions are evaluated once per calendar year and during the audit review period when the annual TB testing occurs per the master calendar on Lifeline. As the audit review period for FCRF's current audit did not encompass the month when the facility provided annual TB testing and screening to its CDCR patient population, these questions could not be evaluated for compliance with this requirement.

4. Questions 13.6 through 13.9 – Not applicable. Per the methodology, these questions are evaluated once per calendar year during the time when the onsite audit is conducted within the first half of the fiscal year (July through December). As the current onsite audit for FCRF was not conducted during the first half of the fiscal year, this question will be evaluated during the subsequent audit.

14. EMERGENCY MEDICAL RESPONSE/DRILLS & EQUIPMENT

Case Review Rating:
Not Applicable

Quantitative Review Score [Rating]:
61.7% [Inadequate]

Overall Rating:
Inadequate

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

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

The facility received a compliance score of 61.7%, resulting in an *inadequate* overall rating for the *Emergency Medical Response/Drills & Equipment* indicator. Six out of 18 questions rated below an adequate range of 85.0% compliance and require the facility's immediate attention in resolving these deficiencies. Refer to the *Comments* section, following the table below, for additional information and details on the deficiencies identified during the quantitative review of this indicator.

Quantitative Review Results

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

Emergency Medical Response/Drills & Equipment		Yes	No	Compliance
14.1	Does the facility conduct emergency medical response drills quarterly on each shift when medical staff is present?	1	5	16.7%
14.2	Does a Basic Life Support certified health care staff respond without delay after emergency medical alarm is sounded during an emergency medical response (man-down) and/or drill?	6	0	100%
14.3	Does a registered nurse or a primary care provider respond within eight minutes after emergency medical alarm is sounded for an emergency medical response (man-down) and/or drill?	6	1	85.7%
14.4	Does the facility hold an Emergency Medical Response Review Committee a minimum of once per month?	5	1	83.3%
14.5	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required documents?	0	7	0.0%
14.6	Is the facility's clinic Emergency Medical Response Bag secured with a seal?	93	0	100%
14.7	If the emergency medical response and/or drill warrant an opening of the Emergency Medical Response Bag, is the bag re-supplied and re-sealed before the end of the shift?	0	1	0.0%
14.8	If the emergency medical response bag has not been used for emergency medical response and/or drill, is it being inventoried at least once a month?	1	5	16.7%
14.9	Does the facility's Emergency Medical Response Bag contain only the supplies identified on the Emergency Medical Response Bag Checklist in compliance with Inmate Medical Services Policies and Procedures requirements?	0	1	0.0%
14.10	Is the facility's Medical Emergency Crash Cart secured with a seal? (COCF Only)		Not applicable	
14.11	If the emergency medical response and/or drill warrant an opening and use of the medical emergency crash cart, is the crash cart re-supplied and re-sealed before the end of the shift? (COCF Only)		Not applicable	
14.12	If the medical emergency crash cart has not been used for a medical emergency and/or drill, was it inventoried at least once a month? (COCF Only)		Not applicable	
14.13	Does the facility's crash cart contain all the medications as required/approved per *Inmate Medical Services Policies and Procedures*? (COCF Only)		Not applicable	
14.14	Does the facility's crash cart contain the supplies identified on the facility's crash cart checklist? (COCF Only)		Not applicable	
14.15	Does the facility have a functional Automated External Defibrillator with electrode pads located in the medical clinic?	2	0	100%
14.16	Does the facility have a functional 12-lead electrocardiogram machine with electrode pads? (COCF Only)	1	0	100%
14.17	Does the facility have a functional portable suction device?	1	0	100%
14.18	Does the facility have a portable oxygen system that is operational ready?	2	0	100%
	Overall Quantitative Review Score:			**61.7%**

Comments:

1. Question 14.1 – For the audit review period of November 2015 through April 2016, FCRF conducted only one emergency medical response (EMR) drill out of a total of six EMR drills the facility was required to conduct during the time frame. This equates to 16.7% compliance.
2. Question 14.2 – For the audit review period of November 2015 through April 2016, FCRF conducted one EMR drill and had six actual medical emergencies. During the actual response on February 23, 2016, it was found that no time was documented when the BLS certified health care staff responded to an

emergency. However, per the double failure rule, this non-compliant incident was not included in the compliance rating of this question as it was rated non-compliant in Question 14.3.

3. Question 14.3 – For the audit review period of November 2015 through April 2016, FCRF conducted one EMR drill and had six actual medical emergencies. During the actual response that occurred on February 23, 2016, the time when the RN or PCP responded to the emergency was not documented. This equates to 85.7% compliance.

4. Question 14.4 – Of the six Emergency Medical Response Review Committee (EMRRC) meetings the facility conducted during the audit review period, the meeting minutes for November 2015 had not been signed by the Warden per the requirement stated in IMSP&P. This equates to 83.3% compliance.

5. Question 14.5 – Although during the audit review period the EMRRC performed timely reviews of the incident packages; the incident packages did not include all the required documents. Of the seven incident packages submitted to the EMRRC for review and discussion, all were missing documents. The incident packets submitted for emergency responses that occurred on November 21 and December 13, 2015, and February 23 and March 6, 2016 were missing treatment flow sheets and nurse's notes. The incident packets for the emergency responses that occurred on February 25 and March 26, 2016 were missing treatment flow sheets. The incident packet for the drill conducted on March 31, 2016, was missing both the nurse's notes and cardiopulmonary resuscitation report. This equates to 0.0% compliance.

6. Question 14.7 –Of the seven emergency medical responses/drills reviewed, only one drill warranted opening of the EMR bag. The EMR bag log reviewed reflected the EMR bag was not restocked and re-sealed before the end of the shift following the incident. This equates to 0.0% compliance.

7. Question 14.8 – Review of the EMR bag log for the audit review period of November 2015 through April 2016 revealed that the facility health care staff had not inventoried the EMR bag during the months of November 2015 through March 2016 when the bag had not been used for emergency medical response and/or drills. This equates to 16.7% compliance.

8. Question 14.9 – The facility has one EMR bag, which when inspected and reconciled with the EMR Bag Checklist, was found to be missing supplies that were listed on the checklist such as one oral airway and four "Ace" wraps. Additionally, it was found that the sterile eye drops had expired. This equates to 0.0% compliance.

9. Question 14.10 through 14.14 – Not applicable. These questions do not apply to in-state correctional facilities as they do not maintain a medical emergency crash cart.

15. CLINICAL ENVIRONMENT

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

Case Review Rating:
Not Applicable

Quantitative Review Score [Rating]:
85.9% [Adequate]

Overall Rating:
Adequate

The facility received a compliance score of 85.9% in the *Clinical Environment* indicator, equating to an overall rating of ***adequate***. The facility demonstrated poor record keeping in some of the areas such as maintenance of cleaning log and sharp count logs. The facility did not have records of cleaning for almost 15 days for the month of May 2016 despite the clinic being operational 24 hours a day. The sharp count logs also had several missing entries as well as inconsistencies on some dates and nursing shifts. Although the required frequency of sharp instrument count is three times a day (corresponding to three eight-hour nursing shifts), the documentation in the log reflected inconsistencies in times and shifts when the sharps were being counted. Refer to *Comments* section following the table below for information on the two deficiencies identified in this indicator.

Quantitative Review Results

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

Clinical Environment		**Yes**	**No**	**Compliance**
15.1	Are packaged sterilized reusable medical instruments within the expiration dates shown on the sterile packaging?	Not Applicable		
15.2	If autoclave sterilization is used, is there documentation showing weekly spore testing?	1	0	100%
15.3	Are disposable medical instruments discarded after one use into the biohazard material containers?	2	0	100%
15.4	Does clinical health care staff adhere to universal hand hygiene precautions?	3	0	100%
15.5	Is personal protective equipment readily accessible for clinical staff use?	3	0	100%
15.6	Is the reusable non-invasive medical equipment disinfected between each patient use when exposed to blood-borne pathogens or bodily fluids?	3	0	100%
15.7	Does the facility utilize a hospital grade disinfectant to clean common clinic areas with high foot traffic?	1	0	100%
15.8	Is environmental cleaning of common clinic areas with high foot traffic completed at least once a day?	17	14	54.8%
15.9	Is the biohazard waste bagged in a red, moisture-proof biohazard bag and stored in a labeled biohazard container in each exam room?	4	0	100%
15.10	Is the clinic's generated biohazard waste properly secured in the facility's central storage location that is labeled as a "biohazard" area?	0	1	0.0%
15.11	Are sharps/needles disposed of in a puncture resistant, leak-proof container that is closeable, locked, and labeled with a biohazard symbol?	4	0	100%
15.12	Does the facility store all sharps/needles in a secure location?	1	0	100%
15.13	Does the health care staff account for and reconcile all sharps at the beginning and end of each shift?	76	17	81.7%
15.14	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	1	0	100%
15.15	Is the facility's biomedical equipment serviced and calibrated annually?	14	2	87.5%
15.16	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	1	1	50.0%

15.17	Does the clinic visit location ensure the patient's visual and auditory privacy?	1	0	100%
			Overall Quantitative Review Score:	**85.9%**

Comments:

1. Question 15.1– Not applicable. FCRF does not use reusable medical instruments; therefore, this question could not be evaluated.
2. Question 15.8 – The facility's cleaning log for the month of May 2016 was reviewed. Of a total of 31 days, daily cleaning was documented for 17 days. There was no documentation available for May 1, 7, 8, 10, 14-22 and May 27, 2016. This equates to 54.8% compliance.
3. Question 15.10 – The facility had one central location for storage of biohazard waste. Upon inspection, the location was found to be inadequately secured and did not display the "biohazard" label. Additionally the biohazard waste was stored along with recyclable materials and non-operational appliances. This equates to 0.0% compliance.
4. Question 15.13 – The facility's sharps logs were inspected for the month of May 2016. It was found that out of a total of 93 shifts (31 days x 3 shifts), sharps counts were completed during 76 shifts. This equates to 81.7% compliance.
5. Question 15.15 – Of the 16 pieces of medical equipment inspected, 2 pulse oximeters were missing calibration stickers. This equates to 87.5% compliance.
6. Question 15.16 – The facility's two exam rooms were inspected and one of the exam rooms was missing an Ophthalmoscope and Otoscope. This equates to 50.0% compliance.

16. QUALITY OF NURSING PERFORMANCE

Case Review Rating:
Inadequate

Quantitative Review Score [Rating]:
Not Applicable

Overall Rating:
Inadequate

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

Case Review Results

The *Quality of Nursing Performance* at FCRF was rated *inadequate*. This determination was based upon the detailed case review of all the nursing services provided to 10 patients housed at FCRF during the audit review period of November 2015 through April 2016. Of the 10 detailed case reviews conducted by the CCHCS nurse consultant, six were found *adequate* and remaining four were found *inadequate*. Out of a total of 213 nursing encounters/visits assessed within the 10 detailed case reviews, 49 deficiencies were identified related to nursing care and performance. The majority of the deficiencies involved inadequate nursing assessment, non-compliance with Standard Nursing Protocols, IMSP&P policies and

procedures, and the medication management processes. The nursing services found to be inadequate/ deficient at FCRF include:

- Nursing staff's failure to document date of receipt on the CDCR Form 7362 (identified in Case # 5).
- Incomplete nursing subjective and objective assessments related to patient's chief medical complaints (identified in Case # 4).
- Incomplete nursing assessments of patient's wounds, pain, vital signs and history of illness (identified in Case # 4).
- Incorrectly dispensing unapproved medications such as throat lozenges or cough drops for upper respiratory infections; this is not compliant with CDCR Standard Nursing Protocols (identified in Cases 2 and 3).
- Incomplete nursing documentation of nursing diagnosis or treatment plan (identified in Case # 6).
- Missing signature of the RN to indicate if the medication was provided to the patient as ordered (identified in Case # 5).
- Delay in obtaining a signed CDCR Form 7225 *Refusal of Examination and/or Treatment* form from the patient for refused specialty care services (identified in Case # 5).
- Failure of facility's nursing staff to document if services such as diagnostic tests, blood pressure checks, specialty care referrals etc., were provided to the patient per PCP's orders (identified in Cases 2, 3, 6, 8 and 9).
- Missing and/or incomplete documentation of RN completing an initial health screening of the patient upon her arrival to the facility (identified in Cases 10, 11, 12 and 13).
- Missing CDCR Form 7371 *Health Care Transfer Information* form for patients who transferred out of the facility (identified in Cases 8, 14 and 15).
- Missing documentation of RN screening the patient for signs and symptoms of TB upon arrival (identified in Cases 10, 11, 12 and 13).
- Delays in administration of ordered medications (identified in Cases 1 and 5).
- Wrong dosage of the ordered medication administered to the patient (identified in Case # 8).
- Missing documentation of the patient receiving prescribed medications (identified in Cases 1, 2, 3, 4, 5, 7, 8, 9 and 10).

Case Number	Deficiencies
Case 1	***Adequate.*** A 30-year old patient was diagnosed with vaginitis due to mycoplasma and ureaplasma. Of 24 nursing encounters reviewed for this patient, only three encounters were found deficient (previously discussed under Chapter 10 - *Medication Management*). Two deficiencies involved absence of the MAR in the EHRS, which would show that Doxycycline and Imodium were given as ordered. The third deficiency involved a late administration of Avelox, which was ordered on March 25, 2016 but it was not given until April 1, 2016. Since the deficiencies did not have significant impact on patient care, nursing performance was

	deemed adequate.
Case 2	***Adequate.*** A 29-year old patient complained of a heavy menstrual period and abdominal cramps. The PCP ordered a gynecology referral for the patient for heavy menstrual period and fibroid. A total of 27 nursing encounters were reviewed for this patient and five encounters were deemed deficient. Two deficiencies were related to the non-availability of the MAR in the EHRS during the time of review; another deficiency pertains to non-administration of the last doses of Amoxicillin and Acyclovir on March 9, 2016 (discussed under Chapter 10 *Medication Management*). The fourth deficiency involved non-compliance with Nursing Protocol related to the administration of cough drops (discussed under Chapter 4 - *Access to Care*). The fifth was related to non-availability of documentation showing a gynecological consult was carried out as ordered (discussed under Chapter 12 - *Specialty Services*). Since the deficiencies did not have significant impact on patient care, nursing performance was deemed adequate.
Case 3	***Inadequate.*** A 26-year old patient with no chronic diagnoses complained of one episode of chest pain and on and off difficulty breathing. A total of 32 nursing encounters were reviewed and 11 deficiencies were found. Six out of 11 deficiencies were related to absence of a MAR showing medications were administered as ordered. Medications involved were Amitriptyline, Ranitidine/TUMS, Amoxicillin, Omeprazole, Guiacon cough syrup, Benadryl, Prednisone, and CTM (discussed under Chapter 10 - *Medication Management*). Four of 11 deficiencies were related to nursing staff's non-compliance with the treatment plan specified in the Standard Nursing Protocol, e.g., administration of non-approved throat lozenges, administration of 81 mg instead of 325 mg of aspirin, administration of Pepto bismuth in lieu of Loperamide for diarrhea. Due to multiple and significant nature of deficiencies, which could potentially impact patient care, nursing performance was deemed inadequate.
Case 4	***Inadequate.*** A 42-year old patient complained of multiple episodes of upper respiratory problems such as sore throat, nasal stuffiness and she also complained of headaches and rashes on the chest area during the audit review period. A total of 29 nursing encounters were reviewed for this patient and nine encounters were deficient. Three of nine deficiencies were related to non-availability of a MAR that would show that ibuprofen, Loratadine and hydrocortisone were administered as ordered. Two deficiencies were related to non-compliance with the Standard Nursing Protocol regarding the non-approved use of cough drops and senna tablets. Another two deficiencies were related to inadequate nursing assessments such as no documentation of pain scale when the patient complained of pain and no assessment of the causes, extent, and description of the patient's rash. One deficiency was inappropriate nursing action related to the patient's complaint such as the use of Bacitracin ointment for treatment of a rash. The last deficiency pertained to absence of a signed CDCR Form 7225 *Refusal of Examination and/or Treatment* form when the patient refused ibuprofen for headache. Due to multiple and significant nature of deficiencies, which could potentially impact patient care, nursing performance was deemed inadequate.
Case 5	***Inadequate.*** A 41-year old patient with chronic diagnoses of morbid obesity, tinea corporis, Hepatitis C, complaints of blurry vision, persistent rash under the breast and infected toe during the audit review period. A total of 21 nursing encounters were reviewed for this patient and six encounters were found deficient. Four of six deficiencies were related to medication administration as follows: A dose of Hepatitis B vaccine was ordered STAT on December 4, 2015 but was given late on December 16, 2015; nursing administered hydrocortisone cream on January 25, 2016 when it had been discontinued on January 15, 2016; no documentation that Simvastatin was given as ordered; no documentation that Bisacodyl was given as ordered since there was no nurse signature against the medication in the MAR. One of six deficiencies had no receipt date on the CDCR Form 7362's. The last deficiency was related to untimely nursing action; the patient refused an optometry test on January 16, 2016 but the CDCR Form 7225 *Refusal of Examination and/or Treatment* form was obtained on January 19, 2016. Due to multiple and significant nature of deficiencies, which could potentially impact patient care,

	nursing performance was deemed inadequate.
Case 6	***Adequate.*** A 31-year old patient with chronic diagnoses of morbid obesity and HTN was seen for consistently high BP, otitis externa and abdominal pain due to cholelithiasis. A total of 16 nursing encounters were reviewed for this patient and four encounters were found deficient. Three deficiencies pertained to implementation of provider's order: Blood pressure was not consistently monitored as ordered; no laboratory report or nursing documentation that a comprehensive metabolic panel (CMP) and lipid panel (x2) were done as ordered. The fourth deficiency pertained to absence of nursing documentation regarding treatment plan and nursing diagnoses. Since the deficiencies did not have a significant impact on patient care, nursing performance was deemed adequate.
Case 7	***Adequate.*** A 33-year old female patient with chronic diagnoses of hepatitis C and obesity complained of persistent nausea and abdominal pain during the review period. A total of 35 nursing encounters were reviewed for this patient and only three encounters were found deficient. Two deficiencies were related to the absence of documentation or MAR showing Hepatitis A & B vaccines and Ranitidine/Omeprazole were given as ordered. The third deficiency was related to nursing staff administering Pepto bismuth to the patient which is against Standard Nursing Protocol. Since the deficiencies were minimal and minor in nature, nursing performance was deemed adequate.
Case 8	***Inadequate.*** A 47-year old with chronic diagnoses of HTN, Diabetes Mellitus, palpitations and morbid obesity complained of infected left big toe and persistent abdominal pain during the audit review period. A total of 16 nursing encounters were reviewed for this patient and five encounters were found deficient. Three deficiencies were related to medication administration: First, a wrong dosage of Lisinopril was given to the patient on November 16, 2015; the ordered dose was 5 mg tab daily but the patient was given 25 mg; absence of MAR that would show Flagyl, Cipro (x1) and Nystatin (x1) were given as ordered. The second deficiency was related to the absence of laboratory reports or nursing documentation showing ordered laboratory exams (lipid panel, BMP, HbA1C, urine micro albumin) were done. The third deficiency was the non-completion of a CDCR Form 7371, *Health Care Transfer Information* form when the patient was transferred out of the facility to CCWF. It is worthy to note that the wrong dosage of Lisinopril could adversely impact patient care and therefore, due to the nature and frequency of deficiencies, nursing performance was deemed inadequate.
Case 9	***Adequate.*** A 62-year old female patient with chronic diagnoses of HTN, Gastro Esophageal Reflux Disease (GERD), and hyperlipidemia with a history of recurrent UTI complained of abdominal pain, weakness and headache. A total of 14 nursing encounters were reviewed and four encounters were found deficient. Three deficiencies were related to no documentation in the MAR that medications such as Bactrim, Ranitidine, Loratadine and Lisinopril were given as ordered. The fourth deficiency was no documentation that urinalysis was done as ordered. Since the deficiencies did not have significant impact on patient care, nursing performance was deemed adequate.
Case 10	***Adequate.*** A 49-year old female patient with chronic diagnoses of hypertension, anemia, and menorrhagia was diagnosed with uncontrolled hypertension, upper respiratory infection and heavy menstrual flow during the audit review period. A total of 12 encounters were reviewed and two encounters were found deficient. The two deficiencies were: No MAR showing Vitamin D and Lisinopril were given as ordered for December; Initial Health Screening and TB screening were not done when the patient transferred in from another facility. Due to the minimal and minor nature of deficiencies, nursing performance was deemed adequate.

Majority of the deficiencies were related to the non-availability of the MAR in the EHRS. The facility should work collaboratively with their hub institution (CCWF) to ensure the scanning of documents in the EHRS is completed and ensure expedition of the process. A few significant medication errors such as wrong dosages and administration of non-ordered and non-protocol medications must be seriously

addressed by the facility's management since these errors could adversely impact patient care. Likewise, the nursing staff should be very diligent in their documentation of every encounter with the patient. One of the essential and basic principles of nursing practice is adequate and accurate documentation. Anything not documented is considered not done. Therefore, it is imperative that nursing documentation is accurate, complete, timely, valid, relevant, and legible. Additionally, nursing staff must be very conscientious and follow the providers' orders correctly and thoroughly, especially as it relates to medication administration.

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

- Implement an internal monitoring process to ensure documents submitted to the hub by the facility are being scanned into the EHRS in a timely manner.
- Monitoring of medication administration by conducting focused audits.
- Implement a process that ensures chronic care medications are ordered and received by the patient prior to the patient finishing the existing supply.
- Implement a process to ensure correct doses of medications are administered to the patient as indicated in the PCP's orders and the medication administration is promptly documented in the MAR.
- Facility's health care management staff to provide training for nursing staff with an emphasis on the importance of documenting all services provided to the patients in the medical records.
- Implement a process to ensure that nursing staff consistently follow IMSP&P Standard Nursing Protocols when dispensing over the counter medications to the patients and providing non-pharmacological advice to patients regarding self-management of symptoms.
- Facility's health care management staff to provide training for nursing staff with an emphasis on the importance of a conducting a complete subjective and objective nursing assessment related to the patient's complaint and documenting a diagnosis following the assessment.

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

17. QUALITY OF PROVIDER PERFORMANCE

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

Case Review Results

Based on the 15 in-depth case reviews completed by CCHCS physician, the facility provider performance was *inadequate*. Of the 15 detailed case reviews conducted, two were found to be *adequate*, and thirteen were *inadequate*. Out of a total of 99 physician encounters/visits assessed, 56 deficiencies were identified. These deficiencies ranged from severe to minor and a number of deficiencies were due to the provider's tendency to treat patients with excessive doses of medications notwithstanding the lack of symptoms or findings to justify the treatments. The provider seemed inclined to prescribe services that do not meet the "medical necessity" criteria established by Title 15. Overall, the care provided by the PCP did not meet applicable standards of care as established in published CCHCS clinical guidelines, state law (Title 15) and federal standards for adequate health care. The physician services found to be inadequate/deficient at FCRF include:

Case Review Rating:
Inadequate

Quantitative Review Score [Rating]:
Not Applicable

Overall Rating:
Inadequate

- Vaginal cultures ordered without medical necessity and provider ignorant regarding care and treatment for vaginitis (identified in Cases 1 and 3).
- Provider failed to establish a diagnosis following evaluation of patient symptoms (identified in Cases 1, 2, 7, 8, 9, 13 and 15).
- Provider's tendency to use polypharmacy to treat symptoms (the patients were prescribed multiple medications and antibiotics without any clinical evidence or laboratory finding to substantiate treatments chosen) (identified in Cases 1, 3, and 4).
- Provider failed to effectively communicate with patients regarding weight control and non-pharmacological methods to alleviate symptoms (identified in Cases 7, 10 and 15).
- Provider failed to refer patients to appropriate specialty care services in a timely manner in spite of the patient's critical condition and/or patient's pre-existing risk factors for cancer (identified in Cases 6 and 13).
- Provider did not effectively monitor weight control of patients with BMI of 34 and above (identified in Cases 5, 7, 8, 10, 11, 13 and 14).
- Provider did not follow best practices and manufacturer's recommendations when ordering medications (identified in Cases 1, 3 and 15).
- Provider failed to consider the likelihood of patients' other existing health issues as contributing factors while determining diagnoses (identified in Cases 2, 6 and 9).
- Limited history and examination for patient complaints (identified in Cases 2, 6 and 8).

Case Number	Deficiencies
Case 1	***Inadequate.*** A 30-year old patient complaining about vaginal discharge was seen by the PCP; vaginal cultures were ordered multiple times and the patient was repeatedly treated with alternating anti-bacterial and anti-fungal agents with no marked improvement. The patient's symptoms worsened due to repeated antibiotic therapy and she developed candidal vaginosis. The PCP did not seem very knowledgeable about rendering basic care for vaginitis. The PCP referred for a gynecology consultation which was not appropriate or effective. There was no

	evidence of clinical infection that required specialty consultation. There was no documentation in the medical record to show the PCP had a conversation with the specialist regarding the patient's condition. The patient suffered needlessly from recurrent vaginitis due to bacterial and yeast infections apparently due to the PCP's efforts to treat the infection with multiple antibiotics and other medications without any significant clinical and/or laboratory findings to justify the treatments. The CCHCS physician concluded that vaginal cultures are worthless for diagnostic purposes in any immuno competent patient. Patients, who are not sexually active, do not need pharmacological treatment for bacterial vaginosis as that condition usually improves/resolves spontaneously. Repeated antibiotic therapies, as in this case, can make the patient's condition worse due to prolific growth of yeast or the patients may develop side-effects to the antibiotics. CCHCS physician's review of this patient's care on site suggested overzealous treatment by PCP, demonstrated by the excessive use of antibiotics for treating mild/physiological discharge.
Case 2	***Inadequate.*** A 29-year old patient complained of heavy menstrual period and abdominal cramps. There were no significant findings in the lab results to explain the patient's complaints of tiredness. The PCP ordered benzoyl peroxide for patient's mild acne although benzoyl peroxide did not meet *Title 15* criteria. In spite of patient's obesity, anxiety and situational depression, the facility PCP did not consider possible mental health issues while making the diagnosis. When the same patient complained of sore throat and vesicular rash in the genitalia, the PCP prescribed Amoxicillin and Acyclovir. Treatment with Amoxicillin was inappropriate in the absence of strep throat and/or bacterial sinusitis. Additionally, the prescribed dose was determined to be too high. Similar to the previous case, treatment with antibiotics was excessive and unnecessary. Treatment of sinusitis with antibiotics is an exceedingly common practice these days; however, it is an incorrect practice to follow. The PCP also failed to describe significant details of the patient's vesicular rash in the progress note such as, if the rash was painful, recurrent, etc. The CCHCS physician counseled the PCP to refrain from prescribing antibiotics for non-bacterial sinusitis without the evidence of a bacterial infection. The PCP was also advised against prescribing benzoyl peroxide for cosmetic treatments.
Case 3	***Inadequate.*** A 26-year old morbidly obese patient with vague chest complaints, likely mild GERD, was treated with high doses of multiple antibiotics similar to Cases 1 and 2. When the patient complained of cough, the PCP prescribed high doses of multiple antibiotics after making a presumptive diagnosis of pneumonia. The patient's temperature was normal and the respiratory rate (18 breaths per minute) did not indicate pneumonia. The PCP also prescribed Amitriptyline for the patient's migraine without any clinical findings or evidence supportive of diagnosis and the medication that was prescribed was determined to be inappropriate to treat the condition. When the patient complained of vaginal discharge, the PCP prescribed antibiotics without any clinical evidence of an infection. Vaginal cultures shall not be used to establish diagnoses that are properly made on clinical grounds. When the vaginal culture tested positive for Trichomonas, the PCP prescribed another antibiotic for treating the condition. The patient was also ordered triple antibiotic therapy for H. pylori gastritis without any significant symptoms indicating a need for the antibiotic treatment. CCHCS physician found the PCP's practice of prescribing excessive amounts of unnecessary antibiotics and polypharmacy, in the absence of evidence based diagnoses to justify presumed diagnoses and/or treatments, to be alarming and dangerous.
Case 4	***Inadequate.*** A 42-year old patient complained of multiple episodes of upper respiratory problems such as sore throat, nasal stuffiness and she also complained of headaches and rashes on the chest area during the audit review period. The patient had a history of migraine but refused to take low dose Nortriptyline because it caused her to "act crazy". The PCP prescribed Topamax without objective evidence or confirmed history of migraine headaches. According to CCHCS physician auditor, even if the diagnosis of migraine had been established by evidence (which was not, in this case), the ideal first line of prophylactic treatment would be with a calcium channel blocker. The physician auditor determined Topamax to be non-formulary and

	potentially toxic for the patient. The patient was seen for macular eruption on left side of the neck and chest, the PCP made a presumptive diagnosis of contact dermatitis and prescribed a systemic steroid, prednisone to be taken for three days. Systemic steroid is inappropriate treatment for minor contact dermatitis. The PCP continued to prescribe medications without appropriate and necessary assessment of risks versus benefits and did not monitor Creatinine in the patient's blood per manufacturer's recommendation when the patient was on Topamax. When the CCHCS physician auditor met with the PCP and the patient during the onsite audit, patient reported unilateral face pain and stuffy nose consistent with cluster headache syndrome. Physician's reviewed the patient's record and found that a complete history had been documented which had been previously incomplete at the time of initial review.
Case 5	***Inadequate.*** A 41-year old morbidly obese patient, who was pre-diabetic was not adequately treated and monitored to promote weight loss. The patient was diagnosed with Hepatitis C and had a BMI of 44. The PCP did not follow up with the patient as frequently as needed to address the issue of morbid obesity and chronic Hepatitis C which posed a risk for fatty liver. CCHCS physician determined that there was a high risk of life threatening liver failure if the patient's weight reduction was not intensely monitored and managed. PCP's lack of attention to weight with office visits spaced 30 - 90 days apart does not demonstrate sufficient concern for health outcomes. As in previous cases, the PCP prescribed excessive antibiotics for a minor toe irritation and failed to adequately educate the patient on non-pharmacological measures to alleviate skin rashes and toe inflammation.
Case 6	***Inadequate.*** A 32-year old patient with suspected gallbladder disease was shuttled back and forth from hospital with risky treatments as an out-patient. When the patient complained of worsening right lateral quadrant pain, the PCP did not perform a detailed appraisal and prescribed ibuprofen for the pain. The patient's condition worsened and she was transported to the community hospital ED. Upon the patient's return from the ED, PCP's evaluation indicated acute gallbladder disease and the patient's lab results showed elevated liver enzymes. The PCP ordered triple antibiotics for the patient and submitted in a routine request for a referral for surgical evaluation and sent the patient to the dorm. The PCP did not communicate with the ED physician and the surgeon which posed a grave risk to patient's life. The patient developed a fever when housed in the dorm and her symptoms grew worse. The patient was once again sent to the hospital where the patient underwent a Cholecystectomy. Due to the PCP failing to expedite the request for a surgical evaluation and the resultant delay in the patient's evaluation unnecessarily placed the patient at risk of death from Cholecystitis. The CCHCS physician determined the patient was extremely fortunate to have undergone laparoscopic gallbladder removal before becoming morbidly ill.
Case 7	***Inadequate.*** A 52 year old patient was prescribed multiple BP medications although the patient's BP was well within normal range without medications. The patient was also prescribed Nortriptyline for unclear reasons. The PCP's documentation in the progress notes vaguely indicated that it had been ordered for the patient's foot pain. The patient returned to the clinic a month later complaining of palpitations and dizziness, possibly due to being overmedicated with BP medications. However, the PCP did not discontinue the BP medications and did not advise the patient on weight reduction. There was no diagnosis made regarding the foot pain and the diagnosis of BP appeared to be suspicious. The patient was being overmedicated for no valid reason. When the patient was diagnosed with UTI, the PCP ordered Bactrim which was appropriate. However, the patient developed diarrhea, a possible side-effect from Bactrim and the PCP diagnosed the condition as C. difficile infection. The PCP prescribed an antibiotic as treatment. The CCHCS physician did not find sufficient evidence that suggested C. difficile infection and treatment with an antibiotic was therefore considered inappropriate. The PCP failed to advise non-pharmacological methods to the patient to alleviate the symptoms such as bowel rest and avoiding dairy products. This case also further demonstrates the PCP's practice of polypharmacy.

Case 8	***Inadequate.*** A 31-year old obese patient complained of right ear pain and discharge. The PCP diagnosed the condition as Otitis Externa without considering the possibility of Diabetes Mellitus which could have possibly predisposed patient to the condition. The CCHCS physician auditor noted that the PCP did not focus on advising the patient of a focused weight control plan in spite of patient's BMI of 45 and PCP ordered Cortisporin otic solution to be administered BID instead of four times a day (QID) which is the recommended dose for effective treatment of Otitis Externa. The PCP also prescribed amoxicillin which was unnecessary. The patient was followed up by the PCP one week later, which was much delayed. The patient should have been followed up sooner.
Case 9	***Inadequate.*** A 37-year old female patient with a history of migraines. In February 2016, this patient was seen for complaint of sore throat, fever, and cough. During examination, the patient's temperature was recorded as 99.3 and the tonsils were observed to be swollen without exudates. The patient diagnosed with pharyngitis and prescribed Amoxicillin. The diagnosis of pharyngitis does not justify treatment with Amoxicillin. Treatment of viral pharyngitis (as in this case) with antibiotic is inappropriate. Even if the diagnosis had been bacterial pharyngitis, the prescribed dose was incorrect. A month later, the patient was seen for a follow-up upon her return from hospital visit for nausea and headache and the exam was normal. The PCP prescribed Omeprazole, Simethicone, Colace, and a breath test for H. Pylori. PCP failed to document a diagnosis to support treatment with Omeprazole or the reason for conducting a breath test for H Pylori. In the month of April 2016, the patient was once again seen for complaint of nausea and vomiting for one day in association with migraine. The examination was normal. However, the patient was diagnosed with "nausea and vomiting" and prescribed the medication Benadryl, Reglan, and electrolytes. Patient was ordered to return for a follow-up visit in three days. "Nausea and Vomiting" are symptoms, not a diagnosis. The treatment provided is not according to best practice. There was no indication for treatment with Benadryl, Reglan or electrolyte solution. Proper treatment would be to advise patient to consume clear liquids and the follow-up appointment should have been completed the following day.
Case 10	***Inadequate.*** A 39-year old obese female patient with history of BP and treated with the medication Lisinopril. Patient seen for chronic care appointment for HTN and the BP was found to be well controlled. PCP failed to adequately discuss lifestyle changes or weight control. Lisinopril dose prescribed was more than the manufacturer recommended dose. Return appointment set for "as needed". The patient should be seen more frequently to monitor weight. The patient was seen ten days later for follow-up laboratory tests and blood pressure check. The patient's Low-Density Lipoprotein (LDL) was 165 and BP was recorded as 143/84. Lisinopril dose continued and the medication Simvastatin added. Two months later the patient was seen for complaint of runny nose. The patient had gained weight since the previous visit. The PCP failed to adequately address the patient's weight and diagnosed the patient with allergic rhinitis and prescribed the medication Zyrtec. The patient did not need medication for a transient runny nose and there was no clinical finding to support diagnosis of allergic rhinitis. Patient advised to follow-up as needed. Next scheduled follow-up (as needed) is inadequate as patient's obesity remains an issue and requires more attention.
Case 11	***Adequate.*** A 29-year old obese female patient was diagnosed with diabetes and was being treated with the medication Metformin. The patient's Hemoglobin A1c (HbA1c) deteriorated from 7.5 to 9.9 during the time period December 2015 through March 2016. During the February 2016 chronic care visit, the patient's blood sugars were noted to range from 193-369. The PCP increased the patient's Metformin dosage but failed to prescribe a restrictive diet or provide dietary counseling. During a March 2016 chronic care appointment, the patient's HbA1c was noted to be 9.9. The PCP advised exercise and diet and follow-up in one week. The patient was seen one week later with increased weight gain. The PCP failed to provide more aggressive care for the patient's uncontrolled diabetes by implementing a more intense monitoring of the patient's diet and increasing the diabetic medications (such as prescribing a higher dose of Metformin, sulfonylurea, or insulin). The patient required a closer follow-up to ensure diabetes

	was brought under control.
Case 12	***Adequate.*** A 37-year old patient followed up by ophthalmology at hub institution for iritis which was resolved; however, the patient was diagnosed with acute papilledema soon after. Patient seen by PCP for follow-up following ophthalmology visit. FCRF care appropriate.
Case 13	***Inadequate.*** A 40-year old obese female patient with a family history (mother at age 44) of breast cancer was recommended by the PCP to conduct self-exam of breasts during history and physical examination held in February 2016; however, the PCP failed to order a mammogram. During the same month, the patient complained of vaginal discharge and a vaginal culture was taken but no diagnosis was documented. During March 2016, the patient was prescribed anti-thyroid drug just based on low TSH levels even though other clinical symptoms related to hyperthyroidism was absent. The presumption of hyperthyroidism based on TSH test without overt clinical signs consistent with hyperthyroidism is errant. The PCP should have considered other reasons for the low TSH levels like AIDS, Hepatitis, effects of the drugs the patient was taking at the time, and even the possibility of an erroneous lab result instead of presuming hyperthyroidism just based on low TSH levels. Additionally, the anti-thyroid drug, Methimazole can be toxic and cause adverse side-effects in patients without thyroid disease. In April 2016, the patient complained of decreased urine frequency and the PCP diagnosed the condition as UTI and prescribed Bactrim. Since the patient has some vaginal discharge, it would be difficult to assess or obtain a clean catch urine sample due to vaginal discharge at the time of exam, to justify treatment with antibiotic. Under such circumstances, the CCHCS physician auditor considered treatment with Bactrim to be excessive. The patient discontinued the Methimazole as it caused stomach upset. Ranitidine was prescribed. Patient continued to complain of nausea and pelvic pain and was diagnosed with H. pylori Gastritis and prescribed Flagyl, Tetracycline and bismuth. PCP failed to follow-up with endocrinology or to discuss the patient's symptoms with the hub PCP staff. Polypharmacy causes epigastric distress. Significant side effects of medicine likely to be more harmful than beneficial. The patient was later seen for heaviness of breasts. During examination, breasts were tender to palpation but no diagnosis was made. Additionally, the PCP identified the thyroid gland to be mildly enlarged. The PCP failed to refer the patient for specialty services to address the risk of breast cancer or the enlarged thyroid nodule. Inaccurate or delayed diagnosis results in a delay of medically necessary services and puts the patient at risk of harm.
Case 14	***Inadequate.*** A 28-year old obese patient with purported history of hyperthyroidism and palpitation was prescribed Methimazole and Metoprolol. The patient had a body mass index (BMI) of 37 and continued to gain weight. There were no laboratory findings to support the diagnosis of hyper or hypothyroidism. The patient's TSH is marginally lower than normal. The patient was prescribed synthetic thyroid medication for unclear reasons. The diagnosis of hyperthyroidism is questionable. There are no laboratory results or clinical support for the diagnosis. A specialty consultation is required if the diagnosis is uncertain or unusual. The patient was continued on a high dose of Metoprolol even though she had a low blood pressure and her High-Density Lipoprotein (HDL) was 42. The PCP failed to schedule a follow-up to ensure compliance with diet and monitor the patient's weight. No diagnosis was established to justify pharmacological treatment of palpitations.
Case 15	**Inadequate.** A 38-year old patient was seen during the month of December 2016, for complaints of heartburn and headache. Although the examination turned out to be normal, the patient's diagnosis was "headaches" and was prescribed Nortriptyline. "Headaches" is not a diagnosis and treatment with an anti-depressant is inappropriate. It is dangerous to dispense psychoactive central nervous system depressants as KOP medications. When the patient continued to complain of headache, the PCP increased the dosage of Nortriptyline and ordered additional medications Tylenol and Ibuprofen; however, the PCP failed to make a diagnosis. During the same month, The same patient was seen for inflammation due to ingrown hairs and was prescribed the medication Doxycycline. Appropriate care would be to advise local hygiene

and hot soaks, not antibiotics. In March 2016, the patient was again seen for one day history of diarrhea and vomiting with no weight loss or signs of dehydration. The patient was assessed as having "acute gastroenteritis" and was treated with the following medications: two doses of Reglan, one dose of Flagyl, and three doses of electrolytes. The PCP failed to obtain laboratory diagnostic tests to establish if the gastroenteritis was viral or bacterial kind to justify the prescribing of the Flagyl. Electrolytes are unnecessary unless there is evidence of dehydration or electrolyte imbalance. The patient was scheduled for follow-up on nurse line for abdominal pain and diarrhea. No follow-up was completed. The diagnosis was not supported by clinical evidence and treatment was inappropriate as unnecessary medication exposed the patient to risk of harm from side effects. The PCP was observed to recurrently exercise Polypharmacy and the medications prescribed were inappropriate and exposed the patient to risk of harm from side effects.

The physician findings and recommendations in this report were based upon the observations made during the facility tour, interviews with medical staff, interview with Inmate Advisory Committee (IAC) patients, and review of selected medical records. Following are some recommendations provided by CCHCS physician auditor on how the provider's performance at FCRF may be improved:

- Provider shall confer regularly with the staff nurses for a collective review of patients with significant complaints, chronic diseases, or any case determined to be challenging.
- Provider shall request hub medical leadership's advice regarding patient complaints for which a diagnosis has been elusive or if there no noticeable improvement in patients' symptoms.
- Pharmacological therapy should be provided in accordance with *Title 15*, which calls for the provision of **ONLY** those services that are medically necessary. For example, no prescription is indicated to treat minor acne, or physiological vaginal discharges.
- Medications shall be prescribed only in accordance with the Food and Drug Administration (FDA) approved indications and at doses described as proper and effective by authoritative references. Examples are:
  - Amoxicillin is not prescribed 500mg QID even when antibiotics are indicated.
  - Amitriptyline and Nortriptyline are not appropriate therapies for headaches.
  - Topamax is not a first line of drug for migraine prophylaxis.
  - Anti-thyroid medications shall be prescribed to patients only if there is clear laboratory proof of hyperthyroidism and these medications should not be prescribed to patients who are clinically euthyroid (normal).
  - Systemic treatment for bacterial vaginosis is inappropriate except in rare circumstances such as when in association with pregnancy.
  - Treatments for GERD shall follow algorithm that requires a preliminary diagnosis of significant dyspepsia that is unrelated to non-steroidal anti-inflammatory drugs (NSAID), drug side effect, or transient conditions, before initiating triple drug therapy.
  - Reglan and Flagyl are not appropriate treatments for non specific gastroenteritis and therefore should not be prescribed for such cases.

- Obesity that significantly affects patient's health (such as morbid obesity or any patient overweight and diabetic) needs to be treated as a serious medical condition with regular monitoring and frequent visits.
- Abnormal findings and/or reports should be documented, followed with focused history and examinations, and then treated in accordance with best practices. A notable example of abnormal findings not properly followed up was evidenced in Case # 13, where the patient reported her mother's breast cancer at the age 40. However, no BRCA gene testing was done for the patient and no repeat mammograms were completed as recommended by American Congress of Obstetricians and Gynecologist, American Academy of Family Physicians, and United States Preventive Services Task Force Standards.
- Recommendations for outside consultations need to be considered cautiously in view of *Title 15* (For example, a patient with bacterial vaginosis probably does not need gynecology consultation; however, a patient with a high risk of breast cancer does merit consultation, as does a patient with hyperthyroidism).
- Patient privacy needs to be respected and maintained at all times during clinic visits. The provider shall inquire with the patient for permission to keep the door open during interviews and exams. If the patient chooses the door to be closed, the provider can request a nurse or custody officer to be present in the room during the encounter.
- Lab results placed on the provider's desk should be accompanied by the patient chart for easy reference.
- As a general rule, the provider shall provide patient with materials only from the approved patient information sheets and not from the Physician Guidelines.
- The provider should be instructed by the Obstetrics and Gynecology (Ob-Gyn) specialist at the hub institution regarding current standards of care for women's health care matters.
- The provider needs to access *UpToDate* and current textbooks to review best practices for all conditions she treats, particularly the following:

  - Graves Disease and other causes of hyperthyroidism
  - Migraine headaches
  - Cholecystitis
  - Vaginitis
  - Hypothyroidism
  - Obesity
  - Urinary tract infections
  - Abdominal pain and gastroenteritis
  - Somatic symptom disorder, factitious disorders

PRIOR CRITICAL ISSUE RESOLUTION

The audit from February 2015 resulted in the identification of 31 quantitative and 5 qualitative critical issues. On November 4, 2015, CCHCS auditors performed a Corrective Action Plan (CAP) Review where the previously identified critical issues were reviewed. At the time of the CAP Review, 26 of the 36 items were found to be resolved and 10 remained unresolved. During the current audit, auditors found four of the ten remaining issues resolved; of the remaining six issues, three issues are no longer measured in the new audit instrument due to elimination of those questions from the audit instrument and three issues were determined to be unresolved. Below is a discussion of each previous critical issue:

1. *Question 2.2 (Formerly Question 6.5) – THE QUALITY MANAGEMENT COMMITTEE DOES NOT COMPLETE AN ANALYSIS FOR EACH "OPPORTUNITY FOR IMPROVEMENT" AS LISTED ON THE ASPECTS OF CARE MONITORING FORM OR SIMILAR FORM.*

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

This issue was initially identified during the February 2015 audit. During the CAP Review, three quarterly QMC meeting minutes were reviewed. The meeting minutes indicated that the QMC did not complete analyses for the identified opportunities for improvement nor recommended an action plan to improve performance for any of the identified issues. During the current audit, five months of QMC meeting minutes were reviewed and all meeting minutes contained a complete analysis for identified opportunities for improvement, resulting in 100% compliance. The findings show that FCRF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

2. *Question 7.2 – THE PRIMARY CARE PROVIDER DOES NOT CONSISTENTLY REVIEW, INITIAL, AND DATE ALL PATIENT DIAGNOSTIC TEST REPORTS WITHIN THE SPECIFIED TIMEFRAME.*

Prior Compliance	Current Compliance	Status
80.0%	100%	**Resolved**

This issue was initially identified during the February 2015 audit. During the CAP Review, five patient medical files were reviewed and four were found compliant with this requirement, resulting in 80.0% compliance. During the current audit all 18 records were compliant with this requirement resulting in 100% compliance. The findings show that FCRF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

3. *Question 6.1 (Formerly Question 8.4) – THE FACILITY'S NURSING STAFF DOES NOT CONSISTENLY DOCUMENT THE REVIEW OF THE PATIENT'S DISCHARGE PLAN UPON THE PATIENT'S RETURN TO THE FACILITY FROM THE COMMUNITY HOSPITAL EMERGENCY DEPARTMENT.*

Prior Compliance	Current Compliance	Status
80.0%	N/A	**Unresolved**

This issue was initially identified during the February 2015 audit. During the CAP Review, five patient medical files were reviewed and four were found compliant with this requirement, resulting in 80.0% compliance. During the current audit, 13 patients were sent to a community hospital emergency department; ten patients returned to FCRF without being admitted to the hospital and the remaining three patients were permanently transferred to the hub following

their discharge. There were no valid samples available to evaluate compliance for this requirement; therefore, this standard could not be evaluated. This deficiency is considered unresolved and will continue to be monitored during subsequent audits.

4. *Question 6.2 (Formerly Question 8.5) – THE FACILITY'S NURSING STAFF DOES NOT CONSISTENTLY DOCUMENT THE FACE-TO-FACE EVALUATION OF THE PATIENTS UPON THEIR RETURN TO THE FACILITY FROM THE COMMUNITY HOSPITAL EMERGENCY DEPARTMENT.*

Prior Compliance	Current Compliance	Status
80.0%	N/A	**Unresolved**

This issue was initially identified during the February 2015 audit. During the CAP review, five patient medical files were reviewed and four were found compliant with this requirement, resulting in 80.0% compliance. During the current audit, 13 patients were sent to a community hospital emergency department; ten patients returned to FCRF without being admitted to the hospital and the remaining three patients were permanently transferred to the hub following discharge. There were no valid samples available to evaluate compliance for this requirement; therefore, this standard could not be evaluated. This deficiency is considered unresolved and will continue to be monitored during subsequent audits.

5. *Part of Question 1.4 (Formerly Question 10.1) – THE PATIENT ORIENTATION MANUAL/HANDBOOK DOES NOT EXPLAIN THE HEALTH CARE GRIEVANCE/APPEAL PROCESS IN DETAIL.*

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

This issue was initially identified during the February 2015 audit. During the CAP Review, the audit team found there were no revisions or updates made to this section of the handbook, resulting in 0.0% compliance. During the current audit, the audit team found that FCRF continued to be non-compliant by failing to update the health care grievance/appeal process in the patient handbook, resulting in 0.0% compliance. This deficiency is considered unresolved and will continue to be monitored during subsequent audits. The facility's management is strongly encouraged to take immediate action to address and resolve this critical issue as it has been outstanding for over 18 months.

6. *Question 10.1 (Formerly Question 14.2) – THE PRIMARY CARE PROVIDER DOES NOT CONSISTENTLY DOCUMENT THAT THE NEWLY PRESCRIBED MEDICATION WAS EXPLAINED TO THE PATIENT.*

Prior Compliance	Current Compliance	Status
80.0%	100%	**Resolved**

This issue was initially identified during the February 2015 audit. During the CAP review, five patient medical files were reviewed and four were found to be compliant with this requirement, resulting in 80.0% compliance. During the current audit all 18 records were compliant with this rating resulting in 100% compliance. The findings show that FCRF has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

7. *Question 15.2 – BASED ON THE SPECIALTY CARE MONITORING LOG, THE PATIENTS ARE NOT CONSISTENTLY SEEN WITHIN THE SPECIFIED TIME FRAMES AS SET FORTH IN THE SPECIALTY CARE POLICY.*

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

8. *Question 15.3 – BASED ON THE EMERGENCY/HOSPITAL SERVICES MONITORING LOG, THE PATIENTS ARE NOT CONSISTENTLY SEEN WITHIN THE SPECIFIED TIME FRAMES AS SET FORTH IN THE EMERGENCY/HOSPITAL POLICY.*

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

9. *Question 15.4 – BASED ON THE CHRONIC CARE MONTORING LOG, THE PATIENTS ARE NOT CONSISTENTLY SEEN WITHIN THE SPECIFIED TIME FRAME AS SET FORTH IN THE CHRONIC CARE POLICY.*

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

10. *Question 5.1* (Formerly Question 5.1) – THE PATIENT'S CHRONIC CARE FOLLOW-UP VISITS ARE NOT CONSISTENLY COMPLETED WITHIN THE 90-DAY OR LESS TIME FRAME, OR AS ORDERED BY THE TREATING PRIMARY CARE PROVIDER.

Prior Compliance	Current Compliance	Status
60.0%	86.7%	**Resolved**

This issue was initially identified as a qualitative CAP item during the February 2015 audit. During the November 2015 CAP Review, five patient medical records were reviewed for compliance with this requirement. Two cases were found non-compliant as the patients were not seen within the time frames specified by the PCP, resulting in 60.0% compliance. During the current audit, auditors reviewed 30 patient records of which only four did not meet this requirement, resulting in 86.7% compliance. The findings show that FCRF has successfully addressed this deficiency and is within the compliance threshold of 85.0% compliance; therefore, this critical issue is considered resolved.

NEW CRITICAL ISSUES

As a result of the current audit, there were 25 new critical issues identified. There were no new qualitative critical issues identified. All of the quantitative review existing and new critical issues are addressed in the "Audit Findings – Detailed by Quality Indicator" section of this report.

CONCLUSION

The audit findings presented in this report encompass evaluation of care provided by the facility to its patient population from November 1, 2015 through April 30, 2016. The facility's overall performance during this time frame was rated *inadequate*. Of the 15 quality indicators evaluated, CCHCS auditors rated one *proficient*, six *adequate* and eight *inadequate* (see Executive Summary Table on page 4). Although the facility has resolved four of the seven outstanding critical issues and three were not measured at this time, 25 new critical issues were identified during the current audit.

Some of the specific issues that raise the audit team's concern are:

- facility's LOPs are not in compliance with the IMSP&P guidelines,
- inconsistency in holding the QMC and EMRRC meetings monthly,
- facility's failure in conducting the emergency medical response drills quarterly as required by policy,
- patients not receiving their medications timely or as ordered by provider,
- not administering the prescribed medication as ordered by PCP,
- nursing staff's failure to conduct a thorough assessment of patients based on the information on the CDCR Forms 7277 and7277 A,
- failure to screen the patients for signs and symptoms of TB upon their arrival at the facility,
- failure to fill new and existing prescription medication orders within the specified time frame for newly arrived patients,
- inadequate monitoring of patients on anti-TB medications,
- inadequate management of the emergency medical response equipment and inventory,
- facility's failure to properly secure and label the biohazard waste in the central storage location,
- facility's failure in updating the health care grievance/appeal process in the patient handbook,
- health care staffs' failure to establish effective communication with the patients regarding self-management of minor clinical symptoms,
- missing and/or incomplete documentation in the patients' medical records,
- provider practice of polypharmacy,
- provider's lack of training in female specific health care issues,
- provider's failure in establishing definitive diagnoses based on clinical or laboratory findings,
- provider's lack of communication with the hub specialists, physicians, ED physicians, surgeons, other outside providers to discuss complicated cases,
- provider's failure to follow best practices, IMSP&P and Title 15 guidelines when providing treatment to patients, and
- provider's failure in adequately monitoring patients with dangerous health issues and risk factors.

These are some of the more critical issues that were identified during current audit which may create barriers preventing the patients from receiving an adequate level of care. The audit team recommended the executive team establish self-auditing tools and processes in the areas that require a more focused approach and close monitoring to ensure compliance with the established protocols and guidelines.

CCHCS physician auditor noted that although the facility provider had access to CCHCS policies and guidelines, in a substantial number of medical encounters evaluated through case reviews, patient care varied substantially from the best practices deployed at the hub. CCHCS physician determined that the provider care did not meet applicable standards of care as established in published CCHCS clinical guidelines, California Code of Regulations (*Title 15*) and federal standards for adequate health care. Of the 15 cases reviewed, 13 were deemed to be *inadequate* mostly because there was not sufficient evidence of diseases or conditions described by the provider to merit the treatment provided. The provider did not meet with the staff nurses to discuss challenging cases and did not monitor the care provided by the nursing and specialty care services and thus failed to exercise quality management with regard to monitoring the overall care provided to the patient. The provider also did not regularly audit the medical care or medical record documentation completed by the nursing staff. The communications between the facility provider and the outside providers such as specialists, hub physicians, hub Ob-Gyn consultant, ED physicians and surgeons were very scarce. When interviewed by the physician auditor, the provider did not describe any instance where she consulted with the above mentioned medical consultants or specialists to discuss complicated cases (such as purported vaginitis, suspected hyperthyroidism, headaches, abdominal pain, and breast cancer). The CCHCS physician auditor observed the provider had a tendency to over-prescribe for the patient's complaint. The provider also limited her attention to patient's immediate complaint rather than take responsibility as a PCP for health maintenance. CCHCS physician auditor concluded that there was much room for improvement.

CCHCS physician auditor did not observe any apparent back log for patient care. There were no instances of medication lapses or discontinuity of care. Aside from the provider's reticence to call the hub for consultation, patients were able to access needed services including optometry, dental, mental health and emergency services.

CCHCS nurse auditor found several discrepancies during the onsite observations and inspections of various logs maintained by the facility which have been described in detail in the previous sections of the report. Overall, the facility did not perform well based on required standards.

GEO Group Incorporated (GEO) has recently appointed a new regional health services manager, who is responsible for assisting the facility health care staff with addressing identified issues and helping FCRF reach the required performance standards and achieve compliance in all health care delivery areas. The health services manager seems to be conscientious and enthusiastic to implement changes to assist the facility in achieving the goal of improving the quality of patient care and compliance to the IMSP&P standards of care. The facility is adequately staffed with RNs working three eight-hour shifts. The facility recently hired a Director of Nursing who was in the orientation process at the time of the audit; she will serve as the HSA after completion of her orientation. She has previous experience working in other prison facilities; however, she is yet to familiarize herself with the PPCMU Audit Tool and other CCHCS requirements. The regional health services manager is currently providing her with all the necessary tools and training in order for her to successfully perform her duties as HSA once appointed.

At the conclusion of the onsite visit on Friday, June 10, 2016, the audit team met with the Warden, GEO's Western Region Health Services Manager, the day shift RN, and the facility's provider to present the findings of the audit. This meeting afforded the audit team an opportunity to provide feedback and recommendations on the case review, the chart review and the onsite findings. The facility's health care staff were receptive and open to the findings presented by the audit team. CCHCS physician auditor recommended to GEO and the facility management that the provider care requires monitoring on a regular basis for improvement in the deficient areas noted in the earlier sections of the report. The audit team reiterated to the facility health care staff and management that it is imperative that the

facility diligently work with their hub institution to facilitate training to all of the facility's health care staff. The facility provider needs a lot of guidance from the hub physicians and specialists regarding female specific health care issues and their treatment and training on CCHCS best practices in order to provide adequate treatment to the patient population. Conversely, it must be pointed out that the majority of the deficiencies mentioned in the quantitative sections of this report are easily correctable and are within the management's scope of control to ensure compliance.

PATIENT INTERVIEWS

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

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

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

Comments:

During the onsite visit in June 2016, the audit team interviewed three IAC representatives.

Inmate Advisory Council interview – During the interview with the IAC representatives, all three representatives reported that the patient population at FCRF have no issues in accessing medical care when required. They also stated that all emergency cases received the necessary care without delay. The IAC representatives did not voice any issues with regards to accessing

optometry, dental and mental health care services at FCRF. One of the IAC representatives claimed that if they ran out of their over-the-counter pain medications, it took a month to receive refills. CCHCS physician auditor informed the patient that it was not required by the health care staff to provide a refill since it was not a prescription medication and if the patients felt that they needed the medication for chronic pain management, they could inform the PCP of their needs and request the PCP to prescribe pain medication for effective pain management. However, the final decision will be taken by the PCP based on the PCP's evaluation of the patient to validate the need for such medication.

1. Regarding questions 1 through 4 – All ten interviewed patients were aware of the sick call process and had ready access to the forms, if needed.
2. Regarding questions 5 through 8 – Of the ten patients interviewed, all were aware of the health care grievance/appeal process and some have even utilized the process in the past.
3. Regarding questions 9 through 21 – There was only one ADA patient housed at FCRF during the audit. This patient was interviewed and the patient did not raise any concerns regarding the accommodations or health care provided at the facility. The patient also was aware of the ADA grievance/appeal process although the patient had not submitted any appeals in the past. The patients stated that health care staff at FCRF were attentive to all her health care needs and effectively communicated with her when necessary.