May 23, 2016

Jim MacDonald, Warden
La Palma Correctional Center
5501 N. La Palma Road
Eloy, AZ 85131

Dear Warden MacDonald:

The staff from California Correctional Health Care Services (CCHCS) completed an onsite health care monitoring audit at La Palma Correctional Center (LPCC) on February 22-25, 2016. The purpose of this audit was to ensure that LPCC is meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006.

On April 13, 2016, a draft report was sent to your management providing the opportunity to review and dispute any findings presented in the draft. On April 27, 2016, your facility submitted responses disputing five of the audit team's quantitative findings and three of the case review findings. The attached documents reflect four of the five quantitative items and two case review findings disputed which have been reconsidered. Acceptance of these disputes has resulted in the removal of two items from the *Identification of Critical issues* section and the ratings of two disputed case reviews have been changed to *adequate*. Additionally the overall rating for chapter 8, "Emergency Services" has been changed from *inadequate to adequate* which has resulted in an increase in overall audit rating from ***1.0*** to ***1.1***. Refer to the attached documents for the CCHCS's detailed response to questions and items disputed by LPCC.

Also attached you will find the final audit report in which LPCC received an overall audit rating of ***adequate***. 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, LPCC was providing adequate health care to CDCR inmate-patients housed at the facility. However, a number of minor and critical deficiencies were identified in the following program components and require facility's immediate attention and resolution:

- Chronic Care Management
- Diagnostic Services
- Specialty Services
- Preventive Services

The facility's lack of improvement in resolving critical issues that were previously identified in health care delivery areas like chronic care management, diagnostic services and medication management will potentially result in significant impediments to patient care. This is especially true with regards to patients not receiving their chronic care medications in a timely manner and the patients not being referred to the provider for medication non-compliance. With only about 41 percent of the previous deficiencies resolved, efforts to overcome these issues must be expedited. These deficiencies require the facility's immediate attention and resolution.

The deficient areas listed above 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* and the contract.

Thank you for your assistance and please extend my gratitude to your staff for their professionalism and cooperation during this audit. Should you have any questions or concerns, you may contact Donna Heisser, Health Program Manager II, PPCMU, 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: Richard Kirkland, Chief Deputy Receiver, CCHCS
Diana Toche, Undersecretary, Health Care Services, California Department of Corrections and Rehabilitation (CDCR)
R. Steven Tharratt, M.D., M.P.V.M., F.A.C.P., Director, Health Care Operations, CCHCS
John Dovey, Director, Corrections Services, CCHCS
Kathleen Allison, Director, Division of Adult Institutions (DAI), CDCR
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Ricki Barnett, M.D., Assistant Statewide Medical Executive and Deputy Director, Medical Services, CCHCS

Jeffrey Carrick, M.D., Deputy Medical Executive, Utilization Management, CCHCS
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Cheryl Schutt, Statewide Chief Nurse Executive, Nursing Services, CCHCS
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Kelly Medina, Correctional Administrator, Female Offender Programs and Services, CDCR
John Baxter, M.D., Vice President, Health Services, California Contract Facilities, Corrections Corporations of America (CCA)
Keith Ivens, M.D., Chief Medical Officer, CCA
Susan Montford, R.N., Regional Director, Health Services, California Contract Facilities, CCA
William Crane, M.D., Regional Medical Director, California Compliance Physician, CCA
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Kala Srinivasan, Health Program Specialist I, PPCMU, Field Operations, Corrections Services, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT

LA PALMA CORRECTIONAL CENTER

February 22-25, 2016

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INTRODUCTION

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

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

This report provides the findings associated with the onsite audit conducted between February 22 and 25, 2016, at La Palma Correctional Center (LPCC), which is located in Eloy, Arizona, in addition to the findings associated with the review of various documents and patient medical records for the audit review period of June 2015 through November 2015. At the time of the audit, CDCR's *Weekly Population Count*, dated February 19, 2016, indicated a budgeted bed capacity of 3,146 beds, of which 2,661 were occupied with CDCR inmates.

EXECUTIVE SUMMARY

From February 22 through 25, 2016, the CCHCS audit team conducted an onsite health care monitoring audit at LPCC. The audit team consisted of the following personnel:

B. Barnett, MD, JD, MBA, CCHP, Chief Medical Consultant
L. Pareja, RN, MSN, Nurse Consultant Program Review
K. Srinivasan, Health Program Specialist I
N. Pratap, 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 LPPC. The end product of the quantitative review is expressed as a compliance score, while the end product of clinical case reviews is a quality rating.

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

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

Based on the quantitative reviews and clinical case reviews completed for the 17 operational areas/quality indicators during the audit, LPCC achieved an overall point value of ***1.1*** which resulted in an overall audit rating of ***adequate***.

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	100.0%	Proficient	Proficient	2.0
2. Internal Monitoring & QM	N/A	86.4%	Adequate	Adequate	1.0
3. Licensing/Certification, Training & Staffing	N/A	90.1%	Proficient	Proficient	2.0
4. Access to Care	Adequate	93.1%	Proficient	Adequate	1.0
5. Chronic Care Management	Proficient	25.8%	Inadequate	Inadequate	0.0
6. Community Hospital Discharge	Adequate	84.4%	Inadequate	Adequate	1.0
7. Diagnostic Services	Adequate	72.1%	Inadequate	Adequate	1.0
8. Emergency Services	Adequate	N/A	N/A	Adequate	1.0
9. Health Appraisal/Health Care Transfer	Adequate	65.4%	Inadequate	Adequate	1.0
10. Medication Management	Adequate	93.5%	Proficient	Adequate	1.0
11. Observation Cells	Adequate	96.4%	Proficient	Adequate	1.0
12. Specialty Services	Proficient	89.1%	Adequate	Proficient	2.0
13. Preventive Services	N/A	60.6%	Inadequate	Inadequate	0.0
14. Emergency Medical Response/Drills & Equipment	N/A	82.9%	Inadequate	Inadequate	0.0
15. Clinical Environment	N/A	95.8%	Proficient	Proficient	2.0
16. Quality of Nursing Performance	Adequate	N/A	N/A	Adequate	1.0
17. Quality of Provider Performance	Adequate	N/A	N/A	Adequate	1.0
				Average	1.1
				Overall Audit Rating	Adequate

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 (starting from page 13 onward) sections of this report.

BACKGROUND AND PROCESS CHANGES

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

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

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

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

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

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

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

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

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

Quantitative Review

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

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

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

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

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

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

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

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

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

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

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

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

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

Qualitative Review

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

This methodology is useful for identifying systemic areas of concern that may compel further investigation and quality improvement. Typically, individuals selected for the case review are those who have received multiple or complex services or have been identified with poorly controlled chronic conditions. The cases are analyzed for documentation related to chronic care, specialty care, diagnostic services, medication management and urgent/emergent encounters. The CCHCS 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 reviews. For all those chapters under the *Medical Quality Indicator* section, whose compliance is evaluated utilizing both quantitative and clinical case reviews, more weight is assigned to the rating results from the clinical case reviews, as it directly relates to the health care provided to patients. However, the overall quality rating for each operational area is not determined by clinical case reviews alone. This is determined on a case by case basis by evaluating the deficiencies identified and their direct impact on the overall health care delivery at the facility. The physician and nurse auditors discuss the ratings obtained as a result of their case reviews and ratings obtained from quantitative review to arrive at the overall rating for each operational area.

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

Overall Audit Rating

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

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

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

- **Proficient** - Since the cut-off value for a proficient rating in the quantitative review is 90.0% and the highest available point value for quality rating is 2.0, 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

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

Scoring for Non-Applicable Questions and Double-Failures:

Questions that do not apply to the facility are noted as Not Applicable (N/A). For the purpose of chapter 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 – La Palma Correctional Center	
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 2.7	The facility does not accurately document all the dates on the hospital stay/emergency department monitoring log.
Question 2.9	The facility does not accurately document all the dates on the initial intake screening monitoring log.
Question 2.13	The facility does not process the patients' first level health care appeals within the 30 day time frame.
Question 3.3	Some of facility's health care staff is not trained on the facility's policies and procedures based on IMSP&P requirements.
Question 3.5	The facility does not have the required provider staffing per contractual requirement.
Question 4.6	The registered nurse (RN) does not consistently document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data.
Question 4.13	The RN does not consistently conduct daily rounds in segregated housing units to collect sick call request forms.
Question 5.2	The patient's chronic care medications are not consistently received by the patient without interruption.
Question 5.4	The RN does not refer the patients to the provider for medication non-compliance if the patients do not show or refuse the nurse administered/direct observation therapy chronic care medications for three consecutive days or 50 or more doses in a week.
Question 5.6	The RN does not refer the patients to the provider for medication non-compliance if they do not show or refuse their insulin.
Question 6.1	The RN does not consistently review the patient's discharge plan upon the patient's return from a community hospital.
Question 6.4	The facility does not consistently administer/deliver all prescribed medications to the patient per policy or as ordered by the provider.
Question 7.1	The facility does not consistently complete the diagnostic tests within the time frame specified by the provider.
Question 7.3	The facility does not consistently provide a written notification of the diagnostic test result to the patient within two business days of receipt of result.
Question 7.4	The patient is not consistently seen by the provider for clinically significant/abnormal test results within 14 days of the provider's review of the results.

Question 9.2	The RN does not consistently document an assessment of the patient was completed if the patient answered 'yes' to any of the medical problems listed on the *Initial Health Screening* form.
Question 9.7	The patient is not consistently seen by the provider within the specified time frame if the patient had been referred by the sending facility's provider for a medical, dental or mental health appointment.
Question 9.10	The patients arriving at the facility with existing medication orders do not consistently receive their prescribed medications timely.
Question 10.2	The facility does not consistently administer the initial dose of a newly prescribed medication to the patient as ordered by the provider.
Question 11.1	The patient is not consistently assessed by the RN every eight hours or more frequently as ordered by the provider when housed in an observation cell.
Question 12.4	The RN does not consistently notify the provider of any immediate orders or follow-up instructions provided by the specialty care consultant or emergency department physician upon the patient's return from a specialty consult appointment or community emergency department visit.
Question 13.2	The nursing staff does not notify the provider or public health nurse when the patient misses or refuses the anti-Tuberculosis medication.
Question 13.3	The facility does not consistently monitor the patient monthly when the patient is on anti-Tuberculosis medication.
Question 14.7	The facility's health care staff does not consistently re-supply and re-seal the Emergency Medical Response Bag before the end of the shift if the emergency medical response and/or drill warranted an opening of the bag.
Question 14.11	The facility's health care staff does not consistently re-supply and re-seal the crash cart before the end of the shift if the emergency medical response and/or drill warranted an opening and use of the crash cart.
Question 14.13	The facility's crash cart does not contain all the medications as required/approved per IMSP&P.
Question 14.14	The facility's crash cart does not contain all the supplies as required/approved per IMSP&P.
Question 15.4	The facility's clinical health care staff does not consistently adhere to universal hand hygiene precautions.
Question 15.6	The facility health care staff does not consistently disinfect reusable non-invasive medical equipment between each patient use when exposed to blood borne pathogens or bodily fluids.
Question 15.15	The facility's biomedical equipment is not consistently calibrated and serviced on a regular basis.

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]:
100% [Proficient]
Overall Rating:
Proficient

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

The facility received a compliance score of 100% in the *Administrative Operations* indicator, equating to the overall rating of *proficient*.

Quantitative Review Results

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

Administrative Operations		**Yes**	**No**	**Compliance**
1.1	Does health care staff have access to the facility's health care policies and procedures and know how to access them?	5	0	100%
1.2	Does the facility have written health care policies and/or procedures that are in compliance with *Inmate Medical Services Policies and Procedures* guidelines?	15	0	100%
1.3	Does the facility have current contracts/agreements for routine oxygen tank maintenance service, hazardous waste removal, and repair, maintenance, inspection, and testing of biomedical equipment?	3	0	100%
1.4	Does the patient orientation handbook/manual or similar document explain the sick call and health care grievance/appeal processes?	2	0	100%
1.5	Does the facility's health care staff access the California Correctional Health Care Services patient's electronic medical record?	12	0	100%
1.6	Does the facility maintain a Release of Information log that contains all the required data fields?	3	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?	N/A	N/A	N/A
			Overall Quantitative Review Score:	**100%**

Comments:

1. Question 8 – Not Applicable (N/A). 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 Quality Management Committee (QMC) meetings to determine if the facility identifies opportunities for improvement, implements action plans to address the identified deficiencies identified and continuously monitors the quality of health care provided to patients. Also, CCHCS auditors evaluate whether the facility promptly processes patient medical appeals and appropriately addresses all appealed issues.

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
86.4% [Adequate]
Overall Rating:
Adequate

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

LPCC received an *adequate* compliance score of 86.4% in the *Internal Monitoring and Quality Management* indicator. Eight of the 13 questions assessed in this component scored in the *proficient* range and 5 questions scored in the *inadequate* range (below 85.0% compliance). The low-scoring questions were those related to the monitoring logs and health care grievance and appeal process. Although LPCC has shown remarkable improvement in submitting the weekly and monthly monitoring logs on time, the facility still struggles to accurately record the dates of service provided to patients as evidenced during the review of the sick call, specialty care, and intake screening monitoring logs. There has been significant improvement in accuracy of dates documented on the chronic care and intake screening logs. The auditors discussed the issues identified with the data entered in the monitoring logs with the assigned staff and recommended steps they could adopt to resolve the identified issues.

There were various issues identified with LPCC's first level health care appeal (CDCR 602-HC) process. Upon inspecting the health care appeals tracking log, it was found that the dates documented on the log

were different from the dates documented on the CDCR 602-HC forms. In certain cases, it took more than four days for the appeal responses to reach the Grievance Coordinator's office, as a result the patients received the responses later than the 30 day time frame. Most of the appeals submitted by the patients were regarding co-pays and money that was deducted for medical appliances such as glasses, dentures, etc. and LPCC had granted more than half of these appeals. It was also noted on the appeal that the co-pay charges had been reversed to the patient's account. These findings correlated with the patients' claims regarding the facility overcharging them for sick call visits. The discrepancies with the dates on the logs were discussed with the HSA. The auditor was informed that the clerk, who was responsible for the log, is no longer employed at LPCC.

Quantitative Review Results

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

Internal Monitoring & Quality Management		**Yes**	**No**	**Compliance**
2.1	Does the facility hold a Quality Management Committee a minimum of once per month?	6	0	100%
2.2	Does the Quality Management Committee's review process include documented corrective action plan for the identified opportunities for improvement?	6	0	100%
2.3	Does the Quality Management Committee's review process include monitoring of defined aspects of care?	6	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?	88	2	97.8%
2.5	Are the dates documented on the sick call monitoring log accurate?	25	27	48.1%
2.6	Are the dates documented on the specialty care monitoring log accurate?	31	17	64.6%
2.7	Are the dates documented on the hospital stay/emergency department monitoring log accurate?	28	10	73.7%
2.8	Are the dates documented on the chronic care monitoring log accurate?	54	6	90.0%
2.9	Are the dates documented on the initial intake screening monitoring log accurate?	48	12	80.0%
2.10	Are the CDCR Forms 602-HC, *Patient-Inmate Health Care Appeals,* readily available to patients in all housing units?	30	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?	30	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?	48	22	68.6%
	Overall Quantitative Review Score:			**86.4%**

Comments:

1. Question 2.4 – During the audit review period of June through November 2015, 90 submissions of monitoring logs were required. Of the 90 monitoring logs submitted, 88 were timely. This equates to 97.8% 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	26	0
Specialty Care	weekly	26	26	0
Hospital Stay/Emergency Department	weekly	26	26	0
Chronic Care	monthly	6	5	1
Initial Intake Screening	monthly	6	5	1
	Totals:	**90**	**88**	**2**

2. 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, 25 were found to be accurate with dates matching the dates of service reflected in the patients' medical records. Discrepancies identified within the remaining 27 entries were mostly within the dates the sick call request was received and reviewed and the RN face-to-face appointment dates. Some of the entries recorded on the log could not be validated as the sick call request forms could not be located or found in the patients' medical record. This equates to 48.1% compliance.

3. Question 2.6 – A total of 48 entries were randomly selected from the weekly specialty care monitoring logs to assess the accuracy of the dates reported on the log. Of the 48 entries reviewed, 31 were found to be accurate with dates matching the dates of service reflected in the patients' medical records. Discrepancies identified within the remaining 17 entries were mostly within the dates of provider referral to specialty services. This equates to 64.6% compliance.

4. Question 2.7 – A total of 38 entries were randomly selected from the weekly hospital stay/emergency department (ER) log to assess the accuracy of the dates reported on the log. Of the 38 entries reviewed, 28 were found to be accurate with dates matching the dates of service reflected in the patients' medical records. Discrepancies identified within the remaining 10 entries were within the dates of the patients' transport to the ER, the patients' date of return to the facility following a hospital stay and/or ER visit and the dates of RN and provider follow-up appointment. This equates to 73.7% compliance.

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, 54 were found to be accurate with dates matching the dates of service reflected in the patients' medical record. The remaining six deficiencies were related to missing and/or incorrect assessment dates documented on the log. This equates to 90.0% compliance.

6. Question 2.9 – A total of 60 entries were randomly selected from the monthly intake screening monitoring logs to assess the accuracy of the dates reported on the log. Of the 60 entries reviewed, 48 were found to be accurate with dates matching the dates of service reflected in the patients' medical record. Discrepancies identified within the remaining 12 entries were mostly within the patient's date of arrival and the date of intake screening. This equates to 80.0% compliance.

7. Question 2.13 – The facility received a total of 70 first level health care appeals during the audit review period June through November 2015. Of the 70 appeals received, 48 were processed and the response delivered to the patient within the 30 day time frame. Of the 22 appeals that were non-compliant, 2 had tracking numbers that were different from the numbers documented on the appeals tracking log and

therefore could not be validated. The remaining 20 appeals were processed outside the 30 day time frame. This equates to 68.6% compliance.

3. LICENSING/CERTIFICATIONS, TRAINING, & STAFFING

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
90.1% [Proficient]
Overall Rating:
Proficient

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

The facility received a compliance score of 90.1% in *Licensing/Certifications, Training, and Staffing* indicator, equating to an overall rating of *proficient*. The main deficiencies identified were concerning health care staffs training on the facility's policies and procedures and staffing. At the time of the audit the facility had vacancies for two mid-level providers, one registered nurse (RN) and one licensed vocational nurse (LVN). Additionally, the facility had finalized hiring one mid-level provider whose credentials had been approved by CCHCS. The provider's scheduled start date is March 14, 2016.

Quantitative Review Results

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

Licensing/Certifications, Training, & Staffing		Yes	No	Compliance
3.1	Are all health care staff licenses current?	40	0	100%
3.2	Are health care and custody staff current with required medical emergency response certifications?	453	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?	30	14	68.2%
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?	2.0	2.0	50.0%
3.6	Does the facility have the required nurse staffing complement per contractual	26.0	2.0	92.9%

	requirement?			
3.7	Does the facility have the required clinical support staffing complement per contractual requirement? (COCF Only)?	7.0	0.0	100%
3.8	Does the facility have the required management staffing complement per contractual requirement? (COCF Only)	4.0	0.0	100%
3.9	Are the peer reviews of the facility's providers completed within the required time frames?	2	0	100%
			Overall Quantitative Review Score:	**90.1%**

Comments:

1. Question 3.3 – Of a total of 44 health care staff at the facility, 30 staff were current on their training. The remaining 14 staff had not completed their training on the facility's policies and procedures that had been revised recently based on the latest revisions to the IMSP&P. This equates to 68.2% compliance.
2. Question 3.5 – The facility is contractually required to be staffed with 2.0 full time equivalent (FTE) primary care provider (PCP) and 2.0 FTE mid-level provider positions. Of a total of four providers, the facility only had two PCPs at the time of the audit and had two vacancies for mid-level providers. This equates to 50.0% compliance. Since the audit, recruitment for one mid-level provider had been completed and the provider is scheduled to start on March 14, 2016. The approval process for hiring the other mid-level provider is currently in progress.
3. Question 3.6 – The facility is contractually required to be staffed with 14.0 FTE RN and 14.0 FTE LVN positions for a total of 28.0 nursing positions. The facility was staffed with 26.0 FTE nursing staff positions at the time of the audit and had one vacancy each for a RN and LVN. This equates to 92.9% compliance.

4. ACCESS TO CARE

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

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
93.1% [Proficient]
Overall Rating:
Adequate

For *Access to Care* indicator, the case review and quantitative review processes yielded different results. The case review received an *adequate* rating while the quantitative review resulted in overall score of 93.1% 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 patient's health care condition. Taking into account all the findings related to *Access to Care*, CCHCS clinicians rated this indicator *adequate*.

Case Review Results

The CCHCS clinicians reviewed a total of 69 encounters/clinical visits related to *Access to Care* which included 8 physician encounters and 61 nursing encounters. There were no nursing deficiencies identified. One deficiency was identified during physician case reviews and was related to inadequate supervision of the mid-level provider by the PCP and/or the mid-level provider not consulting with the PCP regarding patient treatment plans. The identified deficiency is described below:

- In Case 3, the patient persistently complained of dizziness and vertigo. Although the patient was referred to the provider for a follow-up, patient was not seen by a PCP for physical assessment. There is no documentation of a follow up in the chart since August 2015. No diagnosis was made.

As these deficiencies were minor in nature and unlikely to contribute to patient harm, the case review resulted in an *adequate* rating for this indicator.

Quantitative Review Results

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

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?	24	0	100%
4.2	Following the review of the CDCR Form 7362, or similar form, does the registered nurse complete a face-to-face evaluation of a patient within the specified time frame?	24	0	100%
4.3	Does the registered nurse document the patient's chief complaint in the patient's own words?	24	0	100%
4.4	Does the registered nurse document the face-to-face encounter in Subjective, Objective, Assessment, Plan, and Education (SOAPE) format?	24	0	100%
4.5	Is the focused subjective/objective assessment conducted based upon the patient's chief complaint?	24	0	100%
4.6	Does the registered nurse document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data?	9	15	37.5%
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?	24	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?	23	1	95.8%
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?	19	2	90.5%
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)	N/A	N/A	N/A

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?	3	0	100%
4.12	Does nursing staff conduct daily rounds in segregated housing units? (COCF only)	123	1	99.2%
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)	100	24	80.6%
4.14	Are CDCR Forms 7362, *Health Care Services Request*, or similar forms readily accessible to patients in all housing units?	30	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?	9	0	100%
	Overall Quantitative Review Score:			**93.1%**

Comments:

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

1. Question 4.6 – Nine patient medical records included documentation of a nursing diagnosis related to subjective/objective assessment data. The 15 non-compliant cases did not include such documentation. This equates to 37.5% compliance.
2. Question 4.8 – Twenty-three patient medical records reflect that effective communication was established and education related to the treatment plan was provided to the patient. The one non-compliant case did not include such documentation. This equates to 95.8% compliance.
3. Question 4.9 –Three of the 24 cases reviewed were found not applicable to this question as the patient did not require a referral to the provider. Of the 21 patient medical records, 19 were found compliant with this requirement. Of the two non-compliant records, one did not have documentation that the patient was seen by the provider within 14 days of referral and the other did not have the time frame documented and therefore the auditor was unable to determine if the patient was seen. This equates to 90.5% compliance.
4. Question 4.10 – This standard is not applicable to out-of-state correctional facilities.
5. Question 4.12 – The daily logs of four segregation units were inspected for the month of January 2016. Of the 124 days (31 days x 4 logs) reviewed for documentation showing health care staff conducting rounds in segregated housing units, 123 days were found compliant. No documentation was found of nursing rounds having been conducted on January 19th in the Apache Charlie segregation area. This equates to 99.2% compliance.
6. Question 4.13 – Of the 124 days (31 days x 4 logs) reviewed for documentation showing health care staff conducting rounds to collect sick call requests in segregated housing units, 100 days were found compliant. There was no documentation for 24 days to show that sick call requests had been picked up. This equates to 80.6% compliance.

5. CHRONIC CARE MANAGEMENT

For this indicator, the CCHCS clinicians 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.

For *Chronic Care Management* indicator, the case review and quantitative review processes yielded different results. The case review received a *proficient* rating while the quantitative review resulted in overall score of 25.8% compliance, equating to a quality rating of *inadequate*. The non-compliance rating was related to the patients not receiving their chronic care medications within the specified time frame without interruption and the patients not being referred and seen by the provider for medication non-compliance. This has been a systemic issue that had been identified during the previous audit in June 2015 and the facility had scored only 24.0% compliance due to not being compliant with these requirements.

Case Review Rating:
Proficient
Quantitative Review Score [Rating]:
25.8% [Inadequate]

Overall Rating:
Inadequate

Therefore, the overall rating for this indicator was rated as *inadequate* due to the facility being predominantly non-compliant for the requirements during two consecutive audits and the management's failure to correct this issue following the previous audit.

These issues were discussed with the management during the onsite audit. The facility's current practice is to refer all patients to the nursing staff for counseling if they are a no-show or refuse their medications. The auditors reiterated to the nursing staff that all patients non-compliant for medications are required to be referred to the provider for counseling. The facility agreed to comply with this requirement. With regards to the facility's inability to provide refills to the patients within specified time frames without interruption, the management stated that sometimes they were unable to meet time frames because they utilized a mail order pharmacy (Diamond pharmacy) for the medications. The HSA stated that the refills for all chronic care medications (both Keep on Person(KOP) and Directly Observed Therapy (DOT)) are automatically re-ordered every 23 days by the main pharmacy nurse and are received within two days unless they are ordered on a Friday in which case, the medications are delivered the following Monday. All DOT (non- chronic care) medication refills are ordered by the pharmacy nurses in each compound when the patients have seven days' of medication remaining with them. All KOP (non-chronic care) medications are ordered by the charge nurse on the same day the patient submits a written request for the medication. Since these medications are usually prescribed to be used only as needed (PRN), the facility places the order only if the patient submits a request for a refill. All new prescription orders are ordered on the same day it is written and the facility receives the medications by overnight shipping. However, all STAT medications are procured from a local pharmacy and administered to the patient without delay.

Case Review Results

The CCHCS physician reviewed seven encounters related to *Chronic Care Management* and found one minor deficiency which was related to the dosage of a patient's diabetic medication. The issue was discussed with the facility's PCP during the onsite audit. There were no nursing case reviews completed for this indicator since the auditor was unable to find patients that fit the case review criteria. The case review rating for this indicator was determined as *proficient*.

Quantitative Review Results

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

Chronic Care Management		**Yes**	**No**	**Compliance**
5.1	Is the patient's chronic care follow-up visit completed as ordered?	30	0	100%
5.2	Are the patient's chronic care medications received by the patient without interruption within the required time frame?	1	29	3.3%
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?	N/A	N/A	N/A
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?	0	3	0.0%
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?	N/A	N/A	N/A
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?	0	1	0.0%
	Overall Quantitative Review Score:			**25.8%**

Comments:

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

1. Question 5.2 – Only one record was compliant with the requirement and the remaining 29 records showed that the patients did not receive their chronic care medications without interruption. This equates to 3.3% compliance. Most of the non-compliance was related to the patients not having any medication to take after their initial 30-day supply had depleted and until they received their refills. See below for additional information regarding the 29 non-compliant record reviews:

    - Records 3, 4, 5, 6, 7, 15, 16, 18 and 20 – There were considerable delays in the patients receiving refills for Aspirin. The KOP Medication Administration Record (MAR) showed that the delay ranged from three days, for up to a month for the patients to receive their refills. Documentation in one of the records showed that the patient received his initial 30 day supply of Aspirin on 2/8/15. No more refills were provided to the patient although the order was to administer the medication for six month period, from 2/3/15 through 8/7/15.
    - Records 2 and 19 – There were delays in the patients receiving the 30-day refills for their prescribed medication (Amlodipine Besylate). The delay ranged from two days to up to two weeks.
    - Records 9 and 14 – There were delays in the patients receiving the 30-day refills for their prescribed medication (Aspirin EC). The delay ranged from four days to up to two and a half weeks.

- Records 8 and 30 – There were delays in the patients receiving the 30-day refills for their prescribed medication (Hydrochlorothiazide). The delay ranged from nine days to up to two weeks.
- Records 10, 13, 20, 21, 23, and 25 – Refills for the prescribed medication (Atorvastatin Calcium) were not dispensed on a monthly basis to the patients as ordered. The delay ranged from two days to up to almost 3 months.
- Record 12 –There was a delay in the patient receiving his 15-day refills for Glyburide medication. There was a delay of one and a half months noted in providing the refills.
- Records 17, 24, 26 and 27 – The patients did not receive the 30-day refills for the prescribed medication (Metformin HCL) in a timely manner. The delay ranged from four days to up to almost one month.
- Records 28 and 29 – The patients did not receive their 30-day refills for prescribed medication (Lisinopril) in a timely manner. The delay ranged from eight days to up to three weeks.

2. Question 5.3 – Not applicable. None of the patients selected for review refused their KOP medications during the audit review period. Therefore, this question could not be evaluated.
3. Question 5.4 – Twenty seven records were found not applicable to this question since the patients were either not on KOP and/or DOT medications or did not meet the criteria for a referral. The remaining three records were found to be non-compliant with this requirement because these patients were not referred to a provider when they refused or were a no show for their NA/DOT chronic care medications for three consecutive days or 50 percent or more doses in a week. This equates to 0.0% compliance.
4. Question 5.5 – Not applicable. Per the double failure rule, this question was found not applicable as the facility was rated non-compliant for question 5.4.
5. Question 5.6 – Twenty five records were found not applicable to this question since these patients were not prescribed insulin. Of the remaining five records, four were non-applicable because the patients were not a no-show or did not refuse their insulin medication. One record was found to be non-compliant with this requirement since the patient did not show for his insulin and was not referred to the provider for medication non-compliance. This equates to 0.0% compliance.

6. COMMUNITY HOSPITAL DISCHARGE

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

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

For *Community Hospital Discharge* indicator, the case review and quantitative review processes yielded different results. The case review received an *adequate* rating while the quantitative review resulted in overall score of 84.4% compliance, equating to a quality rating of *inadequate*. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the degree of the deficiencies identified during case reviews and their potential impact on

patient's health care condition. The case review results revealed just one minor deficiency which did not significantly impact the patient's access to health care and the quantitative review score of 84.4% is very close to the adequate range. As a result, the CCHCS physicians determined the appropriate overall rating for this indicator was *adequate*.

Case Review Results

The findings of the clinical case review as it relates to *Community Hospital Discharge* indicator revealed the quality of provider care to be *adequate*.

CCHCS physician reviewed two encounters related to *Community Hospital Discharge* indicator. Of the two cases reviewed, one deficiency was identified in provider care.

- In case 3, a 35 year old patient dizzy after contusion, with possible syncope was sent to emergency department (ED). Upon his return, follow up was completed by the mid-level provider, and not by the PCP. The PCP was not consulted by the mid-level provider and no diagnosis was made.

Only one case was selected for nurse case review. However, a detailed review of this patient's records showed that the patient did not return to the facility because he had expired in the hospital within seven days of his transfer to the ED and subsequent hospitalization. Therefore, the patient did not meet the criteria for *community hospital discharge* indicator since his discharge hadn't occurred. As a result, this patient's case review was reviewed for *Emergency Services* indicator.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review consisting of 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.

Community Hospital Discharge		**Yes**	**No**	**Compliance**
6.1	*For patients discharged from a community hospital or returned from the hub:* Does the registered nurse review the discharge plan upon patient's return?	5	3	62.5%
6.2	*For patients discharged from a community hospital or returned from the hub:* Does the registered nurse complete a face-to-face assessment prior to the patient being re-housed?	8	0	100%
6.3	*For patients discharged from a community hospital or returned from the hub:* Is the patient seen by the primary care provider for a follow-up appointment within five calendar days of return?	7	0	100%
6.4	*For patients discharged from a community hospital:* Are all prescribed medications administered/delivered to the patient per policy or as order by the primary care provider?	6	2	75.0%
	Overall Quantitative Review Score:			**84.4%**

Comments:

For questions 6.1 through 6.4, a random sample of eight patient medical records was reviewed for the audit review period of June through November 2015. There were no records available for review for the month of July and October 2015 since no patients were discharged from a community hospital during those months.

1. Question 6.1 – Five records were found to be compliant with this requirement. The three records were non-compliant due to no documentation being found in the records of the RN's review of the discharge plan. This equates to 62.5% compliance.
2. Question 6.4 – Six records were found to be compliant with the requirement. Of the two records that were non-compliant, one record did not have documentation of medication being administered to the patient nor was there any documentation of the patient's no- show or refusal of medications. The other record was non-compliant due to the patient not receiving the prescribed medication as ordered by the provider. This equates to 75.0% compliance.

7. DIAGNOSTIC SERVICES

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
72.1% [Inadequate]
Overall Rating:
Adequate

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

For *Diagnostic Services* indicator, the case review and quantitative review processes yielded different results. The case review received an *adequate* rating while the quantitative review resulted in overall score of 72.1% compliance, equating to a quality rating of *inadequate*. To determine the overall rating for this indicator, the CCHCS clinicians evaluated the magnitude of all deficiencies identified in both processes and their potential impact on patient's health care condition. Most of the deficiencies identified in the quantitative review were related to the diagnostic tests not carried out within the specified time frames, the patients not receiving the test results within two days of review of results and the patients not being seen within the time frame for clinically abnormal test results. Most of the deficiencies were determined to be minor in nature and not adversely affecting patient care. Taking into account all the findings related to *Diagnostic Services*, CCHCS physicians determined the overall rating for this indicator as *adequate*.

Case Review Results

CCHCS clinicians reviewed 15 encounters related to *Diagnostic Services*, which consisted of 11 nursing encounters and 4 physician encounters. There were no deficiencies identified within the physician case reviews. However, there was one minor deficiency noted in the nursing encounter related to the nursing staff not completing a routine diagnostic test ordered by the provider within 14 days of the order. This issue was deemed to be minor since it did not adversely impact the patient's health care condition. Therefore, the case review rating for this indicator was determined as *adequate.*

Quantitative Review Results

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

Diagnostic Services		Yes	No	Compliance
7.1	Is the diagnostic test completed within the time frame specified by the primary care provider?	15	3	83.3%
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	1	94.7%
7.3	Is the patient given written notification of the diagnostic test results within two business days of receipt of results?	11	8	57.9%
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?	10	9	52.6%
		Overall Quantitative Review Score:		**72.1%**

Comments:

For questions 7.0 through 7.4, a random sample of 19 patient medical records was reviewed for the audit review period of June through November 2015.

1. Question 7.1 – Fifteen records were found to be compliant with this requirement. One record was found to be non-applicable since the test was done as a routine follow-up blood work for health care maintenance. The remaining three records were found to be non-compliant due to the diagnostic tests not being completed within the time frame specified by the PCP. This equates to 83.3% compliance.
2. Question 7.2 – Eighteen patient medical records included documentation that the provider reviewed, signed, and dated the patient's diagnostic test report within two business day of receipt of results. For the one non-compliant case, the diagnostic test results were not reviewed and signed by the provider within two business days; the report was reviewed by PCP four days later. This equates to 94.7% compliance.
3. Question 7.3 – Eleven patient medical records were found compliant with this requirement. Of the eight non-compliant records, two records did not have any written notification in the patient's medical record and for the remaining six records, a written notification of the diagnostic test results was not provided to the patients within two business days of facility's receipt of results. This equates to 57.9% compliance.
4. Question 7.4 – Ten patient medical records included documentation that the patient was seen by the provider for clinically significant/abnormal diagnostic test results within 14 days and nine cases were found non-compliant with this requirement. This equates to 52.6% 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 files and facility's documentation of 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 findings of the clinical case review reveal the facility performed satisfactorily as it relates to *Emergency Services* indicator. Overall, the CCHCS clinicians found the quality of physician and nursing care in emergency services was *adequate*.

Of the 14 cases (resulting in 35 urgent/emergent encounters) reviewed by both CCHCS nurse consultant and physician auditors, four deficiencies were identified in physician care and only one deficiency in nursing care. Specific example of a deficiency identified by CCHCS nurse reviewer is as follows:

- In case 8, a 36 year old patient with chronic diagnoses of hypertension, anxiety with chest pain, allergic rhinitis, enlargement of spleen, and latent TB of the lung had an episode of chest pain and was brought to the ED. Cardiac work-up was negative and he was diagnosed with "chest pain of uncertain cause". During the review period, it was noted that RN did not consistently administer medications as ordered and did not consistently document proper nursing assessment or diagnosis (chest pain of uncertain cause is a medical and not a nursing diagnosis).

Specific examples of deficiencies identified by CCHCS physician are as follows:

- In case 9, a patient was brought to the clinic with apparent methamphetamine overdose; patient reported to be in delirium ("high as a kite"). The RN contacted the provider and documented that she was directed to return patient to housing without providing any treatment for acute methamphetamine overdose. The provider does not recall giving instructions as documented. There was no provider's progress notes regarding the purported instructions to nursing that patient should return to housing.

- In case 10, a patient, known heroin addict, was found unresponsive in the cell due to an overdose. The patient was not administered Narcan until the paramedics arrived on scene. This could have resulted in patient's death due to the facility medical staff not administering Narcan immediately; however, the patient survived after administration of Narcan by the paramedics.

- In case 14, a hypertensive patient complaining of flank discomfort is sent to the community hospital ED with no provisional diagnosis and no exam to substantiate the need for the trip; extensive ED exams done despite absence of any clinical indication of pathology of any sort, no hint of Pulmonary Embolism (PE), pneumonitis or Acute Coronary Syndrome (ACS). CCHCS physicians found the trip to likely be unnecessary and ED engagement likely unnecessary. This incident did not take place during a weekend or evening hours that explains why sending the patient to ED was reasonable without a better-documented review on site.

- In case 17, a 30 year old patient, an intravenous (IV) drug user, with suspected epidural abscess returned from hospital ED with vague and inaccurate diagnosis. Upon the patient's return, he was placed in observation unit without an accurate diagnosis and the patient was not provided medications for effective pain relief caused by acute disease. There was a lack of PCP follow up and poor documentation in progress notes. Due to the inadequate communication between prison PCP team and the outside providers (ED staff, neurosurgeon and radiologist) the diagnosis of epidural abscess was delayed despite a suspicious clinical course and Magnetic Resonance Imaging (MRI) results that strongly suggested that condition. The patient did return to the hospital for a repeat MRI and draining of abscess after first ED visit failed to provide needed therapy and is now reportedly doing well.

The CCHCS clinician recommendations regarding the LPCC's provider and nursing staff performance improvement are discussed in indicators 16 and 17, *Quality of Nursing Performance* and *Quality of Physician Performance,* respectively.

9. HEALTH APPRAISAL/HEALTH CARE TRANSFER

This 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:
Adequate
Quantitative Review Score [Rating]:
65.4% [Inadequate]
Overall Rating:
Adequate

For *Health Care Appraisal/ Health Care Transfer* indicator, the case review and quantitative review processes yielded different results. The case review received an *adequate* rating while the quantitative review resulted in overall score of 65.4% compliance, equating to a quality rating of *inadequate.* To determine the overall rating for this indicator, the CCHCS clinicians evaluated the magnitude of all deficiencies identified in both processes and their potential impact on patient's health care condition. Most of the deficiencies identified in the quantitative review were related to poor nursing documentation, and the newly arrived patient not receiving his KOP medication within one calendar day of arrival. Most of these deficiencies were determined as minor and not adversely affecting patient care. Taking into account all the findings related to *Health Care Appraisal/ Health Care Transfer*, CCHCS clinicians determined the overall rating for this indicator as *adequate*.

Case Review Results

CCHCS clinicians reviewed 14 encounters related to *Health Care Appraisal/ Health Care Transfer*, which consisted of 13 nursing encounters and 1 physician encounter. There were no deficiencies identified

within the physician case reviews. However, there was one minor deficiency noted in the nursing encounter related to the nursing staff not documenting in the *Initial Health Screening* form that a focused assessment was completed on problems identified. The nursing staff also did not document the nursing assessment or diagnosis. This issue was deemed to be minor since it did not adversely impact the patient's health care condition. Therefore, the case review rating for this indicator was determined as *adequate.*

Quantitative Review Results

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

Health Appraisal/Health Care Transfer		**Yes**	**No**	**Compliance**
9.1	Does the patient receive an initial health screening upon arrival at the receiving facility by licensed health care staff?	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?	1	2	33.3%
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?	N/A	N/A	N/A
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??	N/A	N/A	N/A
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?	N/A	N/A	N/A
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?	N/A	N/A	N/A
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?	0	1	0.0%
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?	6	0	100%
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?	0	1	0.0%
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?	5	0	100%
9.12	Does the Inter-Facility Transfer Envelope contain all the patient's medications, current Medication Administration Record and Medication Profile?	9	1	90.0%
	Overall Quantitative Review Score:			**65.4%**

Comments:

For questions 9.1 through 9.10, a random sample of 18 patient medical records was reviewed for the audit review period of June through November 2015.

1. Question 9.2 – Fifteen out of the 18 randomly selected records did not meet the criterion for this question; therefore, compliance with this requirement was based on the remaining three records. Of the three patient medical records reviewed, one case included documentation of a RN completing an assessment of the patient's medical problem. The other two cases did not include documentation of the RN's assessment of patient's medical problem. This equates to 33.3% compliance.
2. Question 9.3 – Not applicable. None of the 18 patients selected for review had presented with emergent or urgent symptoms during the initial health screening; therefore, this question could not be evaluated.
3. Question 9.4 – Not applicable. None of the 18 patients selected for review were identified as having a chronic disease/illness during initial intake screening and hence did not require a referral to the provider. Therefore, this question could not be evaluated.
4. Question 9.5 – Not applicable. None of the 18 patients selected for review were referred to provider during the initial health screening; therefore, this question could not be evaluated.
5. Question 9.6 – Not applicable. None of the 18 patients selected for review were enrolled in a chronic care program at a previous facility; therefore, this question could not be evaluated.
6. Question 9.7 – Seventeen out of the 18 randomly selected records did not meet the criterion for this question; therefore, compliance with this requirement was based on the remaining one record. This patient had a pending dental cleaning appointment from previous facility. However, there was no documentation in the patient's record to show that this appointment was completed at this facility. This equates to 0.0% compliance.
7. Question 9.10 – Seventeen out of the 18 randomly selected records did not meet the criterion for this question; therefore, compliance with this requirement was based on the remaining one record. This patient had an existing order for a KOP medication; however, the patient did not receive his medication within one calendar day of his arrival. This equates to 0.0% compliance.
8. Question 9.12 – Auditor examined 10 patient transfer envelopes during the onsite audit. Out of 10 envelopes, one envelope did not match the ordered dosage and frequency of medication (Glipizide) listed in the MAR. This equates to 90.0% compliance.

10. MEDICATION MANAGEMENT

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

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
93.5% [Proficient]
Overall Rating:
Adequate

For *Medication Management* indicator, the case review and

quantitative review processes yielded different results. The case review received an *adequate* rating while the quantitative review resulted in overall score of 93.5% compliance, equating to a quality rating of *proficient.* The deficiencies identified in the quantitative review and case reviews were mainly related to poor medication administration practices such as the initial dose of the newly prescribed medication not being administered to the patient in a timely manner, prescribing excessive medication without clear medical necessity, medications not adjusted by conducting regular follow-ups, medications not administered timely, poor documentation in the MAR, medications not filled timely and failure to notify provider when patients are a no show for medications or accucheck. The issue with the medications not being administered and filled in a timely manner is a recurrent issue that has been identified in the current and previous audits and is explained on pages 22 and 23 under the *Chronic Care Management* indicator due to which the facility's overall rating was determined to be *inadequate*. Since the deficiencies identified for this indicator were also related to poor medication management, in order to avoid penalizing the facility twice for the same issue, the overall rating was determined to be *adequate*.

Case Review Results

CCHCS clinicians reviewed 25 encounters related to *Medication Management* indicator. Two deficiencies were identified in physician care and eight deficiencies in nursing care. The majority of the nursing deficiencies were relative to poor medication administration and inadequate nursing documentation in the MAR. Specific examples of deficiencies and areas of concern identified by CCHCS nurse reviewer are as follows:

- In case 2, the patient was prescribed Clotrimazole twice a day for tinea pedis on 10/21/15. The medication was administered late on 10/25/15.
- In case 6, the patient was seen by the PCP for chest pains on 9/23/15 and the patient was prescribed Nitroglycerin (NTG). NTG should have been available within one business day. However, the medication was provided to the patient on 9/25/15. The same patient was sent offsite for a cardiology follow up on 10/07/15. The provider ordered to increase the dosage of Isosorbide to twice a day. This increase was not documented in the MAR.
- In case 8, the patient refused a chronic care follow-up appointment for hypertension on 10/7/15. Provider's progress notes showed that patient's prescription for Lisinopril had been last filled in August 2015. There was no documentation in MAR to show that the prescription was filled in September 2015.
- In case 9, the patient's prescriptions for Alvesco, Ventolin, Pravastatin, and Lisinopril had not been filled for three months and the patient had refused a chronic care follow-up visit on 7/20/15 and the three chronic care appointments previous to this appointment. MAR shows no medication was given for the months of April, May, and June 2015. Lisinopril, Pravastatin, Ventolin, and Alvesco were all initially ordered in April 2015.
- In case 10, the nurse noted that the patient was a no show for pill call and accucheck on 6/27, 7/28 and 08/01/15. However, there was no documentation for any of these instances that nursing staff identified barriers and notified the provider about the patient's non-compliance for medication and accucheck.

Specific examples of deficiencies identified by CCHCS physician are as follows:

- In case 6, the patient was on high dose of Metformin and Glyburide. There was no indication in the medical record that patient's PCP was considering reduction of excessive diabetic medications where risks can exceed benefits.
- In case 16, the patient was on continued therapy with Ranitidine without history or exam to substantiate the need. A muscle rub had also been prescribed. There was no indication in the medical record of ongoing medical need for Ranitidine. Muscle rub has no clinical value. The patient was administered a product banned in California facilities (muscle rub) and the Ranitidine was renewed - both without demonstrated medical need.

Quantitative Review Results

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

Medication Management		**Yes**	**No**	**Compliance**
10.1	Does the prescribing primary care provider document that the patient was provided education on the newly prescribed medications?	18	0	100%
10.2	Is the initial dose of the newly prescribed medication administered to the patient as ordered by the provider?	4	14	22.2%
10.3	Does the nursing staff confirm the identity of a patient prior to the delivery and/or administration of medications?	5	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?	5	0	100%
10.5	Does the medication nurse directly observe a patient taking direct observation therapy medication?	5	0	100%
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?	5	0	100%
10.7	Are medication errors documented on the Medication Error Report form?	3	0	100%
10.8	Are refrigerated drugs and vaccines stored in a separate refrigerator that does not contain food and/or laboratory specimens?	4	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?	124	0	100%
10.10	Does the facility employ medication security controls over narcotic medications assigned to its clinic areas?	3	0	100%
10.11	Are the narcotics inventoried at the beginning and end of each shift by licensed health care staff?	186	0	100%
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)	7	0	100%
	Overall Quantitative Review Score:			**93.5%**

Comments:

For questions 10.1 and 10.2, a random sample of 18 patient medical records was reviewed for the audit review period of June through November 2015.

1. Question 10.2 – Of the 18 patient medical records reviewed, 4 included documentation reflecting the initial dose of the newly prescribed medications was administered to the patients as ordered by the provider. The 14 non-compliant cases reflect the patient receiving the prescribed medication late or not as ordered by provider. This equates to 22.2% compliance.

11. OBSERVATION CELLS

This quality indicator applies only to California out-of-state correctional facilities. The CCHCS clinicians 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.

Case Review Rating:
Adequate
Quantitative Review Score [Rating]:
96.4% [Proficient]
Overall Rating:
Adequate

For this indicator, the case review and quantitative review processes yielded different results. The quantitative review resulted in overall score of 96.4%, 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 all deficiencies identified in both processes and their potential impact on patient's health care condition. Taking into consideration the findings related to *Observation Cells*, CCHCS clinicians rated this indicator as *adequate*.

Case Review Results

A total of 10 encounters were reviewed by CCHCS clinicians, which consisted of nine nursing encounters and one physician encounter. There were no deficiencies identified within the nurse case reviews. There was one major deficiency noted in the provider case review.

Specific deficiency identified by CCHCS physician is as follows:

- In case 17, a 30 year old patient, an IV drug user, with suspected epidural abscess returned from hospital ED with vague and inaccurate diagnosis. Upon the patient's return, he was placed in observation unit without an accurate diagnosis and the patient was not provided medications for effective pain relief caused by acute disease. There was a lack of PCP follow up and poor documentation in progress notes.

Due to the lapse in care noted above, this case was rated by the CCHCS clinician reviewer as *inadequate.* However, the nurse case reviews and quantitative reviews found the care provided in observation cells to be *proficient.* Accordingly, the overall rating for observation cells was deemed *adequate*.

Quantitative Review Results

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

Observation Cells (COCF only)		Yes	No	Compliance
11.1	Is the patient assessed by a registered nurse every eight hours or more frequently as ordered by the primary care provider when housed in an observation cell?	4	2	66.7%
11.2	Does the primary care provider document the need for the patient's placement in the observation cell and a brief admission history and physical examination within 24 hours of placement?	6	0	100%
11.3	Does a licensed clinician conduct daily face-to-face rounds on patients housed in observation cell for suicide precaution/watch or awaiting transfer to a Mental Health Crisis Bed?	2	0	100%
11.4	Is there a functioning call system or a procedure in place where the patient housed in an observation cell has the ability to get the attention of health care staff immediately?	7	0	100%
	Overall Quantitative Review Score:			**96.4%**

Comments:

For questions 11.1 through 11.3, a random sample of 13 patient medical records was reviewed for the audit review period of June through November 2015.

1. Question 11.1 – Seven out of the 13 randomly selected records did not meet the criterion for this question; therefore, compliance with this requirement was based on the remaining six records. Initially, the facility was evaluated for the eight-hour requirement based on the IMSP&P policy Volume 4, chapter 14 which states, " *At a minimum, an RN shall make rounds in the Outpatient Housing Unit (OHU) once each watch and document the rounds in the OHU log*". During the policy revisions in April 2015, the facility was instructed by CCHCS to update their policy 13-63 by changing the monitoring requirement from "*every eight hours*" to "*beginning of each shift*". At that time, CCHCS was not aware that the facility had 12 hour shifts for nursing staff unlike the shifts/watches in the CDCR institutions which are 8 hours long. Therefore, the facility's process has been re-evaluated based on the 12 hour shifts. Of the six patient medical records reviewed, four included documentation that the patient was assessed by a registered nurse every 12 hours or more frequently as ordered by the primary care provider when housed in an observation cell. For the remaining two non-compliant records, there was no documentation available in the medical record to show rounds were completed every 12 hours. This equates to 66.7% compliance.

12. SPECIALTY SERVICES

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

assess whether the approved or scheduled specialty service appointments are received/completed within the specified time frame.

Case Review Rating:
Proficient
Quantitative Review Score [Rating]:
89.1% [Adequate]
Overall Rating:
Proficient

For *specialty Services* indicator, the case review and quantitative review processes yielded different results. The quantitative review resulted in overall score of 89.1%, equating to a quality rating of *adequate*, while the case review resulted in a *proficient* 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 patient's health care condition. Since there were no adverse finding noted during case reviews and the deficiency noted in the quantitative review did not significantly impact the patient's access to health care, CCHCS clinicians rated this indicator as *proficient*.

Case Review Results

A total of 11 encounters were reviewed by CCHCS clinicians, which consisted of five nursing encounters and six physician encounters. There were no deficiencies or deviations in provision of care noted. Therefore, the overall case review rating was determined *proficient*.

Quantitative Review Results

The table below reflects the findings associated with the quantitative review consisting 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)	5	0	100%
12.2	Is the patient seen by the specialist for a specialty services referral within the specified time frame? (COCF Only)	30	0	100%
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?	30	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?	10	12	45.5%
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?	30	0	100%
	Overall Quantitative Review Score:			**89.1%**

Comments:

For questions 12.1 through 12.5, a random sample of 30 patient medical records was reviewed for the audit review period of June through November 2015.

1. Question 12.4 – Eight out of the 30 randomly selected records did not meet the criterion for this question; therefore, compliance with this requirement was based on the remaining 22 records. Of the 22 patient medical records reviewed, 10 records included documentation that the RN notified the primary care provider of any immediate orders or follow-up instructions. The remaining 12 records did not have any such documentation. This equates to 45.5% compliance.

13. PREVENTIVE SERVICES

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

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

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
60.6% [Inadequate]
Overall Rating:
Inadequate

The facility received a compliance score of 60.6% in *Preventive Services* indicator, which equates to an overall rating of *inadequate*. It should be noted that out of a total of nine questions, two were found to be non-compliant and six were scored as non-applicable. Of the six questions found not applicable, two questions could not be rated since there were no patients housed at LPCC who met the criteria of the questions and the other four questions are assessed only once per calendar year during the audit review period when the facility provides TB testing and screening, offers colorectal screening and offers influenza vaccination to its patient population. Refer to the *Comments* section, following the table below, for additional information and details.

Quantitative Review Results

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

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?	11	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?	0	2	0.0%
13.3	*For patients prescribed anti-Tuberculosis medication(s):* Does the facility monitor the patient monthly while he/she is on the medication(s)?	9	2	81.8%

13.4	Do patients receive a Tuberculin Skin Test annually?	N/A	N/A	N/A
13.5	Are the patients screened annually for signs and symptoms of tuberculosis?	N/A	N/A	N/A
13.6	For all patients: Were the patients offered an influenza vaccination for the most recent influenza season?	N/A	N/A	N/A
13.7	*For all patients 50 to 75 years of age:* Are the patients offered colorectal cancer screening?	N/A	N/A	N/A
13.8	*For female patients 50 to 74 years of age:* Is the patient offered a mammography at least every two years?	N/A	N/A	N/A
13.9	*For female patients 21 to 65 years of age:* Is the patient offered a Papanicolaou test at least every three years?	N/A	N/A	N/A
	Overall Quantitative Review Score:			**60.6%**

Comments:

For questions 13.1 through 13.3, a random sample of 17 patient medical records was reviewed for the audit review period of June through November 2015.

1. Question 13.1 – Of the 17 patient medical records reviewed, 6 records did not meet the criterion for this question since the patients were prescribed anti- Tuberculosis (TB) medications for non-TB related conditions. Therefore, the compliance was evaluated for the remaining 11 records. All 11 records were found to be compliant. This equated to 100% compliance.
2. Question 13.2 – Fifteen out of the 17 randomly selected records did not meet the criterion for this question; therefore, compliance with this requirement was based on the remaining 2 records. Of the two patient medical records reviewed, none of the records included documentation that the nursing staff notified the PCP when the patient missed or refused anti-TB medication. This equated to 0.0% compliance.
3. Question 13.3 – Out of the 17 patient medical records selected, six were determined to be non-applicable since the patients had been prescribed anti-TB medications for non-TB related conditions. Of the remaining 11 records reviewed, 9 included documentation that the facility monitored the patients monthly while they were on anti-TB medications. The remaining two non-compliant records did not have any such documentation. This equates to 81.8% compliance.
4. Question 13.4 and 13.5 – Not 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 LPCC's current audit did not encompass the month when LPCC provided annual TB testing and screening to its CDCR patient population, these questions could not be evaluated for compliance with this requirement.
5. Question 13.6 and 13.7 – Not applicable. Per the methodology, these questions are to be evaluated once per calendar year when the audit is conducted during the first half of the fiscal year (July through December). Since the current audit was not conducted during the first half of the fiscal year, this question could not be evaluated. However, this requirement will be evaluated during subsequent audit.
6. Question 13.8 and 13.9 – Not applicable. These questions only apply to correctional facilities housing female patient population.

14. EMERGENCY MEDICAL RESPONSE/DRILLS & EQUIPMENT

For this indicator, the CCHCS clinician reviews 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 emergency medical response (EMR) bags and all of the facility's medical equipment are also inspected during the onsite audit to ensure regular inventory is maintained and service of all equipment is completed in a timely manner.

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
82.9% [Inadequate]
Overall Rating:
Inadequate

This indicator is evaluated by CCHCS nurse consultants entirely through the review of emergency medical response documentation, inspection of EMR 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 an *inadequate* rating with a score of 82.9% in the *Emergency Medical Response/Drills & Equipment* indicator. This is comparable to the previous audit's score of 80.8% compliance in this area. The significant deficiencies were regarding the facility not consistently submitting all the required documents to the Emergency Medical Response Review Committee (EMRRC) following the EMR drills and/or responses in a timely manner and crash carts missing some medications and supplies (this was a repeat finding from the previous audit). Refer to the *Comments* section, following the table below, for additional information and details on the deficiencies identified during the quantitative review of this indicator.

Quantitative Review Results

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

Emergency Medical Response/Drills & Equipment		Yes	No	Compliance
14.1	Does the facility conduct emergency medical response drills quarterly on each shift when medical staff is present?	58	0	100%
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?	75	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?	75	3	96.2%
14.4	Does the facility hold an Emergency Medical Response Review Committee a minimum of once per month?	6	0	100%
14.5	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required documents?	75	3	96.2%
14.6	Is the facility's clinic Emergency Medical Response Bag secured with a seal?	248	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?	5	5	50.0%
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?	24	0	100%
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?	4	0	100%
14.10	Is the facility's Medical Emergency Crash Cart secured with a seal? (COCF Only)	248	0	100%
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)	5	5	50.0%
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)	24	0	100%
14.13	Does the facility's crash cart contain all the medications as required/approved per *Inmate Medical Services Policies and Procedures*? (COCF Only)	0	4	0.0%
14.14	Does the facility's crash cart contain the supplies identified on the facility's crash cart checklist? (COCF Only)	0	4	0.0%
14.15	Does the facility have a functional Automated External Defibrillator with electrode pads located in the medical clinic?	4	0	100%
14.16	Does the facility have a functional 12-lead electrocardiogram machine with electrode pads? (COCF Only)	5	0	100%
14.17	Does the facility have a functional portable suction device?	4	0	100%
14.18	Does the facility have a portable oxygen system that is operational ready?	12	0	100%
	Overall Quantitative Review Score:			**82.9%**

Comments:

1. Question 14.2 – LPCC conducted a total of 58 emergency medical response drills and 20 actual emergency medical responses for the audit review period of June through November 2015. Of a total of 78 emergency medical responses/drills conducted, it was found that during one drill and two actual emergency medical responses, the Basic Life Support (BLS) certified health care staff did not respond to the medical emergency without delay after the alarm was sounded. However, per the double failure rule, this non-compliant incident was not included in the compliance rating of this question as it was rated for compliance in Question 14.3.

2. Question 14.3 – LPCC conducted a total of 58 emergency medical drills and 20 actual emergency medical responses for the audit review period of June through November 2015. Of a total of 78 emergency medical responses/drills conducted, the RN failed to respond in a timely manner on three occasions of which one was a drill and two were actual emergency medical responses. During the first incident, the RN had been notified at 1516 hours, but the RN did not respond to the scene until 16 minutes later at 1531 hours. During the second incident, the RN had been notified at 2131 hours but the patient was not seen by a RN until 9 minutes later at 2140 hours. During the third response, the RN was notified at 1335 hours but the patient was not seen by a RN until 15 minutes later, at 1350 hours. This equates to 96.2% compliance.

3. Question 14.5 – The facility's EMRRC performed reviews of the incident packages for a total of 78 emergency medical responses/drills for the audit review period of June through November 2015. Of the 78 incident packages reviewed, 3 of the packages did not include the required documents. The first one did not include progress notes, injury form and facility emergency flow sheet, the second non-compliant package was missing the RN's signature on facility emergency flow sheet and the third package did not have the facility emergency flow sheet and anatomical flow sheet. This equates to 96.2% compliance.

4. Question 14.7 – Of the 78 emergency medical responses/drills reviewed, 10 scenarios warranted an opening of the EMR Bag. The EMR Bag logs reviewed for the 10 incidents showed that only for 5 of those instances, the EMR bags were resupplied and resealed before the end of the shift. This equates to 50.0% compliance.
5. Question 14.11 – Of the 78 emergency medical responses/drills reviewed, 10 scenarios warranted an opening of the crash cart. The crash cart logs reviewed for the 10 incidents showed that only for 5 of those instances, the crash carts were resupplied and resealed before the end of the shift. This equates to 50.0% compliance.
6. Question 14.13 – A total of four crash carts were inspected and all four were missing some medications. All crash carts were missing Glucagon, one was missing Sodium Bicarbonate, and another was missing Epinephrine. This equates to 0.0% compliance.
7. Question 14.14 – Of a total of four crash carts inspected, all four were missing some supplies. All of the crash carts were missing Nitroglycerin, two were missing Combitube and two carts were missing Ambubag. This equates to 0.0% compliance.

15. CLINICAL ENVIRONMENT

This indicator measures the general operational aspects of the facility's clinic(s). CCHCS clinicians, 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 clinicians' visual inspections/observations during the onsite audit, as well as through the review of various logs and documentation reflecting maintenance of clinical environment and equipment.

Case Review Rating:
Not Applicable
Quantitative Review Score [Rating]:
95.8% [Proficient]

Overall Rating:
Proficient

The facility received a compliance score of 95.8% in the *Clinical Environment* indicator, equating to an overall rating of *proficient*. This is a significant improvement from the previous audit rating of 88.2% compliance in this area. It was observed during the onsite audit that the facility's sharps and narcotics logs are being maintained well with all required documentation and upon review, no missing dates, times, or nurses' signatures were identified. The facility received 90.0% compliance or higher in 14 of the 17 standards/requirements measured; meaning the facility is performing at a *proficient* level in those areas. In the other three areas, LPCC scored below the compliance benchmark of 85.0%. Refer to *Comments* section following the table below for additional information on the deficiencies.

Quantitative Review Results

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

Clinical Environment		Yes	No	Compliance
15.1	Are packaged sterilized reusable medical instruments within the expiration dates shown on the sterile packaging?	41	0	100%
15.2	If autoclave sterilization is used, is there documentation showing weekly spore testing?	4	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?	9	2	81.8%
15.5	Is personal protective equipment readily accessible for clinical staff use?	4	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?	7	2	77.8%
15.7	Does the facility utilize a hospital grade disinfectant to clean common clinic areas with high foot traffic?	4	0	100%
15.8	Is environmental cleaning of common clinic areas with high foot traffic completed at least once a day?	76	0	100%
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?	17	1	94.4%
15.10	Is the clinic's generated biohazard waste properly secured in the facility's central storage location that is labeled as a "biohazard" area?	2	0	100%
15.11	Are sharps/needles disposed of in a puncture resistant, leak-proof container that is closeable, locked, and labeled with a biohazard symbol?	12	1	92.3%
15.12	Does the facility store all sharps/needles in a secure location?	4	0	100%
15.13	Does the health care staff account for and reconcile all sharps at the beginning and end of each shift?	248	0	100%
15.14	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	4	0	100%
15.15	Is the facility's biomedical equipment serviced and calibrated annually?	29	6	82.9%
15.16	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	11	0	100%
15.17	Does the clinic visit location ensure the patient's visual and auditory privacy?	7	0	100%
	Overall Quantitative Review Score:			**95.8%**

Comments:

1. Question 15.4 – During the onsite audit, the auditor observed a total of 11 nurses in four clinics. Of the 11 nurses observed, 2 nurses did not follow universal hand hygiene precautions. This equates to 81.8% compliance.
2. Question 15.6 – During the onsite audit, the auditor observed a total of nine nurses in four clinics. Of the nine nurses observed, two nurses did not wipe off/sanitize the glucometer after each patient's accucheck was completed. This equates to 77.8% compliance.
3. Question 15.9 – A total of 18 treatment rooms/locations were inspected for biohazard containers. The auditor could locate only 17 biohazard containers. The treatment room in Zuni unit did not have a biohazard container. This equates to 94.4% compliance.
4. Question 15.11 – A total of 13 treatment rooms/locations were inspected for sharps containers. The auditor could locate only 12 sharps containers. The treatment room in Zuni unit did not have a sharps container. This equates to 92.3% compliance.

5. Question 15.15 – Auditor inspected a total of 35 pieces of biomedical equipment during the onsite audit; six of them were found to be non-compliant; two wall sphygmomanometers, one mobile blood pressure apparatus, one Ophthalmoscope and one Otoscope did not have calibration stickers on them and one weigh scale had not been serviced since June 2015. This equates to 82.9% compliance.

16. QUALITY OF NURSING PERFORMANCE

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

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

Overall Rating:
Adequate

Case Review Results

The *Quality of Nursing Performance* at LPCC was rated *adequate*. This determination was based upon the detailed case review of all nursing services provided to 10 patients housed at LPCC during the audit period of June through November 2015. Of the 10 detailed case reviews conducted by CCHCS nurse consultant, four were found proficient and six were adequate. None of cases were found inadequate. Of 131 nursing encounters/visits assessed within the 10 detailed case reviews, 10 deficiencies were related to nursing documentation and medication management processes. The nursing services found to be inadequate/ deficient at LPCC include:

- Nursing assessment or diagnosis not adequately documented (identified in case 8).
- Poor nursing documentation in the MAR regarding changes made to the dosage of medication (identified in Case 6).
- Medications not administered as ordered (identified in Cases 6, 8 and 9).
- Nursing not completing a focused assessment of the medical problem identified during patient's initial intake screening (identified in Case 9).
- Failure to document that nursing identified barriers and notified the provider when patient was a no-show for accucheck (identified in Case 10 on three separate occasions).

Case Number	Deficiencies
Case 1	***Adequate***. A 50 year old patient with history of chronic back pain, constipation, diverticulitis, hepatitis C, and tubulovillous adenoma of the rectum was ordered a diagnostic test on 07/27/15. However, the nursing staff collected the sample from the patient only on 08/11/15 thus not meeting the required time frame for carrying out the order within 14 days from the date the order is written. There were no other deficiencies noted in the case.
Case 2	***Adequate.*** A 52 year old patient with current diagnoses of acute gout, hypertensive cardiomegaly, degenerative joint disease, gastro esophageal reflux, HTN, bilateral myopia, bilateral presbyopia, pre-diabetes was seen by the PCP for a chronic care follow-up appointment on 10/21/15. The patient was ordered Clotrimazole cream to be applied twice a day for tinea

	pedis. There was a delay in administering the prescribed medication to the patient, since the medication was given to the patient only on 10/25/15.
Case 6	***Adequate.*** A 71 year old patient with history of allergic rhinitis, arthritis, benign prostatic hyperplasia, esophageal reflux, essential hypertension, and cataract complained of intermittent chest pain and was subsequently diagnosed with angina. On 9/23/15, patient reported having chest pains and was seen by the provider. The provider started the patient on NTG with immediate effect. MAR showed that the medication was administered only on 9/25/15 even though NTG should have been available within one business day. Nursing did not consistently administer medications timely and did not consistently comply with physician's order of increasing medication frequency. The same patient was seen offsite for cardiology follow-up on 10/7/15. The provider ordered to increase Isosorbide dosage to BID (twice a day). Nursing failed to document in the MAR that the dosage had been increased to BID.
Case 8	***Adequate.*** A 36 year old male inmate with a history of hypertension and anxiety had an episode of chest pain and was transported to the ED. The patient returned from the ED on 8/18/15 and the medical diagnosis was "chest pain of uncertain cause". Nursing failed to appropriately document a nursing assessment or diagnosis. Nursing documented a medical diagnosis rather than a nursing diagnosis. The same patient was scheduled for chronic care follow up appointment on 10/07/15 for hypertension but the patient refused the appointment. The provider noted in the progress notes that the patient's Lisinopril had been last filled one and a half months back. Documentation in the MAR for June to October 2015 was reviewed and it was noted that the patient's prescription had not been filled in September 2015. Therefore, nursing failed to consistently administer medications as ordered by the provider.
Case 9	***Adequate.*** A 32 year old patient with chronic diagnoses of hypertension, asthma, drug abuse, hyperlipidemia, blurry vision and mental health problem was observed to be consistently non-compliant for his medications and chronic care follow-ups. During the review period, the patient had refused his chronic care follow-up appointment on 07/20/15 and the provider noted in the progress notes that patient's prescriptions for medications Alvesco, Ventolin, Pravastatin, and Lisinopril had not been refilled during the past three months. Documentation in the MAR showed no medication was given for the months of April, May and June 2015. Lisinopril, Pravastatin, Ventolin, and Alvesco had been previously ordered in April 2015. This patient was transferred out to Florence Correctional Center on 7/27/15 and was transferred back to LPCC on 10/30/15. Upon the patient's arrival, an initial health screening was conducted; however, the nursing staff failed to document that a focused assessment was conducted for the medical problems identified during the initial intake screening. There was also no documentation of any nursing assessment or diagnosis.
Case 10	***Adequate.*** A 56 year old patient diagnosed with chronic hypertension, diabetes, GERD, hyperlipidemia, and constipation complained of left chest pressure accompanied by gassy abdomen. He was diagnosed as having digestive problem and was prescribed Prilosec and Simethicone, which only partially worked for his symptoms because the patient was non-compliant with his medications and other health care regime. The patient had been a no-show for pill call accucheck on 06/27, 7/28 and 08/01/15. Although nursing staff had documented the patient's no-shows for all three dates, the staff failed to identify the barriers to care and did not document if the patient was referred to the provider for treatment non-compliance during any of these instances. Therefore, nursing documentation was rated as deficient/inadequate. However, these deficiencies did not have significant impact on patient care.

Additionally, during the onsite audit, the nurse auditor observed that nursing staff did not conduct a thorough physical examination of the patients during sick call appointments. One patient complained of pain but the location of pain was not physically inspected or examined. Another patient complained of upper respiratory tract infection but simple procedures such as auscultation of breath sounds and throat

check were not performed. As part of adequate nursing assessments, these complaints require auscultation and inspection to document objective assessments.

Based on the deficiencies identified during the case reviews and onsite findings, following are some recommendations provided by CCHCS on how the nursing performance at LPCC may be improved:

- The nursing staff shall conduct detailed objective assessment of all patients' complaints by conducting a detailed physical examination.
- The nursing staff shall be diligent in completing a focused assessment of the problems identified during initial intake screening and prompt documentation of the findings.
- The nursing staff shall identify the barriers to care if the patients fail to show for their appointments or pill calls and promptly notify the provider of such incidents.
- The nursing staff shall follow the providers' orders correctly and thoroughly, especially as it relates to medication administration.
- Nursing staff shall document all changes to the prescriptions promptly in the MAR and promptly refill and administer the modified medication to the patient per provider's order.
- Facility needs to implement a process that ensures chronic care medications are ordered and received by the patient prior to the patient finishing the previous month's supply. This will assist in the patient receiving his therapy without interruption and avoid any health hazard that may result from the patient not receiving his medications timely.

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

17. QUALITY OF PROVIDER PERFORMANCE

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

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

Case Review Results

CCHCS physician completed 17 in-depth case reviews and based on the findings during these reviews, the clinician determined the overall performance of the provider to be *adequate* with a few cases where significant lapse of care and delayed diagnosis were noted. CCHCS clinician selected and reviewed cases that were outside of the audit review period of June through November 2015. These mostly involved the review of more recent patient encounters that had occurred in December, January and into the first week of February 2016.

The clinician also discussed the findings from these cases with the facility providers while onsite. Of the 17 detailed case reviews conducted by CCHCS physician, 5 were found proficient and therefore are not documented below. The remaining 12 case reviews were found to contain 10 deficiencies related to provider performance out of a total of 45 physician encounters/visits assessed. Most of the deficiencies were unlikely to contribute to patient harm, but there were some lapses identified which could have potentially lead to serious harm or even death. The reviewing CCHCS physician promptly addressed these identified health care delivery issues with the facility providers to ensure appropriate treatment to the patient. The physician services found to be inadequate/deficient at LPCC are described below:

- Lack of communication by the facility provider with the outside providers regarding unresolved patient complaints (identified in case 17).
- Facility provider's failure to make an appropriate diagnosis of the patient's health problem despite suspicious clinical course and suspect MRI (identified in cases 3, 14 and 17).
- No adequate follow-ups by the provider following patient's return from the hospital ED (identified in cases 3 and 17).
- Inadequate monitoring and mentoring of the mid-level provider by the PCP (identified in case 4).
- Failure to administer Narcan to treat acute drug overdose (identified in case 9 and 10).
- Patient sent to the ED without making any provisional diagnosis to substantiate the need for the ED visit (identified in case 14).
- Prescribing excessive medications (poly pharmacy) without clear medical necessity (identified in cases 6 and 16).
- Continuing previously prescribed medications without patient exam to evaluate the effectiveness of the prescribed medications (identified in case 16).
- Prescribing non-formulary or banned drugs such as muscle rub with no apparent clinical value (identified in case 16).

Case Number	Deficiencies
Case 3	***Inadequate.*** A 35 year old patient complains of dizziness after falling and hitting his head with possible contusion and syncope; the patient was sent to hospital ED. The patient returned from the ED on 08/13/15 and had a follow-up appointment with the mid-level provider on 08/14/15. The mid-level provider failed to make a diagnosis and the facility provider was not consulted. The patient was seen by a nurse for sick call on 8/21/15 because the patient complained of being dizzy for a week following his return from ED. The patient was not seen by the PCP or mid-level provider and no diagnosis was made.
Case 4	***Adequate.*** A 63 year old hypertensive patient was seen in the clinic on 08/27/15 for dizziness with possible dehydration. The patient's blood pressure (BP) was checked and was found to be too low. The PA failed to reduce the BP medications even though the patient's BP was low. The patient was on more than one BP medication (polypharmacy) during the time. Minimal supervision of the mid-level provider by the facility provider noted. The same patient returned to the clinic on 09/15/15 due to abdominal pain and was evaluated by the nurse. . The nurse consulted the mid-level provider and the mid-level provider referred the patient for X-ray. The mid-level provider did not complete a detailed evaluation of the abdomen.
Case 6	***Adequate.*** A 40 year old patient was prescribed Glyburide and Metformin 1500 mg each to be

	taken daily. The patient was diagnosed as having glycated hemoglobin (HbA1c) level of 6.3. During the patient's chronic care follow-up appointment on 08/05/15, the physician did not reduce the dosage of the medications in spite of the patient having low Hb1Ac levels. The target HbA1c levels in prison is typically 7-8. At 6.3 he was too tightly controlled, and was unnecessarily exposed to risks of hypoglycemia. The patient's Hb1Ac level was checked again on 10/29/15 and it was found to be 5.9, which was lower than the reading obtained two months prior and the Creatinine level was 1.47 which was essentially in the upper limit due to Metformin use. The provider again failed to reduce the dosage of the medications in spite of the low Hb1Ac level. Prescribing high dose of more than one diabetic medication despite low HbA1c levels may have potentially resulted in hypoglycemia. CCHCS physician determined that the patient was on excessive diabetic medications where sometimes risks can exceed benefits associated with these drugs.
Case 8	***Adequate.*** A 54 year old was sent to the hospital ED on 01/20/16 for evaluation of severe headache where no work up or treatment was done. The patient was eventually diagnosed with otitis media. There were no neurological signs exhibited by that patient nor were there any details in the progress note to justify the trip to the ED. There was no lumbar puncture done or any other actions completed as needed in the ED. CCHCS physician determined that excess of caution leads to unnecessary trips to ED putting patients and staff at risk. The provider prescribed Phenergan 25 mg x 4 in 48 hours for the patient on 02/06/16 without seeing the patient. The patient was seen on 02/07/16 for atypical chest pain. Treatment was continued with Phenergan and the provider did not examine the patient. CCHCS physician determined that there was a potential risk of missed diagnosis by continuing the therapy with Phenergan without a re-evaluation for effectiveness of the prescribed medication. Although Phenergan may be commonly used for similar conditions, it may not be best practice.
Case 9	***Inadequate.*** A 33 year old patient, who was in delirium, had a nursing encounter on 01/18/16 and his blood pressure was found to be elevated (Pulse 155, BP 138/92). The RN contacted the provider and documented that she was directed to return patient to housing without providing any treatment for possible methamphetamine overdose. This was an inaccurately recorded because the patient was sent to the ED. The provider does not recall giving instructions for return to housing as documented. Supplemental notes were not written regarding instructions given to nursing staff for patient disposition.
Case 10	***Inadequate.*** A 21 year old patient, known heroin addict, was found unresponsive in his cell due to heroin overdose on 01/08/16. The facility physician failed to promptly administer Narcan. Narcan was administered by the paramedics after they arrived on scene. CCHCS clinician determined that the services provided to the patient were below community standard of care despite this issue having been previously discussed with CCA physicians when a similar incident occurred in the past at a different CCA facility.
Case 11	***Adequate.*** A 21 year old patient with headaches post craniotomy was referred to neurology by the provider. The patient had a neurology consultation on 08/21/15. The neurosurgeon failed to make a diagnosis and instead referred the patient to neurosurgery. The facility provider failed to communicate with the neurologist and there is no documentation to show that the provider discussed with the patient regarding the patient's anxiety and migraine. CCHCS physician determined that the referral to neurosurgery was unnecessary.
Case 12	***Adequate.*** A 41 year old patient with hypothyroidism and thyroid nodule had specialty services appointment on 11/23/15 with the Eyes-Nose-Throat (ENT) specialist and was followed up appropriately by the provider thereafter. No deficiencies noted.
Case 14	***Adequate.*** A 56 year old hypertensive patient was on multiple medications to control his BP. On 01/14/16, the patient complained of flank discomfort. The patient did not exhibit any signs of acute or serious disease. The patient was sent to the hospital ED without the physician completing a history and physical exam or making a provisional diagnosis. Extensive work up

	done at the hospital results of which turned out to be negative. CCHCS clinician determined that there was no need for the ED trip due to the absence of any clinical indication of pathology of any sort, no hint of pulmonary embolism, pneumonitis, or Acute Coronary Syndrome. Moreover, this incident had not taken place during evening hours or weekend.
Case 15	***Adequate.*** A 51 year old patient with borderline microcytic anemia with blood in stools had a chronic care appointment on 08/13/15 and the provider ordered a colonoscopy due to positive results for Fecal Occult Blood (FOB) test and weight loss. The colonoscopy was completed on 09/02/15 and the result was indicative of malignant tumor at proximal ascending colon. The CCHCS physician would have rated this case as *proficient* if the colonoscopy had been completed by the facility provider promptly when the patient tested positive for FOB test. The colonoscopy was done only six weeks after patient was diagnosed with blood in stool. There were no other deficiencies noted in the care provided.
Case 16	***Adequate.*** A 45 year old patient had a chronic care follow-up appointment for Hepatitis C. The patient was prescribed Ranitidine during one of the earlier appointments. The physician continued the patient on Ranitidine without reviewing the patient's history or conducting a physical exam to substantiate the need for the patient to continue the use of medication. In addition, the physician also prescribed a muscle rub during the visit. Although the overall care provided to the patient for his chronic care condition was found adequate, CCHCS physician determined the patient's medication management to be deficient due to the physician prescribing non-formulary drugs and reiterating prescriptions without demonstrated need.
Case 17	***Inadequate.*** A 35 year old patient returned from ED with vague and inaccurate diagnosis on 02/18/16 and was evaluated by the nurse. The nurse contacted the physician over phone and was instructed to place the patient in the observation cell. The patient was not provided medications for effective pain relief caused by acute disease. There was a lack of MD follow up and poor documentation in progress notes. Due to the provider's inadequate communication with ED staff, neurosurgeon and radiologist, there was a significant delay in diagnosing epidural abscess despite a suspicious clinical course and suspect MRI. The patient returned to hospital for a repeat MRI and draining of abscess after first ED visit failed to provide the much needed therapy. CCHCS clinician's intervention on site prompted further effective care. Patient currently under therapy after further consultation with ED and specialists.

In general, medical services provided by physician, physician extenders and nursing generally met the standards of care applied in California prisons. In addition to the auditing clinician, some of the cases were also reviewed by the clinician's peers. As a result of the review, it was determined that services at LPCC, in some cases, deviated significantly from best practices. Physicians at LPCC also agreed with the clinician that there is room for improvement in a number of areas as stated below:

- Oversight of physician extenders should be formalized with signed DSA (Delegated Services Agreements for PA and collaborator agreement for Nurse Practitioner (NP)) on file and onsite.
- The provider should meet with PA and/or NP each week to discuss patient cases. These discussions and signed charts should amount to no less than 5% of cases each month and the discussions should be documented.
- Coordination of nursing, custodian, and physician and outside specialty services can also be improved. In a few cases significant lapses in communication identified in the onsite review increased the risk of adverse clinical outcomes.
- Providers and nurses should be made familiar with California formulary and be especially careful when prescribing medications in Arizona, that are not usually prescribed in CA.

- Physician on call should consider whether the patient can safely await physician exam onsite before transfer.
- Polypharmacy deserves further attention to reduce prescribed medications that may pose more hazard than benefit.
- Better communication with the outside physicians, especially ED physicians who need guidance from facility provider to promote optimal care.

Following are some recommendations provided by CCHCS clinician on how to further improve the provider's performance at LPCC:

- Document monthly meetings between the physicians and the mid-level providers to review challenging cases and provide continuing education.
- Consistent review of logs to identify patients needing further consideration by the medical director.
- Implement logs to document after hours phone call contact with providers and/or document in the chart regarding the engagement of provider on-call after hours.
- Complete peer review among the facility's providers.
- Encourage nurses to seek contemporaneous advice of physical examination of patients with new symptoms or worsening condition.
- Follow up with mental health when a patient's refusal puts his health/life at risk.
- PCP should document phone calls to specialist consultants and ED physicians who have seen patients to assure that the facility provider and specialists are communicating as needed.
- The providers shall adhere to CCHCS formulary. Off formulary medications are to be properly prescribed only after consultation with the facility's physician director or his delegate when medical need for off formulary drug is documented.
- Provider shall meet with custody and nursing to improve communications about patients at risk.
- Nurses need to consistently utilize the nursing protocols during exams.
- Encourage nurses to feel free to refer those patients to the provider, who are requesting further care from a provider, even if the nurse feels he/she has provided sufficient care to the patient.
- The physician's and nurse's progress notes should include details regarding patient's symptoms, diagnosis and treatment provided.
- Patients with borderline indications for pharmacological therapy should be re-evaluated before continuing medications prescribed in the past. Examples include a patient on multiple anti-hypertensive medications with borderline high blood pressure and a patient prescribed 1500 mg of Metformin and 1500 mg Glyburide despite having blood sugar (HbA1c) level of 5.9, which is well below the safe target range.

PRIOR CRITICAL ISSUE RESOLUTION

The previous audit resulted in the identification of 61 quantitative critical issues; however, seven of the critical issues are no longer rated by the Health Care Operations Monitoring Audit.

During the current audit, auditors found 22 of the 54 outstanding issues resolved, with the remaining 32 not resolved to within the established compliance threshold. Five of the 32 issues that are unresolved, were deficiencies identified during December 2014 audit. These deficiencies are mostly related to diagnostic services, medication management and the facility's failure in referring patients to the facility PCP when a patient refuses or is a "no-show" for appointments and/ or medications. It should be noted that 8 of the 32 critical issues could not be evaluated at this time due to lack of valid cases available for review/assessment of that specific requirement. Below is a discussion of each previous critical issue:

1. Question 2.4 (Formerly Question 1.3.1) – *THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE SICK CALL MONITORING LOGS TIMELY.*

Prior Compliance	Current Compliance	Status
57.1%	100%	**Resolved**

The previous audit findings showed that during the six month period, 57.1% of the sick call monitoring logs were submitted on time. The current audit findings reflect that from June through November 2015, 100% of the submissions were timely. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

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

Prior Compliance	Current Compliance	Status
54.0%	48.1%	**Unresolved**

A random sample of 100 entries was selected for review during the previous audit, of which 54 were accurately recorded on the sick call log, resulting in 54.1% compliance. A random sample of 52 entries was selected for review during the current audit, of which 25 were found to have been accurately recorded on the log, resulting in 48.1% compliance. This represents a 5.1 percentage point decline in compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

3. Question 2.4 (Formerly Question 1.3.4) – *THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE SPECIALTY CARE MONITORING LOGS TIMELY.*

Prior Compliance	Current Compliance	Status
57.1%	100%	**Resolved**

The previous audit findings showed that within the six month review period, 57.1% of the specialty care monitoring logs were submitted on time. The current audit findings reflect that from June through November 2015, 100% of the submissions were timely. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

4. Formerly Question 1.3.5 – *THE SPECIALTY CARE MONITORING LOGS SUBMITTED BY THE FACILITY DOES NOT CONSISTENTLY CONTAIN ALL THE REQUIRED INFORMATION.*

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

5. Question 2.6 (Formerly Question 1.3.6) – *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATES ON THE SPECIALTY CARE MONITORING LOG.*

Prior Compliance	Current Compliance	Status
47.4%	64.6%	**Unresolved**

   A random sample of 97 entries was selected for review during the previous audit, 46 of which were accurately recorded on the specialty care monitoring log. A random sample of 48 entries was selected for review during the current audit, 31 of which were found to have been accurately recorded on the log, resulting in 64.6% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

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

Prior Compliance	Current Compliance	Status
57.1%	100%	**Resolved**

   The June 2015 audit findings showed that within the six month review period, 57.1% of the hospital stay/emergency department monitoring logs were submitted on time. The current audit findings reflect that from June through November 2015, 100% of the submissions were timely. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

7. Question 2.7 (Formerly Question 1.3.9) – *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATES ON THE HOSPITAL STAY/EMERGENCY DEPARTMENT MONITORING LOG.*

Prior Compliance	Current Compliance	Status
63.6%	73.7%	**Unresolved**

   A random sample of 33 entries was selected for review during the previous audit, 21 of which were accurately recorded on the log. A random sample of 38 entries was selected for review during the current audit, 28 of which were found to have been accurately recorded on the log, resulting in 73.7% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

8. Question 2.4 (Formerly Question 1.3.10) – *THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE CHRONIC CARE MONITORING LOGS TIMELY.*

Prior Compliance	Current Compliance	Status
20.0%	83.3%	**Unresolved**

   The previous audit findings showed that the facility submitted only one out of a total of four chronic care monitoring logs on time, resulting in 20.0% compliance. The current audit findings

show that out of the six monthly chronic care logs required to have been submitted from June through November 2015, five were submitted on time, resulting in 83.3% compliance. Although this is a significant improvement from the previous audit, the facility failed to receive compliance benchmark rating of 85.0%. Therefore this critical issue remains unresolved and will continue to be monitored in subsequent audits.

9. Formerly Question 1.3.11 – *THE CHRONIC CARE MONITORING LOGS SUBMITTED BY THE FACILITY DOES NOT CONSISTENTLY CONTAIN ALL THE REQUIRED INFORMATION.*

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

10. Question 2.4 (Formerly Question 1.3.13) – *THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE INITIAL INTAKE SCREENING MONITORING LOGS TIMELY.*

Prior Compliance	Current Compliance	Status
0.0%	83.3%	**Unresolved**

The June 2015 audit findings showed that within the six month review period, none of the six initial intake screening monitoring logs were submitted on time. The current audit findings show that out of the six monthly initial intake screening monitoring logs required to have been submitted from June through November 2015, five were submitted on time, resulting in 83.3% compliance. Although this is a significant improvement from the previous audit, the facility failed to receive compliance benchmark rating of 85.0%. Therefore this critical issue remains unresolved and will continue to be monitored in subsequent audits.

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

Prior Compliance	Current Compliance	Status
66.0%	80.0%	**Unresolved**

A random sample of 100 entries was selected for review during the previous audit, 66 of which were accurately recorded on the initial intake screening monitoring log. A random sample of 60 entries was selected for review during the current audit, 48 of which were found to have been accurately recorded on the log, resulting in 80.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

12. Question 3.5 (Formerly Question 1.8.1) – *THE FACILITY DOES NOT HAVE THE REQUIRED PHYSICIAN/PRIMARY CARE PROVIDER STAFFING PER CONTRACTUAL REQUIREMENT.*

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

LPCC is contractually required to be staffed with two physicians and two mid-level providers. During the June 2015 audit, the facility was not staffed with the two mid-level providers and scored a rating of 50.0% compliance. During the current audit, the facility was still short of the two mid-level providers but was in the final stages of the hiring process for one mid-level provider who was scheduled to start on March 14, 2016. However, since there were no mid-level providers providing health care services at the time of the audit, the facility scored a rating

of 50.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

13. Question 3.8 (Formerly Question 1.8.2) – *THE FACILITY DOES NOT HAVE THE REQUIRED MANAGEMENT STAFFING PER CONTRACTUAL REQUIREMENT.*

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

LPCC is contractually required to be staffed with three Clinical Nurse Supervisors (CNS). During the June 2015 audit, the facility was staffed only with two CNSs and scored a rating of 66.7% compliance. During the current audit, it was found that the facility was fully staffed with three CNSs and was 100% compliant with this requirement. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

14. Question 3.6 (formerly Question 1.8.3) – *THE FACILITY DOES NOT HAVE THE REQUIRED REGISTERED NURSE STAFFING PER CONTRACTUAL REQUIREMENT.*

Prior Compliance	Current Compliance	Status
71.4%	92.9%	**Resolved**

The facility is contractually required to be staffed with 14.0 FTE RN positions. During the previous audit, the facility had been staffed with only 10.0 FTE RNs resulting in 71.4% compliance. During the current audit, the facility was staffed with 13.0 FTE RN staff and had one vacancy for a RN. This equates to 92.9% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

15. Formerly Question 2.1.1 – *WHEN THE PATIENTS REFUSE DECONTAMINATION FOLLOWING THE EXPOSURE TO CHEMICAL AGENTS, THE PATIENT IS NOT BEING MONITORED BY THE HEALTH CARE STAFF EVERY 15 MINUTES FOR NOT LESS THAN A TOTAL OF 45 MINUTES.*

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

16. Question 5.2 *(*Formerly Question 2.2.2) – *THE PATIENT DOES NOT CONSISTENTLY RECEIVE HIS CHRONIC CARE KEEP ON PERSON (KOP) MEDICATIONS WITHOUT INTERRUPTION*.

Prior Compliance	Current Compliance	Status
28.0%	3.3%	**Unresolved**

During the previous audit, out of 25 records that were reviewed, 7 had documentation that the patient received his chronic care KOP medications without interruption, which resulted in a rating of 28.0% compliance. During the current audit, a total of 30 medical records were evaluated to measure compliance for this requirement. Of the 30 records reviewed, only one included documentation that the patient received his KOP medication without interruption within the required time frame, which resulted in a rating of 3.3% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

17. Question 5.2 (Formerly Question 2.2.4) – *THE PATIENT IS NOT CONSISTENTLY ADMINISTERED HIS CHRONIC CARE NURSE ADMINISTERED/DIRECT OBSERVATION THERAPY (NA/DOT) MEDICATIONS WITHOUT INTERRUPTION*.

Prior Compliance	Current Compliance	Status
40.0%	N/A	**Unresolved**

During the previous audit, five records were reviewed and two had documentation that the patient received his NA/DOT medications without interruption within the specified time frames, and the facility received a rating of 40.0% compliance. Subsequent to the previous audit, this requirement is currently being measured by question 5.2 in the revised *Private Prison Compliance and Health Care Monitoring Audit Guide*. During the current audit, this requirement could not be evaluated since none of the CDCR patients selected for review were on NA/DOT medications during the audit review period. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

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

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

The June 2015 audit findings showed that the patients' refusals of KOP chronic care medications were not documented on the CDCR Form 7225, resulting in 0.0% compliance. During the current audit, this requirement could not be evaluated since none of the CDCR patients selected for review refused their chronic care KOP medications during the audit review period. This critical issue is considered unresolved and will continue to be monitored in subsequent audits.

19. Question 5.4 (Formerly Question 2.2.5) – *THE PATIENTS WHO DO NOT SHOW FOR THEIR NURSE ADMINISTERED/DIRECT OBSERVATION THERAPY CHRONIC CARE MEDICATIONS FOR THREE CONSECUTIVE DAYS OR 50% OR MORE DOSES IN A WEEK ARE NOT REFERRED TO THE PROVIDER FOR MEDICATION NON-COMPLIANCE.*

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

During the previous audit, three records were reviewed to measure this requirement and out of the three records, none included documentation that the patients were referred to the provider for medication non-compliance, resulting in 0.0% compliance. During the current audit, again three records were reviewed and none had the required documentation. The facility once again received a rating of 0.0% compliance. This critical issue is considered unresolved and will continue to be monitored in subsequent audits.

20. Question 5.5 (Formerly Question 2.2.6) – *THE PATIENTS WHO DO NOT SHOW FOR THEIR NURSE ADMINISTERED/DIRECT OBSERVATION THERAPY CHRONIC CARE MEDICATIONS FOR THREE CONSECUTIVE DAYS OR 50% OR MORE DOSES IN A WEEK ARE NOT SEEN BY THE PROVIDER WITHIN SEVEN CALENDAR DAYS OF THE REFERRAL FOR MEDICATION NON-COMPLIANCE.*

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

During the previous audit, three records were reviewed to measure this requirement and out of the three records, none included documentation that the patients were seen by the provider for medication non-compliance, resulting in 0.0% compliance. During the current audit, per the double failure rule, this question was rated as non-applicable because the facility was non-compliant for question 5.4 since none of the three records reviewed had documentation that the patients had been referred to the provider for medication compliance. This critical issue is considered unresolved and will continue to be monitored in subsequent audits.

21. Question 5.6 (Formerly Question 2.2.7) – *THE PATIENTS WHO DO NOT SHOW FOR THEIR INSULIN ARE NOT REFERRED TO THE PROVIDER FOR MEDICATION NON-COMPLIANCE.*

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

During the previous audit, three records were reviewed to measure this requirement and out of the three records, none included documentation that the patients were referred to the provider for medication non-compliance, resulting in 0.0% compliance. During the current audit, out of five patients who were prescribed insulin, only one had been a no-show for his insulin. Upon reviewing this patient's record; it was found that the patient had not been referred to the provider for medication non-compliance. The facility once again received a rating of 0.0% compliance. This critical issue is considered unresolved and will continue to be monitored in subsequent audits.

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

Prior Compliance	Current Compliance	Status
65.0%	94.7%	**Resolved**

During the June 2015 audit, 13 of the 20 patient medical records reviewed included documentation of the provider timely reviewing, signing, and dating patients' diagnostic reports, which resulted in 65.0% compliance. The current medical record findings showed that 18 of the 19 patient medical records reviewed were in compliance with this requirement, resulting in 94.7% compliance. The findings show that LPCC has achieved a rating above the compliance benchmark of 85.0%; therefore, this critical issue is considered resolved.

23. Question 7.3 (Formerly Question 2.3.3) – *PATIENTS DO NOT CONSISTENTLY RECEIVE WRITTEN NOTIFICATION OF DIAGNOSTIC TEST RESULTS WITHIN THE SPECIFIED TIME FRAME.*

Prior Compliance	Current Compliance	Status
80.0%	57.9%	**Unresolved**

During the previous audit, 16 of the 20 patient medical records reviewed included documentation of the patient receiving written notification of diagnostic test results within two days of facility's receipt of results, resulting in 80.0% compliance. The current audit findings shows a 22.1 percentage point decline in compliance; 11 of the 19 patient medical records

reviewed had documentation that the patients received a written notification of their diagnostic test results, resulting in 57.9% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

24. Question 7.4 (Formerly Question 2.3.4) – *THE PATIENTS ARE NOT CONSISTENTLY BEING SEEN BY THE PRIMARY CARE PROVIDER FOR CLINICALLY SIGNIFICANT/ABNORMAL DIAGNOSTIC TEST RESULTS WITHIN 14 DAYS OF THE PROVIDER'S REVIEW OF RESULTS.*

Prior Compliance	Current Compliance	Status
63.6%	52.6%	**Unresolved**

During the June 2015 audit, 7 of the 11 patient medical records reviewed included documentation of the provider seeing the patient for significant/abnormal diagnostic test results, which resulted in 63.6% compliance. The current audit findings show an 11 percentage point decline in compliance; only 10 of the 19 patient medical records reviewed were in compliance with this requirement, resulting in 52.6% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

25. Question 14.5 (Formerly Question 2.4.7) – *THE EMERGENCY MEDICAL RESPONSE REVIEW COMMITTEE (EMRRC) DOES NOT CONSISTENTLY REVIEW/EVALUATE EACH MEDICAL RESPONSE AND/OR EMERGENCY MEDICAL DRILL THAT IS SUBMITTED TO THE COMMITTEE FOR REVIEW.*

Prior Compliance	Current Compliance	Status
0.0%	96.2%	**Resolved**

During the previous audit, this question was rated 0.0% compliant as all emergency medical response incident packages submitted to EMRRC were missing the CDCR Form 837, *Emergency Medical Drills/Incident Report*, from custody staff. Subsequent to the previous audit, there was a change in methodology where CCHCS no longer requires the facility to include the CDCR Form 837 in the incident package when submitting the emergency documentation to CCHCS for review. During the current audit, the auditor reviewed all 78 incident packages that had been submitted to EMRRC for review, from June through November 2015, and found that 75 out of 78 packages included all the required documents and review of these packages were performed timely resulting in 96.2% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

26. Question 14.7 (Formerly Question 2.4.9) – *IF AN EMERGENCY MEDICAL RESPONSE/DRILL WARRANTED THE OPENING OF THE EMERGENCY MEDICAL RESPONSE (EMR) BAG, THE FACILITY STAFF DO NOT CONSISTENTLY DOCUMENT THAT THE EMR BAG WAS RE-SUPPLIED AND RE-SEALED BEFORE THE END OF THE SHIFT.*

Prior Compliance	Current Compliance	Status
84.2%	50.0%	**Unresolved**

During the previous audit, documentation on the EMR bag log showed that out of a total of 19 EMR drills/responses that occurred during the audit review period, the EMR bags had been re-supplied and re-sealed for 16 incidents, which resulted in 84.2% compliance. The current audit findings reflect a 34.2 percentage point decline in compliance. Out of a total of 10 EMR drills/responses that warranted opening of the EMR bag, the EMR bags were re-supplied and re-

sealed only for 5 instances, which resulted in 50.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

27. Question 14.9 (Formerly Question 2.4.11) – *THE EMERGENCY MEDICAL RESPONSE BAG DOES NOT CONTAIN ALL THE SUPPLIES IDENTIFIED ON THE FACILITY'S EMR BAG CHECKLIST.*

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

During the previous audit, facility's four EMR bags were inspected and it was found that none of the EMR bags had all supplies that were listed on the facility's EMR bag checklist, which resulted in 0.0% compliance. The current audit findings showed that all four EMR bags contained all the supplies listed on the EMR bag checklist, which resulted in 100% compliance. The findings show that LPCC has been successful in addressing this deficiency; therefore this critical issue is considered resolved.

28. Question 14.13 (Formerly Question 2.4.16) – *THE CRASH CARTS DO NOT CONTAIN ALL THE MEDICATIONS AS REQUIRED/APPROVED BY THE INMATE MEDICAL SERVICES POLICIES AND PROCEDURES (IMSP&P).*

Prior Compliance	Current Compliance	Status
75.0%	0.0%	**Unresolved**

During the previous audit, facility's four crash carts were inspected and it was found that three crash carts contained all medications per IMSP&P requirement, which resulted in 75.0% compliance. The current audit findings show a 75 point decline in compliance; none of the facility's four crash carts contained all medications, which resulted in 0.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

29. Question 14.14 (Formerly Question 2.4.17) – *THE CRASH CARTS DO NOT CONTAIN ALL THE SUPPLIES LISTED IN THE FACILITY'S CRASH CART CHECKLIST.*

Prior Compliance	Current Compliance	Status
25.0%	0.0%	**Unresolved**

During the previous audit, facility's four crash carts were inspected and it was found that only one crash cart had all the supplies listed on the facility's crash cart checklist, which resulted in 25.0% compliance. The current audit findings show a 25 percentage point decline in compliance; none of the facility's four crash carts contained all the supplies listed on the crash cart checklist, which resulted in 0.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

30. Question 14.18 (Formerly Question 2.4.20) – *ONE OF THE FACILITY'S PORTABLE OXYGEN SYSTEMS WAS NOT OPERATIONALLY READY DUE TO MISSING A REQUIRED PIECE OF EQUIPMENT.*

Prior Compliance	Current Compliance	Status
13.3%	100%	**Resolved**

During the previous audit, facility's 15 portable oxygen tanks were inspected and it was found that only two of the tanks had the required piece of equipment attached, which resulted in 13.3% compliance. During the current audit, 12 portable oxygen tanks were checked and findings showed that all of the tanks were operationally ready, which resulted in 100% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is now considered resolved.

31. Question 6.1 (Formerly Question 2.5.1) – *THE FACILITY'S NURSING STAFF DO NOT CONSISTENTLY REVIEW THE PATIENT'S DISCHARGE PLAN UPON THEIR DISCHARGE AND RETURN FROM A COMMUNITY HOSPITAL ADMISSION.*

Prior Compliance	Current Compliance	Status
84.6%	62.5%	**Unresolved**

During the previous audit, 13 medical records were reviewed for this requirement and 11 had documentation of the nursing staff reviewing the patient's discharge plan, which resulted in 84.6% compliance. The current audit findings show a 22.1 percentage point decline in compliance; five out of eight records reviewed, had the required documentation, which resulted in 62.5% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

32. Question 6.4 (Formerly Question 2.5.3) – *THE FACILITY DOES NOT CONSISTENTLY ADMINISTER OR DELIVER ALL PRESCRIBED MEDICATIONS TO THE PATIENT PER POLICY OR AS ORDERED BY THE PRIMARY CARE PROVIDER.*

Prior Compliance	Current Compliance	Status
81.8%	75.0%	**Unresolved**

During the previous audit, 11 medical records were reviewed for this requirement and 9 had documentation of the medications being administered/delivered to the patient as ordered by the primary care provider, which resulted in 81.8% compliance. The current audit findings show a 6.8 point decline in compliance; six out of eight records reviewed, had the required documentation, which resulted in 75.0% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

33. Question 15.6 (Formerly Question 2.6.6) – *THE FACILITY'S NURSING STAFF DO NOT CONSISTENTLY DISINFECT RE-USEABLE NON-INVASIVE MEDICAL EQUIPMENT AFTER EACH PATIENT USE.*

Prior Compliance	Current Compliance	Status
25.0%	77.8%	**Unresolved**

During the previous audit, four facility nurses were observed during the onsite visit and only one nurse was observed disinfecting the equipment after patient use, which resulted in 25.0% compliance. The current audit findings show a significant increase in compliance; seven out of nine nursing staff observed, disinfected the non-invasive medical equipment after each patient use, which resulted in 77.8% compliance. Although LPCC has shown some improvement in the compliance rating for this requirement, the facility is well below the compliance benchmark

rating of 85.0%; therefore this critical issue remains unresolved and will continue to be monitored in subsequent audits.

34. Question 15.8 (Formerly Question 2.6.8) – *THE ENVIRONMENTAL CLEANING OF FACILITY'S CLINICS AND ADMINISTRATIVE SEGREGATION UNIT (ASU) CLINIC/EXAM ROOMS ARE NOT COMPLETED DAILY.*

Prior Compliance	Current Compliance	Status
60.8%	100%	**Resolved**

During the previous audit, the cleaning logs for four clinics and two ASU exam rooms were inspected during the onsite visit and it was found that two ASU exam rooms did not have cleaning logs for one month and out of a total of 186 days, there was documentation available only for 113 days, which resulted in 60.8% compliance. During the current audit, the inspection of the cleaning logs for all four clinics and ASU exam rooms showed that daily environmental cleaning was completed for all areas inspected, which resulted in 100% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is now considered resolved.

35. Question 15.13 (Formerly Question 2.6.14) – *THE FACILITY'S HEALTH CARE STAFF DO NOT CONSISTENTLY ACCOUNT FOR AND RECONCILE ALL SHARPS AT THE BEGINNING AND END OF EACH SHIFT.*

Prior Compliance	Current Compliance	Status
75.8%	100%	**Resolved**

During the previous audit, the facility's sharps logs for three clinics were inspected during the onsite visit and the documentation showed that out of a total of 186 required sharps counts for the month, counts were completed 141 times, which resulted in 75.8% compliance. During the current audit, the inspection of the facility's sharps logs showed that sharps counts were completed for all days inspected, which resulted in 100% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is now considered resolved.

36. Question 9.2 (Formerly Question 2.7.2) – *THE FACILITY'S NURSING STAFF DO NOT CONSISTENTLY DOCUMENT AN ASSESSMENT OF THE PATIENT IF THE PATIENT ANSWERED "YES" TO ANY OF THE MEDICAL PROBLEMS LISTED ON THE INITITAL INTAKE SCREENING FORM.*

Prior Compliance	Current Compliance	Status
70.6%	33.3%	**Unresolved**

During the June 2015 audit, 12 of the 17 patient medical records reviewed included documentation of the nursing staff completing an assessment of the patient if they answered "YES" to any of the medical problems in the *Initial Intake Screening* form, which resulted in 70.6% compliance. The current audit findings show a 37.3 percentage point decline in compliance; only one out of three records reviewed had the required documentation, resulting in a rating of 33.3% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

37. Question 9.4 (Formerly Question 2.7.4) – *IF A PATIENT IS NOT ENROLLED IN THE CHRONIC CARE CLINIC BUT IS IDENTIFIED AS HAVING A CHRONIC CARE DISEASE/ILLNESS DURING THE INITIAL INTAKE SCREENING, THE FACILITY'S NURSING STAFF DO NOT CONSISTENTLY REFER THE PATIENT TO THE PROVIDER.*

Prior Compliance	Current Compliance	Status
75.0%	N/A	**Unresolved**

During the June 2015 audit, three of the four patient medical records reviewed included documentation of the nursing staff referring the patient to the provider if they are identified as having a chronic illness/disease during initial intake screening, which resulted in 70.6% compliance. During the current audit, this requirement could not be evaluated since none of the CDCR patients selected for review were identified as having a chronic illness/disease during initial health screening during the audit review period. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

38. Question 9.5 (Formerly Question 2.7.5) – *WHEN PATIENTS ARE REFERRED BY THE NURSING STAFF TO MEDICAL, DENTAL OR MENTAL PROVIDER DURING INITIAL INTAKE SCREENING, THEY ARE NOT CONSISTENTLY SEEN BY THE PROVIDER WITHIN THE SPECIFIED TIME FRAME.*

Prior Compliance	Current Compliance	Status
33.3%	N/A	**Unresolved**

During the June 2015 audit, one of the three patient medical records reviewed included documentation of the provider seeing the patient, referred by the nursing staff during initial intake screening, within the specified time frame, which resulted in 33.3% compliance. During the current audit, this requirement could not be evaluated since none of the CDCR patients selected for review were referred by the nursing staff to the providers during initial health screening during the audit review period. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

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

Prior Compliance	Current Compliance	Status
60.0%	N/A	**Unresolved**

During the June 2015 audit, three of the five patient medical records reviewed included documentation of the provider seeing the patient, within the time frame ordered by the sending facility's provider, which resulted in 60.0% compliance. During the current audit, this requirement could not be evaluated since none of the CDCR patients selected for review were enrolled in a chronic care program at a previous facility during the audit review period. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

40. Question 9.11 (Formerly Question 2.7.11) – *WHEN A PATIENT TRANSFERS OUT OF THE FACILITY, THE FACILITY DOES NOT CONSISTENTLY DOCUMENT THE PATIENT'S SPECIALTY SERVICES*

APPOINTMENTS THAT WERE NOT COMPLETED, ON THE HEALTH CARE TRANSFER INFORMATION FORM (CDCR 7371 OR SIMILAR FORM).

Prior Compliance	Current Compliance	Status
50.0%	100%	**Resolved**

During the June 2015 audit, two of the four patient medical records reviewed included documentation of the patient's pending specialty services appointments on the health care transfer information form, which resulted in 50.0% compliance. During the current audit, five records were reviewed and all five records had the required documentation, which resulted in 100% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is now considered resolved.

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

Prior Compliance	Current Compliance	Status
68.2%	100%	**Resolved**

During the June 2015 audit, 15 of the 22 patient medical records reviewed included documentation of the provider providing education to the patient on the newly prescribed medications, which resulted in 68.2% compliance. During the current audit, 18 records were reviewed and all 18 records were compliant with this requirement, resulting in 100% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is now considered resolved.

42. Question 10.5 (Formerly Question 2.8.5) – *THE FACILITY NURSING STAFF DOES NOT CONSISTENTLY OBSERVE THE PATIENT TAKING HIS DIRECT OBSERVATION THERAPY (DOT) MEDICATIONS.*

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

During the previous audit, six nurses were observed during pill passes, and it was seen that only two of the six nurses observed the patients taking their DOT medications, resulting in 33.3% compliance. During the current audit, five nurses were observed and all five nurses were observed to be compliant with this requirement, resulting in 100% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is now considered resolved.

43. Question 10.11 (Formerly Question 2.8.12) – *THE FACILITY'S NURSING STAFF DOES NOT CONSISTENTLY INVENTORY THE NARCOTICS AT THE BEGINNING AND END OF THE SHIFT.*

Prior Compliance	Current Compliance	Status
75.8%	100%	**Resolved**

During the previous audit, narcotic logs from three clinics were inspected and it was found that out of a total of 186 counts, only 141 counts were documented resulting in 75.8% compliance. During the current audit, all 186 counts were documented in the narcotic logs, resulting in 100%

compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

44. Question 11.1 (Formerly Question 2.9.1) – *THE PATIENTS HOUSED IN OBSERVATION CELLS ARE NOT CONSISTENTLY CHECKED BY NURSING STAFF AT THE BEGINNING OF EACH SHIFT WITHIN TWO HOURS OR AS ORDERED BY THE PROVIDER.*

Prior Compliance	Current Compliance	Status
63.6%	66.7%	**Unresolved**

During the previous audit, 11 records were reviewed for this requirement, and seven had documentation of the nursing staff checking the patients in the observation cells at the beginning of each shift, resulting in 63.6% compliance. Subsequent to the previous audit, this question was modified in the audit tool to reflect the recent updates to the IMSP&P guidelines which currently requires the nursing staff to assess the patient every eight hours or more frequently as ordered by the provider when the patient is housed in the observation cell. During the current audit, four out of six records reviewed were compliant with this requirement, resulting in 66.7% compliance. This critical issue remains unresolved and will continue to be monitored in subsequent audits.

45. Question 11.2 (Formerly Question 2.9.2) – *THE PROVIDERS DO NOT CONSISTENTLY DOCUMENT THE NEED FOR THE PATIENT'S PLACEMENT IN THE OBSERVATION CELL WITHIN THE SPECIFIED TIME FRAME.*

Prior Compliance	Current Compliance	Status
81.8%	100%	**Resolved**

During the June 2015 audit, 9 out of 11 patient medical records reviewed included documentation of the provider explaining the need for patient's placement in the observation cell within 24 hours of the patient's placement, resulting in 81.8% compliance. During the current audit, all six records reviewed were compliant with this requirement, resulting in 100% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is now considered resolved.

46. Question 11.3 (Formerly Question 2.9.3) – *A LICENSED PROVIDER DOES NOT CONSISTENTLY CONDUCT DAILY FACE-TO-FACE ROUNDS ON PATIENTS HOUSED IN THE OBSERVATION CELLS FOR SUICIDE PRECAUTION WATCH OR AWAITING TRANSFER TO A MENTAL HEALTH CRISIS BED.*

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

During the June 2015 audit, five out of six patient medical records reviewed included documentation of the provider conducting daily face-to-face rounds on patients housed in the observation cells for suicide precaution watch or awaiting transfer to a mental health crisis bed. And the facility scored 83.3% compliance. During the current audit, only two records met the criteria for reviewing this requirement and both records were found to be compliant, resulting in 100% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is now considered resolved.

47. Formerly Question 2.10.3 – *THE FACILITY'S NURSING STAFF DO NOT DOCUMENT THAT THEY CONTACTED THE HOUSING UNIT SUPERVISOR TO HAVE THE PATIENT ESCORTED TO THE MEDICAL CLINIC WHEN A PATIENT IS A "NO-SHOW" FOR A SCHEDULED FACE TO FACE APPOINTMENT.*

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

48. Formerly Question 2.10.4 – *THE FACILITY NURSING STAFF DO NOT CONSISTENTLY COMPLETE A CDCR 7225, REFUSAL OF EXAMINATION AND/OR TREATMENT OR SIMILAR FORM AND DOCUMENT THE PATIENT REFUSAL ON A PROGRESS NOTE (CDCR 7230) IF THE PATIENT IS A"NO-SHOW' FOR A SCHEDULED FACE-TO-FACE APPOINTMENT AND REFUSED TO BE ESCORTED TO THE CLINIC.*

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

49. Formerly Question 2.10.5 – *THE FACILITY NURSING STAFF DO NOT CONSISTENTLY DOCUMENT THAT THEY CONTACTED THE PROVIDER TO DETERMINE IF/WHEN A PATIENT SHOULD BE RESCHEDULED IF THE PATIENT IS A "NO-SHOW' FOR A MEDICAL APPOINTMENT WITH THE PROVIDER.*

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

50. Question 13.1 (Formerly Question 2.11.1) – *THE PATIENTS WITH PRESCRIBED ANTI-TB MEDICATIONS ARE NOT CONSISTENTLY RECEIVING THE MEDICATIONS AS PRESCRIBED BY PROVIDERS.*

Prior Compliance	Current Compliance	Status
65.0%	100%	**Resolved**

    During the June 2015 audit, 13 out of 20 medical records reviewed included documentation showing that the patients were administered anti-TB medications as prescribed by provider and the facility scored 65.0% compliance. During the current audit, all 11 records were found to be compliant with this requirement, resulting in 100% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is now considered resolved.

51. Question 13.2 (Formerly Question 2.11.2) – *THE NURSING STAFF DOES NOT CONSISTENTLY NOTIFY THE PROVIDER WHEN A PATIENT MISSES OR REFUSES HIS ANTI-TB MEDICATION.*

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

    During the June 2015 audit, out of six medical records reviewed, none included documentation that nursing staff notified the provider when the patient missed or refused his anti-TB medication and the facility scored 0.0% compliance. During the current audit, two records were

reviewed and both were found to be non-compliant with this requirement, resulting in 0.0% compliance. The findings show that LPCC has not been successful in addressing this deficiency; therefore, this critical issue remains unresolved and will continue to be monitored in subsequent audits.

52. Question 13.3 (Formerly Question 2.11.3) – *THE FACILITY DOES NOT CONSISTENTLY MONITOR PATIENTS ON ANTI-TB MEDICATIONS ON A MONTHLY BASIS.*

Prior Compliance	Current Compliance	Status
65.0%	81.8%	**Unresolved**

During the June 2015 audit, out of 20 medical records reviewed, 13 records included documentation that the facility monitored the patients on a monthly basis when the patient was on anti-TB medications and the facility scored 65.0% compliance. During the current audit, nine out of 11 records reviewed were found to be compliant with this requirement, resulting in 81.8% compliance. The findings show that LPCC has not been successful in addressing this deficiency; therefore, this critical issue remains unresolved and will continue to be monitored in subsequent audits.

53. Question 13.5 (Formerly Question 2.11.4) – *THE FACILITY DOES NOT ANNUALLY SCREEN ALL THE PATIENTS FOR SIGNS AND SYMPTOMS OF TUBERCULOSIS.*

Prior Compliance	Current Compliance	Status
40.0%	N/A	**Unresolved**

Of the 18 patient medical records reviewed during the previous audit, only 8 reflected the patients were screened for TB signs and symptoms within the past year, which resulted in 40.0% compliance. During the current audit, this question was not evaluated. Per the revised audit instruction guide and methodology, this question is evaluated once per calendar year during the audit review period when the annual TB testing occurs per the master calendar on *Lifeline*. As the audit review period (June through November 2015) for LPCC's current audit did not include the month when LPCC provided annual TB testing and screening to its CDCR patient population, this question was not evaluated for compliance at this time. This critical issue remains unresolved and will be assessed in subsequent audits.

54. Question 13.7 (Formerly Question 2.11.7) – *THE FACILITY DOES NOT CONSISTENTLY OFFER COLORECTAL CANCER SCREENING TO PATIENTS 50 TO 75 YEARS OF AGE.*

Prior Compliance	Current Compliance	Status
21.1%	N/A	**Unresolved**

During the June 2015 audit, out of the 19 patient medical records reviewed, four included documentation that the patient was offered colorectal cancer screening, which resulted in 21.1% compliance. During the current audit, this question was not evaluated. Per the revised audit instruction guide and methodology, this question is evaluated once per calendar year during the audit conducted within the first half of the fiscal year (July through December). Since the audit was conducted in February 2016 and not during the first half of the fiscal year, this question was not evaluated for compliance at this time. This critical issue remains unresolved and will be assessed in subsequent audits.

55. Question 4.1 (Formerly Question 2.12.1) – *THE NURSING STAFF DOES NOT CONSISTENTLY REVIEW ALL SICK CALL REQUESTS WITHIN THE SPECIFIED TIME FRAME.*

Prior Compliance	Current Compliance	Status
84.0%	100%	**Resolved**

During the June 2015 audit, out of the 25 patient medical records reviewed, 21 included documentation that the RN reviewed the patient's sick call request on the day it was received, which equated to 84.0% compliance. Twenty four medical records were reviewed for this requirement during the current audit and all 24 records were found compliant, resulting in 100% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is now considered resolved.

56. Question 4.2 (Formerly Question 2.12.3) – *THE NURSES DO NOT CONSISTENTLY DOCUMENT THAT THEY COMPLETED A FACE-TO-FACE EVALUATION OF A PATIENT WITH EMERGENT HEALTH CARE NEEDS, ON THE SAME DAY OF RECEIPT OF THE REQUEST.*

Prior Compliance	Current Compliance	Status
75.0%	100%	**Resolved**

Findings of the previous audit showed that following the RN's review of a patient's emergent sick call request, the RN did not complete a face-to-face evaluation of the patient within the specified time frame. Three out of four patient medical records reviewed included documentation that the patient was seen by an RN on the same day, which equated to 75.0% compliance. During the current audit, 24 patient medical records were reviewed and it was found that only one patient had an emergent health care need; the documentation in this patient's record showed that the patient was seen by an RN within the specified time frame, resulting in 100% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

57. Question 4.3 (Formerly Question 2.12.4) – *THE NURSING STAFF DOES NOT CONSISTENTLY DOCUMENT THE PATIENT'S CHIEF COMPLAINT IN PATIENT'S OWN WORDS.*

Prior Compliance	Current Compliance	Status
84.0%	100%	**Resolved**

During the June 2015 audit, out of the 25 patient medical records reviewed, 21 included the RN's documentation of the patient's complaint in patient's own words, resulting in 84.0% compliance. During the current audit, 24 medical records were reviewed for this requirement and all 24 records were found to be compliant, resulting in 100% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is now considered resolved.

58. Formerly Question 2.12.14 – *THE PATIENTS ARE NOT SEEN FOR A FOLLOW-UP APPOINTMENT WITHIN THE SPECIFIED TIME FRAME.*

This specific requirement is no longer rated in the compliance portion of the Private Prison Compliance and Health Care Monitoring Audit; therefore, no compliance score is available. However, this requirement is currently being assessed during the case reviews completed by

CCHCS physicians and addressed in the *Case Review Findings* section of the applicable quality indicator.

59. Question 4.13 (Formerly Question 2.12.17) – *THERE IS NO EVIDENCE THAT THE NURSING STAFF CONDUCT DAILY ROUNDS IN ADMINISTRATIVE SEGREGATION UNITS (ASU) TO PICK-UP SICK CALL SLIPS.*

Prior Compliance	Current Compliance	Status
2.3%	80.6%	**Unresolved**

During the June 2015 audit, daily logs of three ASU units was reviewed during the onsite visit to determine whether nursing staff conducted daily rounds in these housing units to pick up sick call slips. Since one of the ASU's had been operational only for 26 days, of a total of 88 days were reviewed for the month of May 2015, there was documentation available only for two days showing that nursing staff had picked up sick call slips, which resulted in 2.3% compliance. During the current audit in February 2016, daily logs of four ASU units were reviewed onsite for the month of January 2016. Of a total of 124 days (31 days x 4 logs) reviewed, there was documentation available for 100 days showing that the nursing staff picked up sick call slips in the ASU, resulting in 80.6% compliance. The findings show that LPCC has not been successful in addressing this deficiency; therefore, this critical issue remains unresolved and will continue to be monitored in subsequent audits.

60. Question 15.16 (Formerly Question 2.12.20) – *THE FACILITY DOES NOT PROVIDE ALL THE CLINICS WITH PROPER EQUIPMENT, SUPPLIES, AND ACCOMMODATIONS FOR PATIENT VISITS.*

Prior Compliance	Current Compliance	Status
42.9%	100%	**Resolved**

During the June 2015 audit, 14 exam rooms were inspected, six of which had the proper equipment, supplies, and accommodations for patient visits. The other eight exam room lacked supplies such as cuffs for wall sphygmomanometer, tongue depressors, lubricant jelly and personal protective equipment. This resulted in 42.9% compliance. During the current audit, 11 exam rooms were inspected during the onsite visit. All 11 exam rooms had the essential core medical equipment and supplies available for patient visits, resulting in 100% compliance. The findings show that LPCC has successfully addressed this deficiency; therefore, this critical issue is considered resolved.

61. Question 12.4 (Formerly Question 2.13.6) – *UPON A PATIENT'S RETURN FROM A SPECIALTY CARE CONSULTATION OR COMMUNITY HOSPITAL EMERGENCY DEPARTMENT, THE REGISTERED NURSE DOES NOT CONSISTENTLY NOTIFY THE PROVIDER OF ANY IMMEDIATE MEDICATION ORDERS OR FOLLOW-UP INSTRUCTIONS PROVIDED BY THE SPECIALTY CARE CONSULTANT OR COMMUNITY HOSPITAL PHYSICIAN.*

Prior Compliance	Current Compliance	Status
76.5%	45.5%	**Unresolved**

During the June 2015 audit, out of the 17 patient medical records reviewed, 13 included documentation that upon a patient's return from a specialty care consultation or community hospital ED, the RN notified the provider of any immediate medication orders or follow-up

instructions provided by the specialty care consultant or community hospital physician, resulting in 76.5% compliance. During the current audit, 22 medical records were reviewed for this requirement and only 10 records were found to be compliant, resulting in 45.5% compliance. The findings show that LPCC has not been successful in addressing this deficiency; therefore, this critical issue remains unresolved and will continue to be monitored in subsequent audits.

NEW CRITICAL ISSUES

There were no additional new critical issues identified during this audit besides the issues already addressed in the *Audit Findings – Detailed by Quality Indicator* section of the report.

CONCLUSION

During the current audit, the facility's overall performance was rated ***adequate***. Of the 17 quality indicators evaluated, CCHCS found four *proficient*, ten *adequate*, and three *inadequate* (see *Executive Summary Table* on page 4). The current audit findings clearly indicate that the executive and health care management staff have not been able to address previously identified critical issues in an effective manner; only 22 of the 54 deficiencies were corrected and no improvements were seen with regards to deficiencies related to medication management, diagnostic services and specialty services. Although some of the unresolved issues are non-serious and easily correctable such as documentation on the monitoring logs, EMR bag and crash cart inventory checks, infection control and staffing, the remaining unresolved critical issues are serious in nature and have a direct affect and impediment to patient care. This is especially true with regards to patients not receiving their chronic care medications in a timely manner and the patients not being referred to the provider for medication non-compliance. Facility's adherence to these requirements is extremely critical for effective patient care; therefore these deficiencies need to be resolved by the facility in an expedient manner to avoid patient harm.

The executive and health care management staff are also expected to resolve any critical issues that were identified during the current audit as a result of the observations/inspections conducted onsite, review of the patient's medical records for the previous six months, review of the administrative operations, and clinical case reviews. The continuation of unresolved critical issues over the last several audits combined with the identification of four new critical issues, further accentuates the importance of the facility management's active involvement in resolution of all identified systemic issues in order to maintain the quality of health care services delivered to California patients at a satisfactory level. The outstanding and new deficiencies were addressed and shared with the facility's executive and health care management staff during the audit team's exit meeting.

PATIENT INTERVIEWS

The intent of this portion of the audit is to elicit substantive responses from the patient population, by utilizing each question as a springboard for discussion, with appropriate follow up to identify any areas where barriers to health care access may potentially exist. This is accomplished via interview of all the ADA patients housed at the facility, the Inmate Advisory Council (IAC) executive body and a random sampling of patients housed in general population (GP) and administrative segregation units (ASU). The results of the interviews conducted at LPCC 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 audit conducted in February 2016, the audit team interviewed IAC council members, ten patients from GP, five patients from ASU and nine ADA patients.

Five ASU patients and ten patients from GP were interviewed on the sick process and health care grievance/appeal processes.

1. Regarding questions 1 through 4 – All 15 patients were aware of the sick call process and knew how to access the forms, if needed. None of the patients reported any issues with health care services provided at LPCC.

2. Regarding questions 5 through 8 – Out of 15 patients interviewed, 14 were aware of the health care grievance/appeal process and two patients had utilized the process in the past. One patient seemed not to know the process. The audit team explained the health care appeal process to the patient and informed them where the CDCR 602-HC forms can be located and submitted. The audit team enquired if the patient had been provided with the inmate handbook where the process was listed. The patient stated that he had thrown away the book that was provided to him a while back when he first arrived at LPCC. The auditor advised the patient to request the facility staff to provide him with a handbook and recommended the patient to use the book as a reference.

3. Regarding questions 9 through 21 – Out of nine ADA patients interviewed, two were Spanish speaking and the auditor utilized translation service to communicate with one of the patients and for the other patient, one of the RNs served as the translator. Both patients stated that they understood simple English and when required, health care staff utilized translation service to communicate effectively with them. Most patients did not voice any concerns regarding the accommodations or health care provided by the facility. All patients identified the ADA coordinator by his name. Most of the patients did not have the need to utilize the health care grievance appeal process since they did not have any health care related issues. One of the patients complained that he had been prescribed a BP medication by the mid-level provider and the medication was not working. He alleged that he has not had any chronic care follow-up appointments since October 2015. Upon enquiring with the HSA, the auditors were informed that the patient's BP was well controlled with medication and the patient was not due for an appointment until March 2016. Another patient stated that he has had issues with refilling his medication. The patient stated that although he had informed the mid-level provider regarding his refills expiring and the provider had renewed his prescription, the medications were not ordered on time. Upon further enquiry, the auditors were told that an RN had identified this issue; the RN had ordered the medications from a local pharmacy and provided the refill to the patient before the prescription had expired. There were no other concerns raised during the interviews.

IAC Interviews

In addition to the case reviews, CCHCS clinician interviewed the members of the IAC and the patients raised concerns regarding some of the services provided by the facility's health care staff. Listed below are the issues as stated by the patients during this interview:

- Sick call requests are not always processed timely. Inmates have reported waiting for 20-25 minutes for emergency situations that seemed excessive.
- Dental care is delayed.
- Access to the provider is difficult when the nurse does not refer.
- Custody seems unaware of medical needs of the patients and fails to take the patients to medical even if the patient requests them to do so.

- The diet provided by the facility is not meeting minimum daily amounts for protein and fiber recommended by the Food and Drug Administration (FDA) guidelines.
- Early morning clinic times are hard to attend. Inmates who sleep past wake up for the clinic are written up as "refusals."

Following the interview, CCHCS physician discussed the patients' concerns and health care complaints with the facility providers. Some of the issues that were raised by the patients did not hold any merit and this was especially true with regards to the diet since the HSA confirmed that the meals currently provided at the facility were implemented by the facility's dietician and is in compliance with the FDA guidelines. When auditors enquired with the HSA regarding the patients' concerns regarding long waiting times for sick call appointments, HSA stated that the patients are seen based on their complaints and all emergency cases are handled within the time frames specified in the policy. This was confirmed to be true based on the results of the medical record reviews. The CCHCS physician recommended the providers review each of these patients' health condition, explain the current status to the patients and document patient education in the charts. This will help eliminate the patients' concerns regarding lack of access to providers. The providers agreed to follow the recommendations. CCHCS physician also advised the facility warden and providers that they provide a platform for the IAC committee members to address their health care issues and concerns with the facility staff during the facility's monthly meetings with the committee. Subsequent to the audit, the facility provided information on all discussed health care issues. Upon review, it was found that these health concerns had already been adequately addressed by the facility's health care staff.

Some of the IAC members also volunteered information regarding their personal health care issues that had not been addressed by the facility's health care staff. The various health care concerns raised by the IAC members and facility's responses are stated below:

- First patient complained that he suffered from persistent headache and it was not being treated effectively. Upon enquiring about the issue, the facility provider informed CCHCS physician that the patient currently has a prescription for Ibuprofen and Gabapentin (for which the patient's dosage is currently being reduced gradually) and he had been seen for chronic care on 1/13/16; the patient had denied having a headache at the time. The patient has not put in any sick call requests for headaches to date. CCHCS clinician recommended that the provider have regular follow-ups with the patient in order to monitor the patient's headache after Gabapentin is discontinued.
- Second patient claimed he had been on the waiting list for four months to receive treatment for wisdom tooth pain. Upon enquiring with the facility provider, the CCHCS clinician was informed that the patient had been called to dental on 1/21/16 for extraction of the affected tooth. The patient had refused that appointment. The facility staff had notified the patient at that time that if he needed the appointment in the future, he could request and he would be seen. CCHCS clinician recommended the facility to schedule the patient for a dental follow up.
- Third patient complained that his pterygium was not being treated. This was conveyed to the facility's HSA and the HSA contacted the optometrist for an update regarding this patient's case. The optometrist informed the HSA that the patient's pterygium was only 1mm in size and was not blocking his vision. It was also not in close proximity to the pupil for its removal. The optometrist had also informed the patient that at the current state, the removal of the

pterygium would only serve a cosmetic purpose. The CCHCS clinician recommended that the providers educate the patient on protecting his eyes from sun and wind exposure.

- Fourth patient alleged that the medication that had been provided to treat his Meniere's disease was ineffective in treating his condition. Upon checking with the facility's HSA, the auditor found that the patient hadn't submitted any sick call slips addressing his concern. The facility provider informed CCHCS clinician that the patient will be seen the following week for a re-evaluation of the patient's medications.
- Fifth patient claimed that his hernia was not being treated. The auditors were informed that the patient was seen by the provider on 2/4/16 and the provider informed the patient that he would be followed up monthly until the issue with hernia was resolved. This follow-up also would serve to confirm behavioral compliance, maintain communication and to give the patient an opportunity to voice his concerns. The patient's transfer to CDCR for hernia repair is currently pending. The return paperwork was submitted by the facility's provider on 1/29/16. CCHCS clinician recommended the patient have a visit with the provider while his hernia repair is pending.
- Sixth patient stated that he was unable to see the provider for his back pain. Upon investigating the issue, the auditors found that the patient had been seen on 1/2/16 and had been referred to the provider at that time. The patient was seen by the provider on 1/14/16. The patient's issue had been already addressed.