August 13, 2015

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

Dear Warden MacDonald,

The staff from Private Prison Compliance and Monitoring Unit (PPCMU), Field Operations, Corrections Services, California Correctional Health Care Services (CCHCS) completed an onsite health care monitoring audit at La Palma Correctional Center (LPCC) between June 15 and 17, 2015. The purpose of this audit is to ensure that LPCC is meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006.

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

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 Monitoring Unit - Contract Facility Health Care Monitoring Audit Instruction Guide* was provided for the facility's perusal two months prior to the onsite audit. This transparency afforded the facility the opportunity to make the necessary adjustments within their existing processes to become familiar with the new criteria being used to evaluate performance. Although the audit tool was provided to the facility within a reasonable timeframe, LPCC continues to face ongoing challenges with the ability to demonstrate the provision of adequate health care as evidenced by a number of systemic deficiencies that have been consistently substandard over the past several audits.

Attached you will find the audit report in which LPCC received an overall compliance rating of **73.3%.** The current audit incorporates both *quantitative* and *qualitative* analyses. The quantitative analysis consists of 13 medical and eight administrative components while the qualitative analysis consists of three case review sections: a Nurse Case Review, a Clinical Case Review and a Physician Chart Review. The three qualitative sections were added to the new audit instrument to better assess and evaluate the timeliness and quality of care provided by nurses and physicians at the contract facilities. It should be noted that the qualitative (case review) component was not utilized at this time as a factor for determining an overall rating of compliance or proficiency but was included in the report for the informational benefit of the facility. However, any audits conducted from the 2015/2016 Fiscal Year forward <u>will</u> factor in the findings of the clinical case study component in arriving at an overall rating for the audit.

The audit findings reveal that the facility continues to struggle to provide adequate health care to CDCR inmate-patients housed at LPCC. The health and safety relating to the medical care provided to the inmate-patients has been seriously compromised creating grave concern for the inmate-patient population and their safety while being housed at LPCC. Examples of the continued serious deficiencies are as follows:

- The inmate-patients who are a no-show or those that refuse chronic care medications half of the time or more, in a one week period are not being referred to the LIP.
- Facility providers are not consistently reviewing, initialing and dating inmate-patient diagnostic reports within the specified timeframes.
- Inmate-patients are not consistently receiving written notification of their diagnostic test results within the specified time frame.
- Inmate-patients who are referred to a LIP by nursing staff during the Initial Intake Screening are not being seen within specified time frames.
- Inmate-patients, who were enrolled in a Chronic Care (CC) clinic at a previous facility, are not consistently referred by the Registered Nurse (RN) to the LIP for a CC follow-up.
- The prescribing LIP is not documenting that they explained the medication to the inmate-patient.
- Inmate-patients, who do not show or refuse their prescribed NA/DOT chronic care medication 50% or more doses a week, are not being referred to the LIP.
- Inmate-patients, referred to the LIP for medication non-compliance, are not seen by the LIP within the seven calendar days of referral.
- Upon the inmate-patient's return from a community hospital admission, the RN is not consistently documenting that they reviewed the inmate-patient's discharge plan.
- The nursing staff is not consistently reviewing the sick call slips within one day of receipt.
- The oxygen tanks are not consistently maintained to be operational for emergency response.
- Environmental cleaning of all "high touch surfaces" is not being completed at least once per day in the medical clinics.
- The facility does not have the required Licensed Independent Provider, mid level provider, Clinical Nurse Supervisor, and Registered Nurse complement.

The lack of commitment and follow-through by LPCC represents a serious threat to the health care of the inmates for whom they are being compensated The access and quality of medical care provided to the CDCR inmate-patient population at LPCC is undesirable and does not meet the target performance benchmark of 85.0% compliance. A number of deficiencies involve direct patient care delivery and follow-up and were identified in the following program components and require the facility's immediate attention and resolution:

- Administrative Operations (Policies and Procedures)
- Continuous Quality Improvement

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Elk Grove, CA 95758

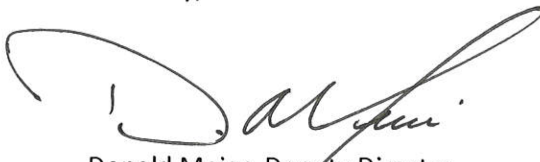
- Monitoring Logs
- Americans with Disabilities Act Compliance (Policy and Procedures)
- Staffing
- Chronic Care Management
- Diagnostic Services
- Medical Emergency Management
- Health Appraisal and Health Care Transfer Process
- Medication Management
- Observation Cells
- Inmate-Patient Refusals/No Show for Medical Services
- Preventive Services

The deficient program areas have been consistently out of compliance and will require immediate attention if the facility intends to improve their performance. However, strict adherence to contract requirements and established policies and procedures, will aid in attaining the established benchmark of 85.0%.

The attached LPCC's audit report contains an executive summary, an explanation of the methodology behind the audit, findings detailed by chapters of the new audit tool, and a corrective action plan (CAP). The facility is encouraged to work diligently in order to improve the quality of medical services provided to the CDCR inmate population and to expediently resolve the concerns and deficiencies identified in the attached report. PPCMU will continuously monitor all CAP items during subsequent audits and the items will be considered as resolved when the facility achieves an acceptable level of compliance.

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

Sincerely,



Donald Meier, Deputy Director
Field Operations, 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
Kelly Harrington, Director, Division of Adult Institutions (DAI), CDCR
Ricki Barnett, M.D., Assistant Statewide Medical Executive and Deputy Director, Medical Services, CCHCS
Steven F. Ritter, D.O., Deputy Director, Medical Services, CCHCS
Roscoe L. Barrow, Chief Counsel, CCHCS
Jeffrey Carrick, M.D., Deputy Medical Executive (A), Utilization Management, CCHCS
Cheryl Schutt, R.N., B.S.N., CCHP, Statewide Chief Nurse Executive, Nursing Services, CCHCS
Joseph W. Moss, Chief (A), Contract Beds Unit, California Out of State Correctional Facility, DAI, CDCR
Grace Song, M.D., Physician Advisor, Southern Region, CCHCS
John Baxter, Vice President, Health Services, California Contract Facilities, Corrections Corporations of America (CCA)
Keith Ivens, M.D., Chief Medical Officer, CCA
William Crane, M.D., Regional Medical Director, California Compliance Physician, CCA
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Anne Diggs, RN, Regional Director, Health Services, California Contract Facilities, CCA
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Greg Hughes, Nurse Consultant, Program Review, Field Operations, Corrections Services, CCHCS
Luzviminda Pareja, Nurse Consultant, Program Review, Field Operations, Corrections Services, CCHCS
Donna Heisser, Health Program Manager II, PPCMU, Field Operations, Corrections Services, CCHCS
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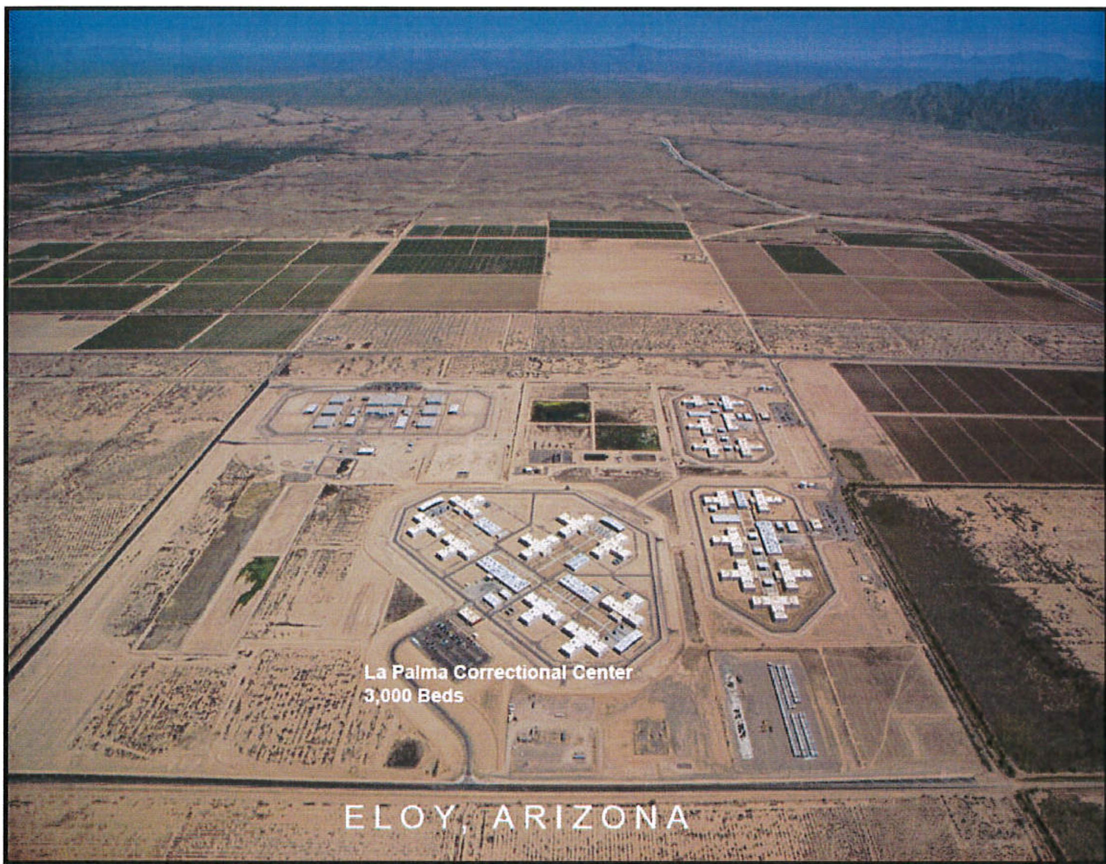
CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT



La Palma Correctional Center

June 15 – 17, 2015

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DATE OF REPORT

August 13, 2015

INTRODUCTION

As a result of an increasing inmate population and a limited capacity to house inmates, the California Department of Corrections and Rehabilitation (CDCR) entered into contractual agreements with private prison vendors 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 policy and procedures, 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. This audit instrument is intended to measure the facility's compliance with various elements of inmate-patient access to health care and to assess the quality of health care services provided to the inmate-patient population housed in these facilities.

This report provides the findings associated with the audit conducted between June 15 and 17, 2015, at La Palma Correctional Center (LPCC) located in Eloy, Arizona, in addition to the findings associated with the review of various documents and inmate-patient medical records for the audit review period of January through May 2015. At the time of the audit, CDCR's *Weekly Population Count*, dated June 12, 2015, indicated a budgeted bed capacity of 8,988 out-of-state beds. LPCC has a design capacity of 3,146 population beds, of which 2,761 beds are occupied with CDCR inmates.

EXECUTIVE SUMMARY

From June 15 through 17, 2015, the CCHCS audit team conducted a health care monitoring audit at LPCC. The audit team consisted of the following personnel:

R. Delgado - Medical Doctor
G. Hughes - Nurse Consultant Program Review (NCPR)
L. Pareja - NCPR
K. Srinivasan- Health Program Specialist I (HPS I)
C. Troughton - HPS I

The audit included two primary components: a *quantitative* analysis of established performance measures consisting of Sections 1 and 2, and a *qualitative* analysis of health care staff performance and quality of care provided to the inmate-patient population at LPCC consisting of Sections 3, 4, and 5. The end product of the quantitative analysis is an overall compliance percentage, while the end product of the qualitative analysis is a summary of findings for <u>each</u> section of the qualitative component (Sections 3, 4, and 5) and is included in this report for information purposes only. The qualitative component will not be utilized at this time as a factor for determining an overall rating of compliance or proficiency. However, it should be noted that audits conducted from the 2015/2016 Fiscal Year forward, will factor in the findings of the clinical case study component, in arriving at an overall rating.

An overall total compliance score of 85.0% or above for the quantitative portion must be achieved during the current round in order for the facility to pass the audit and meet the compliance requirements per the contractual agreement. Based on the findings of the quantitative audit, LPCC achieved an overall compliance rating of **73.3%,** with a rating of 61.2% in *Administration and Governance* and 78.3% in *Medical Services*.

The completed quantitative audit, a summary of clinical case and physician chart reviews, a summary of qualitative and quantitative findings, and the Corrective Action Plan (CAP) request are attached for your review. The following executive summary table below lists the program components the audit team assessed during the audit and provides the facility's overall rating in each section.

Executive Summary Table

Quantitative Audit Rollup	Compliance
Section 1 - Administration & Governance	
1. Administrative Operations	42.1%
2. Continuous Quality Improvement	60.0%
3. Monitoring Logs	58.7%
4. Access to Health Care Information	95.1%
5. Americans with Disabilities Act Compliance	16.7%
6. Health Care Grievance/Appeal Procedure	99.3%
7. Licensure and Training	100.0%
8. Staffing	77.6%
Section 1 Overall Score:	**61.2%**
Section 2 - Medical Services	
1. Chemical Agents/Use of Force	75.0%
2. Chronic Care Management	24.0%
3. Diagnostic Services	74.7%
4. Medical Emergency Management	80.8%
5. Community Hospital Discharge	87.8%
6. Infection Control	88.2%
7. Health Appraisal & Health Care Transfer Process	83.9%
8. Medication Management	84.5%
9. Observation Cells	82.2%
10. Inmate-Patient Refusal/No-Show for Medical Services	59.6%
11. Preventive Services	55.2%
12. Sick Call	86.7%
13. Specialty Services	91.8%
Section 2 Overall Score:	**78.3%**
Final Score	**73.3%**
Qualitative Audit	
Section 3 - Nurse Case Review	Information Only
Section 4 - Clinical Case Review	Information Only
Section 5 - Physician Chart Review	Information Only

NOTE: For specific information regarding any non-compliance findings indicated in the tables above, please refer to the Corrective Action Plan Request (located on page 10 of this report), to the detailed Quantitative Findings (located on page 15), or to the detailed Qualitative Findings (located on page 39).

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 inmate-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 Monitoring Unit - Contract Facility 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 inmate-patient access to health care. This audit instrument is intended to measure facility's compliance with various elements of inmate-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 Monitoring Unit - Contract Facility 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* case, 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 Monitoring Unit - Contract Facility 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 inmate-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, three qualitative sections have been added; a Nurse Case Review, a Clinical Case Review and a Physician Chart Review, to better assess and evaluate the timeliness and quality of care provided by nurses and physicians at the contract facilities.

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 CAP 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 Monitoring Unit - Contract Facility Health Care Monitoring Audit Instruction Guide* was provided for their perusal two months 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 Monitoring Unit (PPCMU) - Contract Facility 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 inmate-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* analyses.

Quantitative Analysis

The *quantitative* analysis uses a standardized audit instrument, which measures compliance against established standards at each facility. The audit instrument calculates an overall percentage score for each of the two quantitative sections, 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 13 medical and 8 administrative components of health care to measure. The medical components cover clinical categories directly relating to the health care provided to inmate-patients, whereas the administrative components address the organizational functions that support a health care delivery system.

The 13 medical program components are: *Chemical Agents/Use of Force, Chronic Care Management, Diagnostic Services, Medical Emergency Management, Community Hospital Discharge, Infection Control, Health Appraisal and Health Care Transfer Process, Medication Management, Observation Cells, Inmate-Patient Refusal of/No-Show for Medical Services, Preventive Services, Sick Call,* and *Specialty Services.* The 8 administrative components are: *Administrative Operations, Continuous Quality Improvement, Monitoring Logs, Access to Health Care Information, ADA Compliance, Health Care Grievance/Appeal Procedure, Licensure and 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 applicable compliance scores within that chapter. The outcome is expressed as a percentage rounded to the nearest tenth. The overall

Section score is calculated in the same manner as the chapter scores. All the applicable questions within the *section* are averaged and the score expressed as a percentage rounded to the nearest tenth.

However, to derive an overall/final score for the quantitative portion of the audit, a weighting system is utilized where a weight percentage is assigned to each section. The weight percentage is derived from the number of chapters within each section, as shown below. This percentage is then multiplied by the sum of all the compliance scores in that section. The resultant numbers (of Section 1 and 2) are then combined to yield an overall/final score for the quantitative portion of the audit. The reason for doing so is to ensure more emphasis is placed upon the medical services component, which unlike the administrative operations component, directly affects inmate-patient care.

Section 1: *Administrative Operations* includes 8 chapters, while Section 2, *Medical Services*, includes 13. Therefore, based on the total number of quantitative chapters, Section 1 comprises 38.1% (8 chapters divided by 21 total quantitative chapters) of the quantitative audit. The weight assigned to Section 2 is accordingly 61.9%.

> EXAMPLE: Assuming the sum of all the compliance scores in Section 1 equates to 50.00 and the sum of all the compliance scores in Section 2 equates to 80.00:
> Section 1 - 50.00 multiplied by 38.1% yields 19.05%
> Section 2 – 80.00 multiplied by 61.9% yields 49.52%
>
> The sum of the two resultant numbers is the overall/final compliance score of the quantitative component of the audit, which in this example is 19.05 + 49.52 = 68.6%.

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 Analysis

The *qualitative* portion of the audit evaluates areas of clinical access and the provision of clinically appropriate care which tends to defy numeric definition, but which nonetheless have a potentially significant impact on performance. The purpose of the *qualitative* review is to help understand and decipher the relative functional merit of the system. This type of review focuses on processes instead of outcomes. By its very nature, a qualitative review is flexible and evolving, even during the brief window of the review itself.

The *qualitative analysis* consists of the following three sections/components: Nurse Case Review, Clinical Case Review, and Physician Chart Review.

1. *Nurse Case Review*

   The CCHCS nursing staff performs a retrospective chart review of selected inmate-patient files to evaluate the care given by the facility's nursing staff for approximately six months of medical care or for the audit review period. A majority of the inmate-patients selected for retrospective chart reviews are the ones with a high utilization of nursing services, as these inmate-patients are most likely to be affected by timely appointment scheduling, medication management, and referrals to health care providers.

2. *Clinical Case Review*
   The clinical case reviews are viewed as a stress test on the various components of the medical delivery system, rather than an overall assessment of the quality of the medical delivery system. This methodology is useful for identifying systemic areas of concern that may compel further investigation and quality improvement. The CCHCS clinician completes two detailed clinical case reviews in order to evaluate the quality and timeliness of care provided to the inmate-patient population housed at that facility.

3. *Physician Chart Review*
   The CCHCS clinician reviews a predetermined number of inmate-patient medical records completed by each of the facility's providers (physician, nurse practitioner, physician assistant). The purpose of this review is to evaluate the standard of care provided by the facility's physicians/mid-level provides, which also serves as a peer review of the providers. The CCHCS clinician will assess the facility provider(s) on the six clinical competencies which include patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice. This review consists of selecting predominantly the medical records of those inmate-patients with chronic care conditions. Up to 12 charts are reviewed for each facility physician/mid-level provider.

Scoring for Non-Applicable Questions and Double-Failures:

Questions that do not apply to the facility are noted as Not Applicable (N/A). For the purpose of chapter and section compliance calculations, N/A questions have zero (0) points available.

Where a single deviation from policy would result in multiple question failures (i.e., "double-fail"), 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.

CORRECTIVE ACTION PLAN REQUEST

The table below reflects all items from the quantitative findings section where the facility was rated non-compliant. The audit results for LPCC require the facility to address and resolve all of the listed items identified as deficient.

Corrective Action Items – La Palma Correctional Center	
Question 1.1.2	Although the facility has a written local policy and procedure that addresses the maintenance/management of inmate-patient medical records, the policy is not fully compliant with IMSP&P guidelines.
Question 1.1.3	Although the facility has a written local policy and procedure that addresses the requirements for the release of medical information, the policy is not fully compliant with IMSP&P guidelines.
Question 1.1.4	Although the facility has a written local policy and procedure related to the Chemical Agent/Use of Force process, the policy is not fully compliant with IMSP&P guidelines.
Question 1.1.5	Although the facility has a written local policy and procedure related to the chronic care management, the policy is not fully compliant with IMSP&P guidelines.
Question 1.1.6	Although the facility has a written local policy and procedure related to the health care transfer process, the policy is not fully compliant with IMSP&P guidelines.
Question 1.1.7	Although the facility has a written local policy and procedure related to medication management process, the policy is not fully compliant with IMSP&P guidelines.
Question 1.1.8	Although the facility has a written local policy and procedure related to the Access to Care (Sick Call) process, the policy is not fully compliant with IMSP&P guidelines.
Question 1.1.9	Although the facility has a written local policy and procedure related to the Specialty Services, the policy is not fully compliant with IMSP&P guidelines.
Question 1.1.10	Although the facility has a written policy and procedure that addresses the Americans with Disabilities Act (ADA) requirements and is in compliance with IMSP&P guidelines, the policy is not specific to LPCC.
Question 1.1.13	Although the facility has a written local policy and procedure related to the health care staff licensure and training requirements, the policy is not fully compliant with IMSP&P guidelines.
Question 1.1.14	Although the facility has a written local policy and procedure related to the emergency medical response process, the policy is not fully compliant with IMSP&P guidelines.
Question 1.2.1	Although the facility has a written local policy and procedure related to Continuous Quality Improvement process, the policy is not fully compliant with IMSP&P guidelines.
Question 1.2.2	The facility is not consistent in holding Quality Improvement Committee meetings monthly.
Question 1.3.1	The facility does not consistently submit the sick call monitoring logs timely.
Question 1.3.3	The facility does not accurately document all the dates on the sick call monitoring log(s).

Question 1.3.4	The facility does not consistently submit the specialty care monitoring logs timely.
Question 1.3.5	The facility does not consistently complete all the fields in the specialty care monitoring log(s).
Question 1.3.6	The facility does not accurately document all the dates on the specialty care monitoring log(s).
Question 1.3.7	The facility does not consistently submit the hospital stay/emergency department monitoring logs timely.
Question 1.3.9	The facility does not accurately document all the dates on the hospital stay/emergency department monitoring log(s).
Question 1.3.10	The facility does not consistently submit the chronic care monitoring logs timely.
Question 1.3.11	The facility does not consistently complete all the fields in the chronic care monitoring log(s).
Question 1.3.13	The facility does not consistently submit the initial intake screening monitoring logs timely.
Question 1.3.15	The facility does not accurately document all the dates on the initial intake screening monitoring log(s).
Question 1.5.1	The facility does not have a local operating procedure to track and monitor Disability Placement Program (DPP) inmate-patients and their accommodations to ensure DPP inmate-patient needs are addressed.
Question 1.5.2	The facility does not have a local operating procedure for tracking the provision of health care appliances for all DPP inmate-patients to ensure health care appliances are provided in a timely manner.
Question 1.5.3	The facility does not have a local operating procedure for tracking the order, repair, and/or replacement of a health care appliance for the DPP inmate-patients.
Question 1.5.4	The facility does not have a local operating procedure that provides directions on provision of interim accommodations while an inmate-patient's health care appliance is being ordered, repaired, or replaced.
Question 1.5.5	The facility does not have a local operating procedure that provides directions on how to ensure effective communication is established and documented during each clinical encounter.
Question 1.8.1	The facility does not have the required physician/primary care provider staffing per contractual requirement.
Question 1.8.2	The facility does not have the required management staffing per contractual requirement.
Question 1.8.3	The facility does not have the required registered nurse staffing per contractual requirement.
Question 2.1.1	Following the exposure to chemical agents and refusing decontamination, the inmate-patient is not being monitored by health care staff every 15 minutes for not less than a total of 45 minutes.
Question 2.2.2	The inmate-patient's chronic care keep on person medications are not consistently being received by the inmate-patient without interruption.
Question 2.2.3	The nursing staff does not document the inmate-patient's refusal of keep on person chronic care medications on the CDCR Form 7225, or similar form.

Question 2.2.4	The inmate-patient's chronic care Nurse Administered/Direct Observation Therapy (NA/DOT) medications are not consistently administered without interruption.
Question 2.2.5	The inmate-patients that do not show or refuse their NA/DOT chronic care medications for three consecutive days or 50% or more doses in a week are not being referred to the provider for medication non-compliance.
Question 2.2.6	The inmate-patients that do not show or refuse their NA/DOT chronic care medications for three consecutive days or 50% or more doses in a week, are not seen by a provider within seven calendar days of the referral for medication non-compliance.
Question 2.2.7	The inmate-patients that do not show or refuse their insulin are not being referred to the provider for medication non-compliance.
Question 2.3.2	The facility does not consistently complete inmate-patient diagnostic tests within the specified timeframes.
Question 2.3.3	The facility does not consistently provide the inmate-patients with a written notification of their diagnostic test results within the two business days of receipt of results.
Question 2.3.4	The inmate-patients are not consistently seen by the provider for clinically significant/abnormal diagnostic test results within 14 days of provider's review of the test results.
Question 2.4.7	The Emergency Medical Response Review Committee does not consistently review/evaluate each medical response and/or emergency medical drill that is submitted to the committee for review.
Question 2.4.9	Following an emergency response/drill, the facility health staff do not consistently document that the emergency response (EMR) bags are re-supplied and re-sealed before the end of the shift.
Question 2.4.11	The EMR bags do not contain all the supplies identified on the facility's EMR bag checklist.
Question 2.4.16	The facility's crash carts do not contain all the required medications as listed in the IMSP&P.
Question 2.4.17	The facility's crash carts do not contain all the supplies identified on the facility's crash cart checklist.
Question 2.4.20	One of the facility's portable oxygen systems was missing a required piece of equipment.
Question 2.5.1	The facility nursing staff do not consistently review the inmate-patients' discharge plan upon their discharge and return from a community hospital admission.
Question 2.5.3	The facility does not consistently administer or deliver all provider prescribed medications to the inmate-patients as ordered or per policy following their discharge and return from a community hospital admission.
Question 2.5.4	The inmate-patients do not consistently receive a follow-up by the facility provider within five calendar days of their discharge and return from a community hospital admission.
Question 2.6.6	The facility nursing staff do not consistently disinfect reusable non invasive medical equipment between each inmate-patient use.
Question 2.6.8	The environmental cleaning of facility's clinics and Administrative Segregation Unit (ASU) clinic/exam rooms are not completed daily.

Question 2.6.14	The facility health care staff do not consistently account for and reconcile all sharps in each clinic at the beginning and end of each shift.
Question 2.7.2	The facility nursing staff do not consistently document an assessment of the inmate-patient if the inmate-patient answered "yes" to any of the questions on the Initial Intake Screening form.
Question 2.7.4	The facility nursing staff do not consistently refer the inmate-patient to the provider during initial intake screening if they are identified as having a chronic disease/illness but is not enrolled in the chronic care clinic.
Question 2.7.5	The inmate-patients are not consistently seen within the specified timeframe if they are referred by the nursing staff to medical, mental or dental provider during initial intake screening.
Question 2.7.9	The facility does not consistently document that inmate-patients enrolled in the chronic care program at a previous facility, were seen by the facility provider within the timeframe ordered by the sending facility's provider.
Question 2.7.11	The facility does not consistently document on CDCR Form 7371 any scheduled specialty appointments for those inmate-patient's transferring out of the facility.
Question 2.8.1	The providers do not consistently educate the inmate-patients on the newly prescribed medications.
Question 2.8.5	The facility nursing staff do not consistently observe an inmate-patient taking DOT medications.
Question 2.8.10	The facility medical staff do not monitor the temperature of the refrigerators used to store drugs and vaccines twice daily.
Question 2.8.12	The facility health care staff do not consistently document that the narcotics were inventoried at the beginning and end of each shift.
Question 2.9.1	The inmate-patients housed in observation cells are not consistently being checked by nursing staff at the beginning of each shift within two hours or as ordered by the provider.
Question 2.9.2	The facility provider does not consistently document the need for the inmate-patients' placement in the observation cell and does not document if a brief admission history and physical examination was conducted, within 24 hours of placement.
Question 2.9.3	A licensed provider does not consistently conduct a daily face-to-face rounds on inmate-patients housed in observation cells.
Question 2.10.3	The facility nursing staff do not document that they contacted the housing unit supervisor to have the inmate-patient escorted to the clinic when an inmate-patient is a "no-show" for a scheduled face-to-face RN appointment.
Question 2.10.4	The facility nursing staff do not consistently complete a CDDR Form 7225, *Refusal of Examination and/or Treatment* or similar form and document the inmate-patient refusal on a Progress Note (CDCR Form 7230) if an inmate-patient is a "no-show" for a scheduled face-to-face RN appointment and refuses to be escorted to the clinic.
Question 2.10.5	The facility nursing staff do not consistently document that they contacted the provider to determine if/when an inmate-patient should be rescheduled if the inmate-patient is a "no-show" for a medical appointment with a provider.

Question 2.11.1	The inmate-patients prescribed anti-TB medication are not consistently receiving the medication as prescribed by provider.
Question 2.11.2	The nursing staff does not consistently notify the provider when an inmate-patient misses or refuses his anti-TB medication.
Question 2.11.3	The facility does not monitor the inmate-patient prescribed anti-TB medication every month while the inmate-patient is on medication.
Question 2.11.4	The facility does not annually screen all the inmate-patients for signs and symptoms of tuberculosis.
Question 2.11.7	The facility does not consistently offer colorectal cancer screening to inmate-patients 50 to 75 years of age.
Question 2.12.1	The nursing staff do not consistently document that they reviewed the inmate-patient's sick call request form on the day it was received.
Question 2.12.3	The nursing staff do not consistently document that the inmate-patients had a face-to-evaluation by the RN within the same day if the sick call request form indicated an emergent health care need.
Question 2.12.4	The nursing staff do not consistently document the inmate-patient's chief complaint in inmate-patient's own words.
Question 2.12.14	The inmate-patients are not consistently seen for a follow-up appointment within the specified timeframe.
Question 2.12.17	There is no evidence that the nursing staff conducts daily rounds in Administrative Segregation Units to pick-up sick call slips.
Question 2.12.20	The facility does not provide all the clinics with proper equipment, supplies, and accommodations for inmate-patient visits.
Question 2.13.6	The facility nursing staff do not consistently document that they notified the provider of any immediate medication orders or follow-up instructions by the specialty care consultant or community hospital provider when an inmate-patient returns from a specialty consult appointment or a community hospital emergency department visit.

NOTE: A discussion of the facility's progress toward resolution of all CAP items identified during *previous* health care monitoring audits is included in the summary narrative portion of this report.

QUANTITATIVE FINDINGS – DETAILED BY CHAPTER

Section 1 - Administration & Governance

Chapter 1. Administrative Operations		Yes	No	Compliance
1.1.1	Does health care staff have access to the facility's health care policies and procedures and know how to access them?	9	0	100%
1.1.2	Does the facility have a written policy and/or procedure that addresses the maintenance/management of inmate-patient medical records that is compliant with IMSP&P guidelines?	0	1	0.0%
1.1.3	Does the facility have a written policy that addresses the requirements for the release of medical information that is compliant with IMSP&P guidelines?	0	1	0.0%
1.1.4	Does the facility have a written policy related to the Chemical Agent/Use of Force process that is compliant with IMSP&P guidelines?	0	1	0.0%
1.1.5	Does the facility have a written policy related to Chronic Care which is compliant with IMSP&P guidelines?	0	1	0.0%
1.1.6	Does the facility have a written policy related to Health Care Transfer Process which is compliant with IMSP&P guidelines?	0	1	0.0%
1.1.7	Does the facility have a written policy related to Medication Management which is compliant with IMSP&P guidelines?	0	1	0.0%
1.1.8	Does the facility have a written policy related to Access to Care (Sick Call) process which is compliant with IMSP&P guidelines?	0	1	0.0%
1.1.9	Does the facility have a written policy related to Specialty Services which is compliant with IMSP&P guidelines?	0	1	0.0%
1.1.10	Does the facility have a written policy related to Americans with Disabilities Act which is compliant with IMSP&P guidelines?	0	1	0.0%
1.1.11	Does the facility have a written Infection Control Plan that is compliant with the California Code of Regulations, Title 8?	1	0	100%
1.1.12	Does the facility have a written Blood-borne Pathogen Exposure Control Plan that is compliant with the California Code of Regulations, Title 8?	1	0	100%
1.1.13	Does the facility have a written policy related to the health care staff licensure and training which is compliant with IMSP&P guidelines?	0	1	0.0%
1.1.14	Does the facility have a written policy related to Emergency Medical Response and Drills which is compliant with IMSP&P guidelines?	0	1	0.0%
1.1.15	Does the facility have a current contract/agreement for routine oxygen tank maintenance service?	1	0	100%
1.1.16	Does the facility have a current contract for the repair, maintenance, inspection, and testing of biomedical equipment?	1	0	100%
1.1.17	Does the facility have a current contract for removal of hazardous waste?	1	0	100%
1.1.18	Does the inmate-patient handbook or similar document explain the health care grievance/appeal process?	1	0	100%

1.1.19	Does the inmate-patient handbook or similar document explain the sick call process?	1	0	100%
			Overall Score:	**42.1%**

Chapter 1 Comments:

1. Question 2 – Although the facility has a written local policy and procedure that addresses the maintenance/management of inmate-patient medical records, the policy is not in full compliance with IMSP&P guidelines. This equates to 0.0% compliance.
2. Question 3 - Although the facility has a written local policy and procedure that addresses the requirements for the release of medical information, the policy is not in full compliance with IMSP&P guidelines. This equates to 0.0% compliance.
3. Question 4 – Although the facility has a written local policy and procedure related to the Chemical Agent/Use of Force process, the policy is not in full compliance with IMSP&P guidelines. This equates to 0.0% compliance.
4. Question 5 - Although the facility has a written local policy and procedure related to the chronic care management, the policy is not in full compliance with IMSP&P guidelines. This equates to 0.0% compliance.
5. Question 6 - Although the facility has a written local policy and procedure related to the health care transfer process, the policy is not in full compliance with IMSP&P guidelines. This equates to 0.0% compliance.
6. Question 7 - Although the facility has a written local policy and procedure related to medication management process, the policy is not in full compliance with IMSP&P guidelines. This equates to 0.0% compliance.
7. Question 8 - Although the facility has a written local policy and procedure related to the Access to Care (Sick Call) process, the policy is not in full compliance with IMSP&P guidelines. This equates to 0.0% compliance.
8. Question 9 - Although the facility has a written local policy and procedure related to the Specialty Services process, the policy is not in full compliance with IMSP&P guidelines. This equates to 0.0% compliance.
9. Question 10 - Although the facility has a policy and procedure related to the Americans with Disabilities Act (ADA) that is in compliance with IMSP&P guidelines, this policy is not specific to LPCC. This equates to 0.0% compliance.
10. Question 13 - Although the facility has a written local policy and procedure related to the health care staff licensure and training requirements, the policy is not in full compliance with IMSP&P guidelines. This equates to 0.0% compliance.
11. Question 14 - Although the facility has a written local policy and procedure related to the emergency medical response process, the policy is not in full compliance with IMSP&P guidelines. This equates to 0.0% compliance.

Chapter 2. Continuous Quality Improvement (CQI)		Yes	No	Compliance
1.2.1	Does the facility have a written policy and procedure for CQI that is compliant with IMSP&P?	0	1	0.0%

1.2.2	Does the facility's CQI Committee meet monthly?	2	3	40.0%
1.2.3	Does the facility's CQI review process include documented corrective action plan for the identified opportunities for improvement?	2	0	100%
1.2.4	Does the facility's CQI review process include monitoring of defined aspects of care?	2	0	100%
			Overall Score:	**60.0%**

Chapter 2 Comments:

1. Question 1 – The facility does not have a written policy and procedure for CQI in compliance with IMSP&P. The IMSP&P requires that CQI meetings be held monthly. LPCC's policy indicates CQI meeting are being held quarterly. This equates to 0.0% compliance.

2. Question 2 – During the audit review period, the facility's CQI committee met in January and April 2015; no meetings were held in February or March 2015. This equates to 50.0% compliance.

Chapter 3. COCF/MCCF Monitoring Logs		Yes	No	Compliance
1.3.1	Does the facility submit the sick call monitoring log by the scheduled date per PPCMU program standards?	12	9	57.1%
1.3.2	Does the facility's sick call monitoring log contain all the required data?	2813	82	97.2%
1.3.3	Are the dates documented on the sick call monitoring log accurate?	54	46	54.0%
1.3.4	Does the facility submit the specialty care monitoring log by the scheduled date per PPCMU program standards?	12	9	57.1%
1.3.5	Does the facility's specialty care monitoring log contain all the required data?	124	80	60.8%
1.3.6	Are the dates documented on the specialty care monitoring log accurate?	46	51	47.4%
1.3.7	Does the facility submit the hospital stay/emergency department monitoring log by the scheduled date per PPCMU program standards?	12	9	57.1%
1.3.8	Does the facility's hospital stay/emergency department monitoring log contain all the required data?	34	0	100%
1.3.9	Are the dates documented on the hospital stay/emergency department monitoring log accurate?	21	12	63.6%
1.3.10	Does the facility submit the chronic care monitoring log by the scheduled date per PPCMU program standards?	1	4	20.0%
1.3.11	Does the facility's chronic care monitoring log contain all the required data?	97	1112	8.0%
1.3.12	Are the dates documented on the chronic care monitoring log accurate?	92	8	92.0%
1.3.13	Does the facility submit the initial intake screening monitoring log by the scheduled date per PPCMU program standards?	0	5	0.0%
1.3.14	Does the facility's initial intake screening monitoring log contain all the required data?	2251	12	99.5%

1.3.15	Are the dates documented on the initial intake screening monitoring log accurate?	66	34	66.0%
			Overall Score:	**58.7%**

Chapter 3 Comments:

1. Question 1 – Out of the 21 sick call monitoring logs submitted by the facility for the audit review period, only 12 logs were submitted on time. This equates to 57.1% compliance.

2. Question 2 – Out of the 2, 895 entries reviewed on the sick call logs for completeness, for the audit review period, 2813 entries were found to be complete with all required data. This equates to 97.2% compliance.

3. Question 3 – A random sample of a total of 100 entries were selected from the weekly sick call monitoring logs to assess the accuracy of the dates reported on the log. Out of the 100 entries reviewed, 54 were found to be accurate with dates matching the dates of service indicated in the inmate-patients' electronic medical records. Discrepancies/inaccuracies identified within the remaining 46 entries were mostly within the dates the sick call request was received and the date it was triaged. This equates to 54.0% compliance.

4. Question 4 – Out of the 21 specialty care monitoring logs submitted by the facility for the audit review period, only 12 logs were submitted on time. This equates to 57.1% compliance.

5. Question 5 – A random sample of a total of 204 entries were selected from the weekly specialty care monitoring logs to assess the accuracy of the dates reported on the log. Out of the 204 entries reviewed, 124 entries were found to be complete with all required data. This equates to 60.8% compliance.

6. Question 6 – A random sample of a total of 97 entries were selected from the weekly specialty care monitoring logs to assess the accuracy of the dates reported on the log. Out of the 97 entries reviewed, 46 were found to be accurate with dates matching the dates of service indicated in the inmate-patients' electronic medical records. Discrepancies/inaccuracies identified within the remaining 51 entries were mostly within the LIP referral dates and dates when the appointment actually occurred. This equates to 47.4% compliance.

7. Question 7 – Out of the 21 hospital stay/emergency department monitoring logs submitted by the facility for the audit review period, only 12 logs were submitted on time. This equates to 57.1% compliance.

8. Question 9 – A random sample of a total of 33 entries were selected from the weekly hospital stay/emergency department monitoring logs to assess the accuracy of the dates reported on the log. Out of the 33 entries reviewed, 21 were found to be accurate with dates matching the dates of service indicated in the inmate-patient electronic medical record. The several discrepancies/inaccuracies identified within the remaining 12 entries were within the time of EMS transport, date of EMS transport and date of return from the ER/hospital. This equates to 63.6% compliance.

9. Question 10 – Out of the five chronic care monitoring logs submitted by the facility for the audit review period, one (1) log was submitted on time. This equates to 20.0% compliance.

10. Question 11 – Out of the 1209 entries reviewed on the chronic care monitoring logs for completeness for the audit review period, 97 entries were found to be complete with all the required data; The remaining 1112 entries were missing initial enrollment dates and initial assessment dates. This equates to 8.8% compliance.

11. Question 12 – A random sample of a total of 100 entries were selected from the monthly chronic care monitoring logs to assess the accuracy of the dates reported on the log. Out of the 100 entries reviewed, 92 were found to be accurate with dates matching the dates of service indicated in the inmate-patients' electronic medical records. The discrepancies/inaccuracies identified within the remaining 8 entries were

mostly within the scheduled appointment dates and LIP assessment dates. This equates to 92.0% compliance.

12. Question 13 – Out of the five initial intake screening monitoring logs submitted by the facility for the audit review period, none were submitted on time. This equates to 0.0% compliance.
13. Question 14 – Out of the 2263 entries reviewed on the initial intake screening monitoring logs for completeness for the audit review period, 2251 entries were found to be complete with all the required data. This equates to 99.5% compliance.
14. Question 15 – A random sample of a total of 100 entries were selected from the monthly initial intake screening monitoring logs to assess the accuracy of the dates reported on the log. Out of the 100 entries reviewed, 66 were found to be accurate with dates matching the dates of service indicated in the inmate-patients' electronic medical records. The discrepancies/inaccuracies identified within the remaining 34 entries were mostly within the date of arrival of the inmate-patients and their initial health screening dates (most were off by 1 day). This equates to 66.0% compliance.

Chapter 4. Access to Health Care Information		**Yes**	**No**	**Compliance**
1.4.1	Does the health care staff know how to access the inmate-patient's CDCR electronic medical record?	6	1	85.7%
1.4.2	Are loose documents scanned into the facility's Electronic Medical Record (EMR) within the required time frames? (COCF Only)	1	0	100%
1.4.3	Are copies of loose documents filed into shadow medical file and the originals sent to the hub facility weekly for uploading into the eUHR? (MCCF only)	Not Applicable		
1.4.4	Does the facility maintain a release of information log?	1	0	100%
1.4.5	Does the release of information log contain all the required information?	50	0	100%
1.4.6	Are all inmate-patient's written requests for health care information documented on a CDCR Form 7385, *Authorization for Release of Protected Health Information*, or similar form and scanned/filed into the inmate-patient's medical record?	45	5	90.0%
1.4.7	Are copies of all written requests for release of health care information from third parties scanned/filed into the inmate-patient's medical record?	Not Applicable		
1.4.8	Are all written requests for release of health care information from third parties accompanied by a CDCR Form 7385, *Authorization for Release of Protected Health Information*, or similar form from the inmate-patient which is scanned/ filed into the inmate-patient's medical record?	Not Applicable		
			Overall Score:	**95.1%**

Chapter 4 Comments:

1. Question 1 – During the onsite audit, a total of six health care staff were requested to demonstrate their access to the CDCR electronic health records site. Of the six staff requested, one of the facility's health care staff, namely the mid-level provider, was unable to log into the CDCR electronic medical record since

the provider had failed to log into the system at least once every thirty days per CDCR requirement and therefore had lost his access. This equates to 85.7% compliance.

2. Question 3 – This question is not applicable to out-of-state correctional facilities.

3. Question 6 – Of the 50 inmate-patient requests for release of health care information received by the facility during the audit review period, 45 requests were scanned into the inmate-patient's medical record. This equates to 90.0% compliance.

4. Questions 7 and 8 – Not applicable. There were no third party requests for release of health care information received during the audit review period; therefore, these questions could not be evaluated.

Chapter 5. Americans with Disabilities Act (ADA) Compliance		Yes	No	Compliance
1.5.1	Is there a local operating procedure to track and monitor Disability Placement Program (DPP) inmate-patients and their accommodations to ensure DPP inmate-patient needs are addressed?	0	1	0.0%
1.5.2	Is there a local operating procedure for tracking the provision of health care appliances for all DPP inmate-patients to ensure health care appliances are provided in a timely manner?	0	1	0.0%
1.5.3	Is there a local operating procedure for tracking the order, repair, and/or replacement of health care appliances for all DPP inmate-patients?	0	1	0.0%
1.5.4	Does the local operating procedure provide directions on provision of interim accommodations while an appliance is being ordered, repaired, or replaced?	0	1	0.0 %
1.5.5	Is there a local operating procedure that provides directions to ensure effective communication is established and documented during each clinic encounter?	0	1	0.0%
1.5.6	Is health care staff knowledgeable on the process of establishing and documenting effective communication during each clinic encounter?	6	0	100%
			Overall Score:	**16.7%**

Chapter 5 Comments:

1. Questions 1 through 5 – The facility does not have a local operating procedures specific to LPCC that address these ADA procedures and requirements. Instead all the CCA facilities utilize the Contract Beds Unit Operational Procedure #613, *Americans with Disabilities Act* (ADA). This equates to 0.0% compliance.

Chapter 6. Health Care Grievance/Appeal Procedure		Yes	No	Compliance
1.6.1	Are the CDCR-602 HC forms readily available to inmate-patients in all housing units?	29	1	96.7%
1.6.2	Are inmate-patients able to submit the CDCR-602 HC forms on a daily basis in secured/locked boxes in all housing units?	9	0	100%

1.6.3	Are inmate-patients who are housed in Administrative Segregation Unit or are in housing units under lockdown, able to submit the CDCR 602-HC forms on a daily basis?	6	0	100%
1.6.4	Are first level health care appeals being processed within the specified time frames?	84	0	100%
1.6.5	Does the Appeals Coordinator document all screened/rejected appeals in the Health Care Appeals tracking log?	22	0	100%
			Overall Score:	**99.3%**

Chapter 6 Comments:

1. Question 1 – Of the 30 housing units inspected for the availability of CDCR- 602 HC forms, 29 units had the forms readily available. This equates to 96.7% compliance.

Chapter 7. Licensure and Training		Yes	No	Compliance
1.7.1	Are all health care staff licenses/certifications current?	37	0	100%
1.7.2	Is there a centralized system for tracking licenses for all health care staff?	1	0	100%
1.7.3	Are the Basic Life Support certifications current for nursing and custody staff?	42	0	100%
1.7.4	Are the Advanced Cardiovascular Life Support certifications maintained current for the facility's medical providers?	2	0	100%
1.7.5	Is there a method in place to address expiring Basic Life Support and Advanced Cardiovascular Life Support certifications?	1	0	100%
1.7.6	Is there is a centralized system in place to track training provided to health care staff?	1	0	100%
1.7.7	Do all the health care staff receive training for new or revised policies based on IMSP&P requirements?	Not Applicable		
			Overall Score:	**100.0%**

Chapter 7 Comments:

1. Question 1.7.7 – Not applicable. The audit team was unable to determine compliance with this requirement. In April of 2015, PPCMU and CCA worked collaboratively to update CCA's policies. As the policies were yet not updated at the time of the onsite audit, the training on the revised policies could not have been provided to health care staff.

Chapter 8. Staffing		Yes	No	Compliance
1.8.1	Does the facility have the required physician/primary care provider staffing per contractual requirement?	2	2	50.0%

1.8.2	Does the facility have the required management staffing per contractual requirement? (COCF only)	2	1	66.7%
1.8.3	Does the facility have the required registered nurse staffing per contractual requirement?	10	4	71.4%
1.8.4	Does the facility have the required licensed practical nurse staffing per contractual requirement? (COCF only)	14	0	100%
1.8.5	Does the facility have the required Certified Medical Assistant (CMA) staffing per contractual requirement? (COCF only)	3	0	100%
			Overall Score:	**77.6%**

Chapter 8 Comments:

2. Question 1 – Per the contractual requirement, the facility is required to be staffed with two full time physicians/Licensed Independent providers and two mid level providers. The facility is currently staffed with only one full time physician and one full time mid-level provider. This equates to 50.0% compliance.

3. Question 2 – Per the contractual requirement, the facility is required to be staffed with three clinical nurse supervisors (CNS). The facility is currently staffed with two CNS's. This equates to 66.7% compliance.

4. Question 3 – Per the contractual requirement, the facility is required to be staffed with 14 registered nurses (RN). The facility is currently staffed with only ten RNs. This equates to 71.4% compliance.

Section 2 – Medical Services

	Chapter 1. Chemical Agents/Use of Force	Yes	No	Compliance
2.1.1	If the inmate-patient was exposed to chemical agents and refused decontamination, was the inmate-patient monitored by health care staff every 15 minutes and not less than a total of 45 minutes?	1	1	50.0%
2.1.2	If the inmate-patient was exposed to chemical agents and if the inmate-patient was clinically unstable, was he medically cleared by a provider before returning to the housing unit? (COCF only)	2	0	100%
			Overall Score:	**75.0%**

Chapter 1 Comments:

1. Question 1 – Of the 24 inmate-patient medical records reviewed for the audit review period, 22 were found not applicable to this question. Of the remaining two cases that were applicable, one (1) inmate-patient's medical record included documentation showing the inmate-patient was monitored every 15 minutes for no less than a total of 45 minutes. This equates to 50.0% compliance.

	Chapter 2. Chronic Care Management	Yes	No	Compliance
2.2.1	Is the inmate-patient's chronic care follow-up visit completed as ordered?	23	0	100%

2.2.2	Is the inmate-patient's chronic care keep on person (KOP) medications received by the inmate-patient without interruption the previous six months?	7	18	28.0%
2.2.3	If an inmate-patient refuses his/her KOP chronic care medications, is there documentation of a refusal on the CDCR Form 7225, *Refusal of Examination and/or Treatment*, or similar form?	0	7	0.0%
2.2.4	Are the inmate-patient's chronic care Nurse Administered/Direct Observation Therapy (NA/DOT) medications administered without interruption during the previous six months?	2	3	40.0%
2.2.5	If an inmate-patient does not show for or refuses his/her NA/DOT chronic care medications for three consecutive days or 50% or more doses in one week, is the inmate-patient referred to a provider?	0	3	0.0%
2.2.6	If an inmate-patient does not show for or refuses his/her NA/DOT chronic care medication for three consecutive days or 50% or more doses in one week, does the provider see the inmate-patient within seven calendar days of the referral?	0	3	0.0%
2.2.7	If an inmate-patient does not show for or refuses his/her insulin medication, is the inmate-patient referred to the provider for medication non-compliance?	0	3	0.0%
			Overall Score:	**24.0%**

Chapter 2 Comments:

1. Question 2 – Of the 25 inmate-patient medical records reviewed for the audit review period, only 7 records included documentation showing that the inmate-patients received their chronic care keep-on-person (KOP) medications without interruption. The 18 non-compliant cases were mostly due to the delay in receiving or not receiving the prescribed medication or the delays in monthly refills of KOP meds. This equates to 28.0% compliance.
2. Question 3 – Of the 25 inmate-patient medical records reviewed for the audit review period, 18 were found not applicable to this question. The remaining seven inmate-patient medical records reviewed indicated that when the inmate-patients refused medication, the refusal form was not completed. This equates to 0.0% compliance.
3. Question 4 – Of the 25 inmate-patient medical records reviewed for the audit review period, 20 were found not applicable to this question. Of the remaining five inmate-patient medical records reviewed, two were found to be compliant with this requirement and three had incomplete documentation for no-shows/refusals. This equates to 40.0% compliance.
4. Question 5 – Of the 25 inmate-patient medical records reviewed for the audit review period, 22 were found not applicable to this question. The review of the remaining three inmate-patient medical records indicated that none of the inmate-patients were referred to the LIP for medication non-compliance. This equates to 0.0% compliance.
5. Question 6 – Of the 25 inmate-patient medical records reviewed for the audit review period, 22 were found not applicable to this question. The review of the remaining three inmate-patient medical records indicated the inmate-patients were not seen by an LIP within seven calendar days of referral. This equates to 0.0% compliance.
6. Question 7 – Of the 25 inmate-patient medical records reviewed for the audit review period, 22 were found not applicable to this question. The review of the remaining three inmate-patient medical records

indicated the inmate-patients were not referred to the LIP for medication non-compliance. This equates to 0.0% compliance.

Chapter 3. Diagnostic Services		Yes	No	Compliance
2.3.1	Is the diagnostic test completed within the time frame specified by the provider?	18	2	90.0%
2.3.2	Does the provider review, sign, and date all inmate-patients' diagnostic test reports within two business days of receipt of results?	13	7	65.0%
2.3.3	Is the inmate-patient given written notification of the diagnostic test results within two business days of receipt of results?	16	4	80.0%
2.3.4	Is the inmate-patient seen by the provider for clinically significant/abnormal diagnostic test results within 14 days of the provider's review of the test results?	7	4	63.6%
			Overall Score:	**74.7%**

Chapter 3 Comments:

1. Question 1 – Of the 21 inmate-patient medical records reviewed for the audit review period, 1 was found not applicable to this question. Out of the 20 applicable cases, 18 included documentation that the diagnostic tests are being completed within the time frame specified by an LIP. This equates to 90.0% compliance.

2. Question 2 – Of the 21 inmate-patient medical records reviewed for the audit review period, 1 was found not applicable to this question. Of the 20 applicable cases, 13 inmate-patient medical records included documentation that the LIP reviewed, signed, and dated the inmate-patient's diagnostic test report within two business days of receipt of results. This equates to 65.0% compliance.

3. Question 3 – Of the 21 inmate-patient medical records reviewed for the audit review period, 1 was found not applicable to this question. Of the 20 applicable cases, 16 inmate-patient medical records included documentation that the inmate-patient was given written notification of the diagnostic test results within two business days of receipt of results. This equates to 80.0% compliance.

4. Question 4 – Of the 21 inmate-patient medical records reviewed for the audit review period, 10 were found not applicable to this question. Of the remaining 11 cases, 7 inmate-patient medical records included documentation of inmate-patient having been seen by an LIP for clinically significant diagnostic test results within 14 days of LIP's review of the results. This equates to 63.6% compliance.

Chapter 4. Medical Emergency Management		Yes	No	Compliance
2.4.1	Does the facility have a local/corporate operating procedure pertaining to medical emergencies/response that contains instructions for communication, response, and transportation of inmate-patients, during medical emergencies?	1	0	100%
2.4.2	Does the facility's local/corporate operating procedure contain instructions on how to obtain Emergency Medical Services (EMS) transportation 24/7?	1	0	100%

2.4.3	Does the facility conduct emergency medical response (man-down) drills quarterly on each shift when medical staff is present?	3	0	100%
2.4.4	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 medical emergency response drill?	19	0	100%
2.4.5	Does a registered nurse respond within eight minutes after emergency medical alarm is sounded for an emergency medical response (man-down) and/or emergency medical response drills?	19	0	100%
2.4.6	Does the facility hold an emergency medical response review committee (EMRRC) a minimum of once per month?	5	0	100%
2.4.7	Do the EMRRC meeting minutes reflect a review of each emergency medical response and/or emergency medical drill that is submitted to the committee?	0	5	0.0%
2.4.8	Is there documentation for each shift that all Emergency Medical Response Bags in each clinic are secured with a seal?	600	0	100%
2.4.9	Is there documentation, after each emergency medical response and/or drill, that the Emergency Medical Response Bag(s) used are re-supplied and re-sealed before the end of the shift?	16	3	84.2%
2.4.10	Is there documentation that all Emergency Medical Response Bags in each clinic are inventoried at least once a month if they have not been used for an emergency medical response and/or drill?	12	0	100%
2.4.11	Does the facility's Emergency Medical Response (EMR) bag contain only the supplies identified on the facility's EMR Bag Checklist?	0	4	0.0%
2.4.12	Does the facility have a functional Automated External Defibrillator (AED) with electrode pads located in the medical clinic?	4	0	100%
2.4.13	Is there documentation, on each shift, that all Medical Emergency Crash Carts are secured with a seal? (COCF only)	248	0	100%
2.4.14	Is there documentation, after each emergency medical response and/or drill, that all Medical Emergency Crash Carts are re-supplied and re-sealed? (COCF only)	20	0	100%
2.4.15	Is there documentation that all Crash Carts in each clinic are inventoried at least once a month, if they have not been used for a medical emergency? (COCF only)	12	0	100%
2.4.16	Does the facility's Crash Cart contain the medications as listed in IMSP&P policy? (COCF only)	3	1	75.0%
2.4.17	Does the facility's Crash Cart contain the supplies identified on the facility's Crash Cart Checklist? (COCF only)	1	3	25.0%
2.4.18	Does the facility have a functional 12 Lead electrocardiogram (ECG) machine with electrode pads? (COCF only)	4	0	100%
2.4.19	Does the facility have a functional portable suction device?	4	0	100%
2.4.20	Does the facility have a portable oxygen system?	2	13	13.3%
2.4.21	Does the facility have their biomedical equipment serviced and calibrated annually?	42	0	100%
			Overall Score:	**80.8%**

Chapter 4 Comments:

1. Question 7 – Of the five EMRRC meeting minutes reviewed for the audit review period, none of the meeting minutes included the emergency medical response evaluation component because the custody had failed to submit the Emergency Medical Drills/Incident Report forms (Form 837) or similar forms to the EMRRC for review following the emergency responses that occurred during the audit review period. This equates to 0.0% compliance.
2. Question 9 – Of the 19 emergency medical response documentation reviewed, 16 showed that the EMR bags were resupplied and resealed following the emergency response. This equates to 84.2% compliance.
3. Question 11 – Of the four EMR bags inspected, all four bags were missing required supplies identified on the facility's EMR Bag Checklist. This equates to 0.0% compliance.
4. Question 16 – Of the four crash carts reviewed, three crash carts contained all the required medications. This equates to 75.0% compliance.
5. Question 17 – Of the four crash carts reviewed, only one crash cart contained all the supplies identified on the facility's crash cart checklist. The remaining three crash carts had some missing supplies and had some extra supplies. This equates to 25.0% compliance.
6. Question 20 – Of the 15 portable oxygen tanks inspected, only 2 tanks had nasal tubing attached. One tank was only 1/4th full. This equates to 13.3% compliance.

Chapter 5. Community Hospital Discharge		Yes	No	Compliance
2.5.1	Upon discharge and return from a community hospital admission, does the registered nurse document a review of the inmate-patient's discharge plan? (COCF only)	11	2	84.6%
2.5.2	Upon discharge and return from a community hospital admission, does the registered nurse document a face-to-face assessment prior to the inmate-patient being re-housed? (COCF only)	13	0	100%
2.5.3	Upon the inmate-patient's discharge and return from a community hospital admission, are all provider prescribed medications administered or delivered to the inmate-patient as ordered or per policy? (COCF only)	9	2	81.8%
2.5.4	Upon discharge and return from a community hospital admission, does the inmate-patient receive a follow-up with a provider within five calendar days of discharge? (COCF only)	11	2	84.6%
2.5.5	Upon return from the hub institution following the discharge from a community hospital admission, does the registered nurse document a review of the inmate-patient's discharge plan? (MCCF only)	Not Applicable		
2.5.6	Upon the inmate-patient's return from the hub institution following the discharge from a community hospital admission, does the registered nurse document the face-to-face assessment prior to the inmate-patient being re-housed? (MCCF only)	Not Applicable		
2.5.7	Following the discharge from a community hospital admission, does the inmate-patient receive a follow-up with a provider within five calendar days of inmate-patient's return from the hub institution? (MCCF only)	Not Applicable		

2.5.8	Does the provider legibly sign the progress note or CDCR form used to document the inmate-patient's follow-up appointment following the discharge from a community hospital admission? (MCCF only)	Not Applicable
	Overall Score:	**87.8%**

Chapter 5 Comments:

1. Question 1 – Of the 13 inmate-patient medical records reviewed for the audit review period, 11 records included documentation that a Registered Nurse had reviewed the inmate-patients' discharge plans upon their return from a community hospital admission. This equates to 84.6% compliance.
2. Question 3 – Of the 13 inmate-patient medical records reviewed for the audit review period, 2 were found not applicable to this question. Of the remaining 11 cases, 9 inmate-patient medical records included documentation that all provider prescribed medications were administered or delivered to the inmate-patient as ordered or per policy upon their return from a community hospital admission. This equates to 81.8% compliance.
3. Question 4 – Of the 13 inmate-patient medical records reviewed for the audit review period, 11 records included documentation that the inmate-patients had received a follow-up with a provider within 5 calendar days of their discharge and return from a community hospital admission. This equates to 84.6% compliance.
4. Questions 5 through 8 – These questions are not applicable to out-of-state correctional facilities.

Chapter 6. Infection Control		Yes	No	Compliance
2.6.1	Are packaged sterilized reusable medical instruments within the expiration dates shown on the sterile packaging?	3	0	100%
2.6.2	When autoclave sterilization is used, is there documentation showing weekly spore testing?	4	0	100%
2.6.3	Are disposable medical instruments discarded after one use into the biohazard material containers? (excludes disposable needles and syringes)	3	0	100%
2.6.4	Does health care staff utilize universal and/or standard precautions for hand hygiene?	1	0	100%
2.6.5	Is personal protective equipment (i.e. gloves, masks, face shields, gowns, etc.) available for staff use?	12	2	85.7%
2.6.6	Is the reusable non invasive medical equipment disinfected between each inmate-patient use and upon exposure to blood-borne pathogens as per facility's established policy?	1	3	25.0%
2.6.7	Does the facility utilize a hospital grade disinfectant to clean common clinic areas with high foot traffic?	3	0	100%
2.6.8	Is environmental cleaning of common clinic areas with high foot traffic completed at least once a day?	113	73	60.8%
2.6.9	Is there a labeled biohazard materials container in each clinic?	12	2	85.7%
2.6.10	Are the central storage biohazard material containers emptied on a regularly scheduled basis?	1	0	100%

2.6.11	Is the biohazard waste in each clinic bagged in a red moisture proof biohazard bag and properly secured in a labeled biohazard container which is locked or stored in a secured location?	1	0	100%
2.6.12	Are sharps/needles in each clinic, medication administration location and Receiving and Release disposed in a puncture resistant, leak-proof container that is closeable, locked, and labeled with the biohazard symbol?	16	0	100%
2.6.13	Does the facility store all sharps/needles in a secure location in each clinic, medication administration locations, and Receiving and Release?	3	0	100%
2.6.14	Does the health care staff account for and reconcile all sharps (needles, scalpels, etc.) in each clinic, medication administration locations and Receiving and Release at the beginning and end of each shift?	141	45	75.8%
			Overall Score:	**88.2%**

Chapter 6 Comments:

1. Question 5 – During the onsite audit, 14 exam rooms were inspected and out of the 14 inspected, 12 exam rooms had personal protective equipment available for staff use. This equates to 85.7% compliance.
2. Question 6 – During the onsite audit, four nurses were observed and only one (1) nurse disinfected blood pressure cuffs and pulse oximeter after each inmate-patient use. This equates to 25.0% compliance.
3. Question 8 – During the onsite audit, the cleaning logs for 4 clinics and 2 ASU exam rooms were reviewed for the month of May 2015. Out of four clinics, the clinic in compound 3 had not been cleaned for 7 days and the main medical clinic for 4 days. The two ASU exam rooms did not have cleaning logs for the month of May. So, out of a total of 186 days, documentation was available for 113 days. The facility started to maintain a cleaning log for the ASU exam room from June onwards. This equates to 60.8% compliance.
4. Question 9 – During the onsite audit, 14 exam rooms were inspected and out of the 14 inspected, 12 exam rooms had biohazard containers. This equates to 85.7% compliance.
5. Question 14 – During the onsite audit, sharp logs for three clinics for the month of the May 2015 was reviewed. Of a total of 186 required sharp counts for the month between the 3 clinics, 141 counts took place. This equates to 75.8% compliance.

Chapter 7. Health Appraisal & Health Care Transfer Process		Yes	No	Compliance
2.7.1	Does the inmate-patient receive an Initial Intake Screening upon arrival at the receiving facility by a licensed health care staff?	25	0	100%
2.7.2	If "YES" is answered to any of the questions on the Initial Health Screening form (CDCR Form 7277/7277A or similar form), does the registered nurse document an assessment of the inmate-patient?	12	5	70.6%
2.7.3	If an inmate-patient presents with emergent or urgent symptoms during the intake screening, does the registered nurse refer the inmate-patient to medical, dental, or mental health provider? (emergent-immediately, urgent-within 24 hours)	1	0	100%

2.7.4	If an inmate-patient is identified as having a chronic disease/illness (asthma, DM, HTN, Hep C, Seizures, etc) but is not enrolled in the chronic care program, does the registered nurse refer the inmate-patient to the provider to be seen within 30 days of arrival?	3	1	75.0%
2.7.5	If an inmate-patient is referred to a medical, dental, or mental health provider by nursing staff during the Initial Intake Screening, is the inmate-patient seen within the specified time frame? (Emergent-Immediately, Urgent-within 24 hours, or within 30 days)	1	2	33.3%
2.7.6	If the inmate-patient had an existing medication order upon arrival at the facility, are Nurse Administered/Direct Observation Therapy (NA/DOT) medications administered without interruption and KOP medications received within one calendar day of arrival?	6	1	85.7%
2.7.7	If the inmate-patient is referred or scheduled by the sending facility's provider for a medical, dental, or mental health appointment, is the inmate-patient seen within the time frame specified by the provider?	Not Applicable		
2.7.8	Does the inmate-patient receive a complete Health Appraisal performed by a provider within 14 calendar days of arrival?	24	0	100%
2.7.9	If the inmate-patient was enrolled in a chronic care program at a previous facility, is the inmate-patient scheduled and seen by the receiving facility's chronic care provider within the time frame ordered by the sending facility's provider?	3	2	60.0%
2.7.10	Does the inmate-patient receive a complete screening for the signs and symptoms of tuberculosis (TB) upon arrival?	25	0	100%
2.7.11	When the inmate-patient is transferred out of the facility, are scheduled specialty service appointments that were not completed, documented on a Health Care Transfer Information Form (CDCR Form 7371) or similar form?	2	2	50.0%
2.7.12	Does the inmate-patient bring all keep on person medications to the designated nurse prior to inter-facility transfer?	1	0	100%
2.7.13	Does the designated nurse verify the keep on person medications against the current medication profile prior to inter-facility transfer?	1	0	100%
2.7.14	Does the Inter-Facility Transfer Envelope contain all the inmate-patient's Nurse Administered/Direct Observation Therapy medications, current Medication Administration Record (MAR), and Medication Profile?	7	0	100%
2.7.15	Is visual and auditory privacy maintained during the Initial Intake Health Screening?	1	0	100%
		Overall Score:		**83.9%**

Chapter 7 Comments:

1. Question 2 – Of the 25 inmate-patient medical records reviewed for the audit review period, 8 were found not applicable to this question. Of the remaining 17 cases, 12 were found to be compliant with this requirement. The remaining five were non-compliant because there was no documentation in the medical records indicating that the registered nurse had completed an assessment of the inmate-patients if the inmate-patients answered "yes" to pertinent questions on the Initial Health Screening form. This equates to 70.6% compliance.

2. Question 4 – Of the 25 inmate-patient medical records reviewed for the audit review period, 21 were found not applicable to this question. Of the remaining four cases, three inmate-patient medical records

included documentation that the registered nurse referred the inmate-patients to the provider to be seen within 30 days of their arrival for their chronic care condition. This equates to 75.0% compliance.

3. Question 5 – Of the 25 inmate-patient medical records reviewed for the audit review period, 22 were found not applicable to this question. Of the remaining three, one (1) was found to be compliant with this requirement. For the two non-compliant cases, there was no documentation to show that the inmate-patients, who were referred to the provider by nursing staff during the Initial Intake Screening, were seen within the specified timeframe. This equates to 33.3% compliance.
4. Question 6 – Of the 25 inmate-patient medical records reviewed for the audit review period, 18 were found not applicable to this question. Of the remaining seven, six were found to be compliant with this requirement. For the one (1) non-compliant case, there was no documentation that the inmate-patient received his medication within the required timeframe. This equates to 85.7% compliance.
5. Question 7 – Not applicable. Of the 25 inmate-patient medical records reviewed for the audit review period, none of the records indicated that the inmate-patients were referred or scheduled by the sending facility's provider for a medical, dental, or mental health appointment.
6. Question 9 – Of the 25 inmate-patient medical records reviewed for the audit review period, 20 were found not applicable to this question. Of the remaining five, three were found to be compliant with this requirement. For the two non-compliant cases, there was no documentation to show that the inmate-patients were enrolled in the chronic care clinic and scheduled to be seen by the facility's chronic care provider within the timeframe ordered by the sending facility's provider. This equates to 60.0% compliance.
7. Question 11 - Of the 25 inmate-patient medical records reviewed for the audit review period, 21 were found not applicable to this question as there were no pending appointments. Of the remaining four cases, two were found compliant with this requirement. For the two non-compliant cases, the inmate-patients' chronic care follow-up appointments were not documented on the transfer form. This equates to 50.0% compliance.

Chapter 8. Medication Management		Yes	No	Compliance
2.8.1	Does the prescribing provider document that he/she provided inmate-patient education on the newly prescribed medication(s)?	15	7	68.2%
2.8.2	Is the initial dose of the newly prescribed medication administered to the inmate-patient as ordered by the provider?	19	3	86.4%
2.8.3	Does the nursing staff confirm the identity of the inmate-patient prior to delivery of keep on person medications and/or administration of Nurse Administered/Direct Observation Therapy medications?	6	0	100%
2.8.4	Does the same nursing staff who administers the Nurse Administered/Direct Observation Therapy (NA/DOT) medication prepare the inmate-patient NA/DOT medication just prior to administration?	6	0	100%
2.8.5	Does the nursing staff directly observe an inmate-patient taking Direct Observation Therapy (DOT) medication?	2	4	33.3%
2.8.6	Does the nursing staff document the administration of Nurse Administered/Direct Observation Therapy medications on the Medication Administration Record once the medication is given to the inmate-patient?	6	0	100%

2.8.7	Does the licensed nurse legibly sign the Nurse Administered/Direct Observation Therapy Medication Administration Record? (MCCF only)	Not Applicable		
2.8.8	Are medication errors documented on the Medication Error Report form?	1	0	100%
2.8.9	Are refrigerated drugs and vaccines stored in a separate refrigerator which does not contain food and/or laboratory specimens?	4	0	100%
2.8.10	Does the health care staff monitor the temperature of the refrigerators used to store drugs and vaccines twice daily and maintain the temperature between 36^0 F (2^0 C) and 46^0 F (8^0 C)?	124	124	50.0%
2.8.11	Does the facility employ medication security controls over narcotic medication assigned to its clinic areas?	3	0	100%
2.8.12	Does the licensed health care staff inventory the narcotics at the beginning and end of each shift?	141	45	75.8%
2.8.13	Do inmate-patients housed in Administrative Segregation Units have immediate access to their Short Acting Beta agonist (SBA) inhalers and nitroglycerine tablets? (COCF only)	3	0	100%
	Overall Score:			**84.5%**

Chapter 8 Comments:

1. Question 1 – Of the 25 inmate-patient medical records reviewed for the audit review period, 3 were found not applicable to this question. Of the remaining 22 cases, 15 included documentation that the LIP provided inmate-patient education on the newly prescribed medication. For the seven non-compliant cases, there was no documentation in the inmate-patient's medical records confirming the LIP provided education on the newly prescribed medication. This equates to 68.2% compliance.

2. Question 2 – Of the 25 inmate-patient medical records reviewed for the audit review period, 3 were found not applicable to this question. Of the remaining 22 cases, 19 included documentation that the initial dose of the newly prescribed medication was administered to the inmate-patient as ordered by the provider. For the three non-compliant cases, several were missing documentation that the medication was administered as ordered and several cases indicated there was a delay from two to five days and sometimes even a week's delay in administering the medication to the inmate-patient. This equates to 86.4% compliance.

3. Question 5 – During the onsite audit, six registered nurses were observed during the medication administration process and only two of the six nurses conducted mouth and cup checks. The four non-compliant nurses were also observed placing the medications directly onto the inmate-patients' hands rather than providing the medications in a cup. This equates to 33.3% compliance.

4. Question 7 – This question does not apply to out-of-state correctional facilities.

5. Question 10 – During the onsite audit, temperature logs for four refrigerators for the month of May 2015 were reviewed and it was found that out of a total of 248 possible checks, only 124 checks were documented. The review indicated that all four refrigerators were monitored only once a day instead of two times per requirement. This equates to 50.0% compliance.

6. Question 12 – During the onsite audit, narcotic logs from three clinics for the month of May 2015 were reviewed and it was found that out of a total of 186 counts, only 141 counts were documented in the log. This equates to 75.8% compliance.

Chapter 9. Observation Cells (COCF only)		Yes	No	Compliance
2.9.1	Is the inmate-patient checked by a registered nurse at the beginning of each shift within two hours, or more frequently as ordered by the provider, when housed in an observation cell?	7	4	63.6%
2.9.2	Does the provider document the need for the inmate-patient's placement in the Observation cell and a brief admission history and physical examination within 24 hours of placement?	9	2	81.8%
2.9.3	Does a licensed clinician conduct daily face-to-face rounds on inmate-patients housed in observation cell for suicide precaution watch or awaiting transfer to a Mental Health Crisis Bed?	5	1	83.3%
2.9.4	Is there a functioning call system in all observation cells and if not, does the facility have a procedure in place that the inmate-patient has the ability to get the attention of health care staff immediately?	7	0	100%
			Overall Score:	**82.2%**

Chapter 9 Comments:

1. Question 1 – Of the 11 inmate-patient medical records reviewed for the audit review period, 7 included documentation that the inmate-patient was checked by an RN at the beginning of each shift when housed in an observation cell. This equates to 63.6% compliance.
2. Question 2 – Of the 11 inmate-patient medical records reviewed for the audit review period, 9 included the provider's documentation that indicated the need for the inmate-patient's placement in the Observation cell and a brief admission history and physical examination within 24 hours of placement. This equates to 81.8% compliance.
3. Question 3 – Of the six inmate-patient medical records reviewed for the audit review period, five included documentation that a licensed clinician conducted daily face-to-face rounds on inmate-patients housed in observation cell for suicide precaution watch or awaiting transfer to a Mental Health Crisis Bed. This equates to 83.3% compliance.

Chapter 10. Inmate-Patient Refusal of / No-Show for Medical Services		Yes	No	Compliance
2.10.1	If an inmate-patient refuses a scheduled nurse face-to-face, provider appointment, chronic care, or specialty service appointment, does the health care staff complete the CDCR Form 7225, *Refusal of Examination and/or Treatment*, or similar form?	24	1	96.0%
2.10.2	If an inmate-patient refuses a scheduled medical appointment, does the health care staff document their discussion of the risks and consequences in refusing the scheduled health care service?	23	2	92.0%
2.10.3	If an inmate-patient is a "no-show" for a scheduled registered nurse (RN) face-to-face appointment, does the RN contact the housing unit supervisor to have the inmate-patient escorted to the clinic?	0	2	0.0%
2.10.4	If an inmate-patient is a "no-show" for a scheduled registered nurse (RN) face-to-face appointment and refuses to be escorted to the clinic, does the RN complete a CDCR Form 7225, *Refusal of Examination and/or Treatment*, or similar form and document the refusal on a Progress Note (CDCR Form 7230)?	1	1	50.0%

2.10.5	If an inmate-patient is a "no-show" for a medical appointment with the provider, does the nursing staff contact the provider to determine if/when the inmate-patient should be rescheduled?	3	2	60.0%
			Overall Score:	**59.6%**

Chapter 10 Comments:

1. Question 1 – Of the 25 inmate-patient medical records reviewed for the audit review period, 24 included documentation that nursing staff completed a CDCR Form 7225 when an inmate-patient refused medical treatment and/or an examination. This equates to 96.0% compliance.
2. Question 2 – Of the 25 inmate-patient medical records reviewed for the audit review period, 23 included include documentation of health care staff's discussion with the inmate-patient of the risks and consequences of refusing a medical treatment/examination. This equates to 92.0% compliance.
3. Question 3 – Of the 21 inmate-patient medical records reviewed for the audit review period, 19 were found not applicable to this question. The remaining two cases were found to be non-compliant because there was no documentation to show that the RN contacted the housing unit supervisor to have the inmate-patients escorted to the clinic when the inmate-patients were "no-shows" for a scheduled registered nurse (RN) face-to-face appointment and refused to be escorted to the clinic. This equates to 0.0% compliance.
4. Question 4 – Of the 21 inmate-patient medical records reviewed for the audit review period, 19 were found not applicable to this question. Of the remaining two cases, one (1) was found to be compliant with the requirement. The one (1) case was determined to be non-compliant because the RN did not complete a CDCR Form 7225, *Refusal of Examination and/or Treatment*, or similar form and did not document the inmate-patient's refusal on a Progress Note (CDCR Form 7230). This equates to 50.0% compliance.
5. Questions 5 – Of the 20 inmate-patient medical records reviewed for the audit review period, 15 were found not applicable to this question. Of the remaining five cases reviewed, three were found to be compliant with the requirement. For the two non-compliant cases, there was no documentation to show that the nursing staff contacted the provider to determine if/when the inmate-patients should be rescheduled when the inmate-patients were a "non-show" for a medical appointment with the provider. This equates to 60.0% compliance.

Chapter 11. Preventive Services		Yes	No	Compliance
2.11.1	*For inmate-patients prescribed anti-Tuberculosis (TB) medication(s):* Does the facility administer the medication(s) to the inmate-patient as prescribed?	13	7	65.0%
2.11.2	*For inmate-patients prescribed anti-Tuberculosis (TB) medication(s):* Does the nursing staff notify the provider or public health nurse when the inmate-patient misses or refuses anti-TB medication?	0	6	0.0%
2.11.3	*For inmate-patients prescribed anti-Tuberculosis (TB) medications:* Does the facility monitor the inmate-patient monthly while he/she is on the medication(s)?	13	7	65.0%
2.11.4	Are the inmate-patients screened for tuberculosis (TB) signs and symptoms annually?	8	12	40.0%
2.11.5	Do the inmate-patients receive a Tuberculin Skin Test (TST) annually?	12	0	100%

2.11.6	Were inmate-patients offered an influenza vaccination for the most recent influenza season?	19	1	95.0%
2.11.7	*For inmate-patients 50 to 75 years of age*: Is the inmate-patient offered colorectal cancer screening?	4	15	21.1%
2.11.8	*For female inmate-patients 50 to 74 years of age:* Is the inmate-patient offered a mammography at least every two years? (FEMALE MCCFs only)	Not Applicable		
2.11.9	*For female inmate-patients 21 to 65 years of age:* Is the inmate-patient offered a PAP (Papanicolaou test) smear at least every three years? (FEMALE MCCFs only)	Not Applicable		
			Overall Score:	**55.2%**

Chapter 11 Comments:

1. Question 1 – Of the 20 inmate-patient medical records reviewed for the audit review period, 13 included documentation the inmate-patients were administered anti-TB medication as prescribed by an LIP. This equates to 65.0% compliance.

2. Question 2 – Of the 20 inmate-patient medical records reviewed for the audit review period, 14 were not applicable as none of these 14 inmate-patients refused or missed any TB medications. Of the six applicable cases, none included documentation of nursing staff notifying the LIP when the inmate-patients refused their TB medications. This equates to 0.0% compliance.

3. Question 3 – Of the 20 inmate-patient medical records reviewed for the audit review period, 13 included documentation that the facility monitored the inmate-patient monthly while he was on TB medication. This equates to 65.0% compliance.

4. Question 4 – Of the 20 inmate-patient medical records reviewed for the audit review period, 8 included documentation that the inmate-patients were screened for TB signs and symptoms within the past year. This equate to 40.0% compliance.

5. Question 6 – Of the 20 inmate-patient medical records reviewed for the audit review period, 19 included documentation that the inmate-patients received flu vaccine for the most recent influenza season. The remaining one (1) had no documentation to confirm if the vaccine was offered to or refused by in the inmate-patient. This equates to 95.0% compliance.

6. Question 7 – Of the 20 inmate-patient medical records reviewed for the audit review period, one (1) was found not applicable to this question since the inmate-patient had been housed in the facility for less than a year. Of the remaining 19 cases, 4 included documentation that the inmate-patients 50 to 75 years of age were offered colorectal cancer screening. The 15 cases that were found to be non-compliant because even though the records included documentation that the tests had been ordered and sometimes were documented as completed, there were no *Fecal Occult Blood Test* (FOBT) results found. This equates to 21.1% compliance.

7. Questions 8 and 9 – These questions are not applicable to correctional facilities housing male inmate-patients.

Chapter 12. Sick Call		Yes	No	Compliance
2.12.1	Does the registered nurse review the inmate-patient's CDCR Form 7362, *Health Care Services Request*, or similar form, on the day it was received?	21	4	84.0%
2.12.2	Does the inmate-patient have a face-to-face evaluation by the registered nurse within the next business day after the CDCR Form 7362, *Health Care Services Request*, or similar form is reviewed, if the sick call request slip indicates a non-emergent health care need?	20	1	95.2%
2.12.3	Does the inmate-patient have a face-to-face evaluation by the registered nurse within the same day if the CDCR Form 7362, *Health Care Services Request*, or similar form indicates an emergent health care need?	3	1	75.0%
2.12.4	Does the registered nurse document the inmate-patient's chief complaint in the inmate-patient's own words?	21	4	84.0%
2.12.5	Is the registered nurses face-to-face encounter documented in the S.O.A.P.E format? (S=Subjective, O=Objective, A=Assessment, P=Plan and E=Education)	25	0	100%
2.12.6	Is a focused subjective/objective assessment conducted based upon the inmate-patient's chief complaint?	24	0	100%
2.12.7	Does the registered nurse document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data?	23	2	92.0%
2.12.8	Does the registered nurse implement a plan based upon the documented subjective/objective assessment data that was within the nursing scope of practice or supported by the Nurse Sick Call protocols?	24	0	100%
2.12.9	Does the registered nurse document education was provided to the inmate-patient related to the treatment plan and effective communication was established?	25	0	100%
2.12.10	Does the registered nurse legibly sign and date the CDCR Form 7362, RN Encounter Form or progress note? (MCCF only)	Not Applicable		
2.12.11	If the inmate-patient was referred to the provider by the registered nurse, is the inmate-patient seen within the specified time frame? (Emergent=same day; Urgent=within 24 hours; Routine=within 14 days)	9	1	90.0%
2.12.12	If the registered nurse (RN) determines the inmate-patient's health care needs are beyond the level of care available at the MCCF, does the RN contact or refer the inmate-patient to the hub institution? (MCCF only)	Not Applicable		
2.12.13	If the inmate-patient presents to sick call three or more times for the same medical complaint, is the inmate-patient referred to the provider by the registered nurse?	3	0	100%
2.12.14	If the provider orders a follow-up appointment, is the inmate-patient seen within the specified time frame?	5	1	83.3%
2.12.15	Does the sick call visit location ensure the inmate-patient's visual and auditory privacy?	11	0	100%
2.12.16	Does nursing staff conduct daily rounds in Administrative Segregation Unit? (COCF only)	88	0	100%

2.12.17	Does nursing staff conduct daily rounds in Administrative Segregation Units to pick-up CDCR Form 7362, *Health Care Services Request*, or similar forms? (COCF only)	2	262	0.8%
2.12.18	Are the CDCR Forms 7362, *Health Care Services Request*, or similar forms readily available to inmate-patients in all housing units?	30	0	100%
2.12.19	Are inmate-patients able to submit the CDCR Form 7362, *Health Care Services Request*, or similar forms on a daily basis in labeled/secured/locked boxes in all yards/building/housing units?	9	0	100%
2.12.20	Does the facility provide and maintain the clinics with proper equipment, supplies, and accommodations for inmate-patient visits?	6	8	42.9%
2.12.21	Does each clinic adequately store non-medication medical supplies?	4	0	100%
		Overall Score:		**86.7%**

Chapter 12 Comments:

1. Question 1 – Of the 25 inmate-patient medical records reviewed for the audit review period, 21 included documentation that the RN reviewed the inmate-patient's sick call request on the day it was received. This equates to 84.0% compliance.

2. Question 2 – Of the 25 inmate-patient medical records reviewed for the audit review period, 4 were not applicable to this question. Of the 21 applicable cases, 20 records included documentation that the inmate-patients had a face-to-face evaluation by the registered nurse within the next business day if the sick call slip indicated a non-emergent health care need. This equates to 95.2% compliance.

3. Question 3 – Of the 25 inmate-patient medical records reviewed for the audit review period, 21 were not applicable to this question. Of the four applicable cases, three records included documentation that the inmate-patients had a face-to-face evaluation by the registered nurse within the same day if the sick call slip indicated an emergent health care need. This equates to 75.0% compliance.

4. Question 4 – Of the 25 inmate-patient medical records reviewed for the audit review period, 21 included documentation that the RN documented the inmate-patient's chief complaint in the inmate-patient's own words. This equates to 84.0% compliance.

5. Question 7 – Of the 25 inmate-patient medical records reviewed for the audit review period, 23 cases included documentation that the RN documented a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data. This equates to 92.0% compliance.

6. Question 10 – This question is not applicable to out-of-state correctional facilities.

7. Question 11 – Of the 25 inmate-patient medical records reviewed for the audit review period, 15 were found not applicable to this question. Of the remaining ten cases, nine included documentation that following the RN referral to the LIP, the inmate-patient was seen by an LIP within the specified time frame. This equates to 90.0% compliance.

8. Question 12 – This question is not applicable to out-of-state correctional facilities.

9. Question 14 – Of the 25 inmate-patient medical records reviewed for the audit review period, 19 were found not applicable to this question. Of the remaining six cases, five included documentation that the inmate-patient was seen within the specified time frame following a follow-up appointment ordered by an LIP. This equates to 83.3% compliance.

10. Question 17 – During the onsite audit, the sign-in logs were reviewed for facility's three ASUs for the month of May 2015. Two ASU's were operational during the entire month and one only for 26 days. So, out of a total of 264 days (88 days X 3 logs = 264 days), only 1 ASU log had documentation for 2 days of

nursing staff conducting rounds to pick up sick call slips. The other two ASUs did not have any documentation of nursing staff conducting rounds to pick up sick call slips. This equates to 0.8% compliance.

11. Question 20 – Of the 14 exams rooms inspected during the onsite audit, 6 had the proper equipment, supplies and accommodations for inmate-patient visits. The other eight exams rooms were missing the proper equipment and/or supplies such as cuffs for the wall sphygmomanometer, tongue depressors, lubricating jelly, and personal protective equipment. This equates to 42.9% compliance.

Chapter 13. Specialty Services		Yes	No	Compliance
2.13.1	Is the provider's request for urgent/high priority specialty services approved or denied within two business days of being requested? (COCF only)	15	2	88.2%
2.13.2	Is the inmate-patient seen by the specialist for an urgent/high priority referral within 14 days of the provider's order? (COCF only)	16	1	94.1%
2.13.3	Is the provider's request for routine specialty services approved or denied within seven calendar days of being requested? (COCF only)	24	0	100%
2.13.4	Is the inmate-patient seen by the specialist for a routine referral within 90 days of the provider's order? (COCF only)	23	0	100%
2.13.5	Upon return from a specialty consult appointment or community hospital emergency department visit, does the registered nurse complete a face-to-face assessment prior to the inmate-patient returning to his assigned housing unit? (COCF only)	23	2	92.0%
2.13.6	Upon return from a specialty consult appointment or community hospital emergency department (ED) visit, does the registered nurse notify the provider of any immediate medication orders or follow-up instructions provided by the specialty consultant, or community hospital ED provider? (COCF only)	13	4	76.5%
2.13.7	Does the provider review the specialty consultant's report or the community hospital emergency department (ED) provider's discharge summary and complete a follow-up appointment with the inmate-patient within required time frame from the date of specialty services appointment or community hospital ED visit? (COCF only)	23	2	92.0%
2.13.8	Upon return from the hub institution following a specialty consult appointment, urgent services provided at the hub, or community hospital emergency department visit, does the registered nurse complete a face-to-face assessment prior to the inmate-patient returning to his/her assigned housing unit? (MCCF only)	Not Applicable		
2.13.9	Does the registered nurse legibly sign the progress note documenting the assessment of the inmate-patient following a specialty consultant appointment or urgent services provided at the hub or after a community hospital emergency department visit? (MCCF only)	Not Applicable		
2.13.10	Upon return from the hub institution following a specialty consult appointment, urgent services provided at the hub, or community hospital emergency department (ED) visit, does the registered nurse notify the provider of any immediate medication orders or follow-up instructions provided by the specialty consultant, CCHCS provider, or community hospital ED provider? (MCCF only)	Not Applicable		

2.13.11	Does the provider review the specialty consultant's report, CCHCS provider's report or the community hospital emergency department (ED) provider's discharge summary and complete a follow-up appointment with the inmate-patient within required time frame from the date of inmate-patient's return from the hub institution following a specialty services appointment, urgent services received at the hub, or community hospital ED visit? (MCCF only)	Not Applicable
	Overall Score:	**91.8%**

Chapter 13 Comments:

1. Question 1 – Of the 21 inmate-patient medical records reviewed for the audit review period, 4 were found not applicable to this question. Of the remaining 17 cases, 15 included documentation that the provider's request for urgent/high priority specialty services was approved or denied within two business days of being requested. This equates to 88.2% compliance.
2. Question 2 – Of the 21 inmate-patient medical records reviewed for the audit review period, 4 were found not applicable to this question. Of the remaining 17 cases, 16 included documentation of the inmate-patient being seen by the specialist for an urgent/high priority referral within 14 days of the provider's order. This equates to 94.1% compliance.
3. Question 5 – Of the 25 inmate-patient medical records reviewed for the audit review period, 23 included documentation of an RN completing a face-to-face assessment upon an inmate-patient's return from a specialty consult appointment or community emergency department visit, and prior to the inmate-patient returning to his assigned housing unit. This equates to 92.0% compliance.
4. Question 6 – Of the 25 inmate-patient medical records reviewed for the audit review period, 8 were found not applicable to this question. Of the remaining 17 cases, 13 included documentation of an RN notifying the provider of any immediate medication orders or follow-up instructions provided by the specialty consultant, or community hospital ED provider. This equates to 76.5% compliance.
5. Question 7 – Of the 25 inmate-patient medical records reviewed for the audit review period, 23 included documentation that the LIP reviewed the specialty consultant's report and completed a follow-up appointment with an inmate-patient within the specified time frame. This equates to 92.0% compliance.
6. Questions 8 through 11 – These questions are not applicable to out-of-state correctional facilities.

QUALITATIVE FINDINGS

As indicated earlier in the report, CCHCS has added a clinical case study component, involving nurse and physician case studies, to the new Private Prison Compliance and Health Care Monitoring audit instrument. Auditors evaluated selected cases in detail to determine the overall quality of health care provided to the inmate-patients to provide a snapshot more complete review of the facility's clinical performance. As a demonstration of CCHCS's investment in a fair and objective evaluation process, the information compiled from the clinical case studies section has been included as an unrated addendum for the informational benefit of the facility. This component will not be utilized at this time as a factor for determining an overall rating of compliance or proficiency. Audits conducted from the 2015/2016 Fiscal Year forward, will factor in the findings of the clinical case study component in arriving at an overall rating. The associated methodology for capturing and evaluating the clinical case studies will be provided to each contracted facility prior to the next round of onsite audits.

Section 3: Nurse Case Review

The goal of the nurse case review is to determine the overall quality of health care provided to the inmate-patients by the facility's nursing staff. A majority of the inmate-patients selected for retrospective chart review are the ones with high utilization of nursing services, as these inmate-patients are most likely to be affected by timely appointment scheduling, medication management, and referrals to health care providers.

For in-depth reviews, CCHCS nurses looked at all encounters occurring in approximately six months of medical care and focused on the following questions:

1) *Did nursing staff complete all required documentation; conduct appropriate assessment of the inmate-patient; provide nursing services as ordered by an LIP; and take appropriate action to avoid delay in health care services and trips to an outside hospital and/or patient death?*

2) *Did the RN conduct a timely and appropriate assessment; perform the appropriate nursing actions to address the inmate-patient's health care condition; provide LIP ordered nursing services; and complete all required documentation?*

For LPCC's nurse case reviews, an in-depth review/analysis of five inmate-patient medical records/charts was conducted. Of the five charts reviewed, the first four chart reviews revealed nursing care provided to the inmate-patients was adequate. Listed below are the deficiencies identified during the review of the fifth case along with recommendations on how to improve the quality of nursing care/services provided to the inmate-patients housed at LPCC.

Case Number	Deficiencies & Recommendations
Case 1	This was a 38 year old inmate-patient with diagnoses of elevated blood pressure, fracture of Left Orbit (closed), Kerion, Pitrosporum Folliculitis, Rash and Seborrhea. Review of this case indicates adequate nursing care was provided and no deficiencies were noted.
Case 2	This was a 52 year old inmate-patient with diagnoses of Cataract, Degenerative Disc Disease, Lumbar Radiculopathy, Spinal Stenosis, TB lung (latent) and Tinea Pedis. Review

of this case indicates adequate nursing care was provided and no deficiencies were noted.

Case 3 This was a 42 year old inmate-patient with diagnoses of allergy, ankle joint pain, back pain, blurry vision, constipation, intervertebral degeneration, diplopia, essential hypertriglyceridemia, eye injury, fracture, gastritis, left orbit fracture, obesity mild, psoriasis and seizure disorder. Review of this case indicates adequate nursing care was provided and no deficiencies were noted.

Case 4 This was a 41 year old inmate-patient with diagnoses of abnormal weight loss, at risk for self-harm, excessive weight loss, hepatitis C, non-compliance with medications, oppositional defiant behavior and low back pain. Although review of this case indicates adequate nursing care was provided, to further improve the quality of nursing care, the following is recommended:

1) When the inmate-patient refused services on several occasions, a CDCR Form 7225, *Refusal of Examination and/or Treatment*, or similar form was not completed by the nursing staff. It is recommended that in the event of an inmate-patient refusing medical services, the nursing staff is to document the refusal on a CDCR Form 7225, *Refusal of Examination and/or Treatment*, or similar form and two witnesses are required to sign the refusal form. Each incident of refusal to receive nursing or medical care is to be considered as a separate event.

Case 5 This was a 47 year old inmate-patient with diagnoses of esophageal reflux, gastritis, headache, left hydrocoele, inguinal hernia and testicular atrophy. Review of this case indicates inadequate nursing care due to the following:

1) Nursing staff did not adequately assess the inmate-patient's constant complaint of pain. But for one time, nursing assessments did not include documentation of pain scale. Nursing staff did not assess if the inmate-patient took any actions to alleviate the pain. Due to lack of or inadequate nursing assessment, auditor was unable to determine if appropriate nursing actions were completed.
2) Nursing staff did not conduct a detailed assessment of the inmate-patient based on the inmate-patient's complaint of constipation and did not document his last bowel movement.
3) Nursing staff did not ensure timely administration of prescribed medications. Documentation showed there was a delay in refill of Omeprazole.

Section 4: Clinical Case Review

The clinical case reviews are viewed as a stress test on the various components of the medical delivery system, rather than an overall assessment of the quality of the medical delivery system. This methodology is useful for identifying system areas of concern that may be targets for further investigation and quality improvement. The CCHCS clinicians conduct clinical case reviews in order to evaluate the quality and timeliness of care provided to the inmate-patient population.

Clinical Case Review Results

During the current audit, clinical case reviews of two inmate-patients with high medical needs were conducted. The following deficiencies were identified:

- Case 1

  - The facility does not file hospital and other diagnostic reports in the inmate-patient medical records in a timely manner. A Computed Tomography (CT) angiogram result was missing in the inmate-patient's chart. There was no documentation by the provider in the chart regarding his plan to obtain the official report. Although there were multiple references to the CT angiogram on other providers' evaluations, the report was never scanned into the inmate-patient's medical records.
  - When the inmate-patient was ordered to be transported to the Emergency Room (ER) due to the concern for acute coronary syndrome, the provider did not order aspirin or nitroglycerin to be administered to the inmate-patient while awaiting ambulance transfer to hospital.
  - The nurse practitioner (NP) did not place orders for the anti-seizure medication (Depakote) that had been prescribed by the neurologist. Instead she increased the existing dose of anti-*seizure medication (Keppra).* This finding substantiates the compliance review findings in *Chapter 6, question number 2.6.3* for which the facility has failed to achieve a rating of 85% compliance.
  - On numerous occasions, the nursing staff did not document the time when inmate-patient's vitals were recorded.
  - The dates and times noted in the progress notes were not same as the date and time the inmate-patient was seen by the provider.

- Case 2

  Although there were no issues noted with the care provided by the facility LIP and PA, below are issues that were identified with the nursing care:

  - There was no follow-up appointment scheduled per the telephonic orders received from the facility's chief physician. There was no documentation of this order in the medical record nor was there any documented evidence for any cancellation if that had been the reason for the delay in completion of the follow-up appointment.

- There was a significant delay in administering the medications prescribed by the discharging physician to the inmate-patient. This finding substantiates the compliance review finding in *chapter 5, question 2.5.3* for which the facility has failed to achieve a rating of 85% compliance.

- The facility nursing staff does not address all the issues listed in the inmate-patient's sick call slip.

As indicated earlier in the report, although this section of the qualitative audit is not rated for the current audit, it is imperative the facility take immediate action in resolving the deficiencies listed above.

Below is a short summary of each clinical case reviewed along with any specific issues identified by the CCHCS clinician during the review. Additionally, if applicable, recommendations may be provided to offer insight on how the identified issues can be addressed and resolved.

<u>Synopsis of Case 1</u>

In Case 1, a 35 year old inmate-patient developed acute chest pain and was found to have an abnormal EKG at the prison. The on-call provider assessed the patient to be at risk for altered cardiac perfusion. This inmate-patient had a history of numerous hospital and emergency room visits for chest pain. A secondary medical condition addressed was the patient's seizure disorder. The overall quality of care surrounding his cardiac and seizure disorders were appropriate. No major deviations were noted. However several issues were found in the following areas:

1. Inmate-patient developed chest pain on 12/31/14 and was seen in Sick Call by an RN who appropriately completed the chest pain protocol. The on-call provider ordered the inmate-patient to be transported to the ER. However, the provider did not order aspirin or nitroglycerin to be administered to the inmate-patient while awaiting ambulance transfer to hospital which is a part of the chest pain protocol.
2. A CT angiogram was ordered for the inmate-patient on 1/29/15. At the time of this review (5/21/15), the CCHCS clinician auditor could not find the angiogram report in the inmate-patient medical record even though the facility providers referred to the angiogram in their progress notes on numerous occasions. Even though it had been over three months since the test had been prescribed, the auditor could not find any documentation to show that the test was completed.
3. Upon the inmate-patient's return from the neurology consult, the NP did not place orders for the anti-seizure medication that had been prescribed by the neurologist deeming it unnecessary to switch to a different medication and even though there was documented evidence of the inmate-patient's non-compliance to the medication which was being administered at that time. Although this provider is no longer employed at LPCC, the recommendation to the provider would have been to read the progress notes pertaining to the inmate-patient including inmate's history of non-compliance with taking the existing anti-seizure medication Keppra. If the NP did read the previously documented notes including patient's non-compliance to taking his seizure medications, she did not document why she disregarded the hospital neurologist's recommendations for new medication.

4. The nursing staff did not consistently document the time on various occasions when inmate-patient's vitals were recorded. It is recommended that the nursing staff consistently document the time whenever inmate-patient's vital signs are recorded.
5. The dates and times noted in the progress notes were not same as the date and time the inmate-patient was seen by the provider. This inconsistency made it hard for the CCHCS clinician auditor to follow the course of events in the medical record.

Synopsis of Case 2

In case 2, the inmate-patient is a 56 year old who was found unresponsive and the RN informed the facility mid-level provider. The inmate-patient was given intravenous fluids and transported to the ER on the same day. The inmate-patient was admitted in the ER due to past history of seizures and loss of consciousness while in the prison. The inmate-patient was seen by the neurologist while at the hospital. The inmate-patient was discharged on 3/5/15. The follow-up appointment was completed on 3/9/15. Overall, the care provided was adequate but the three issues that were identified are noted below:

1. The facility staff does not document telephone orders in the inmate-patient's medical record nor do they document when an appointment is cancelled, refused or rescheduled. Upon his return from the hospital on 3/6/15, the inmate-patient was not scheduled for a follow-up appointment as ordered by the physician on duty. There was no documentation of this order in the medical record nor was there any documentation of cancellation. The inmate-patient was seen by the LIP three days later on 3/9/15. It is recommended all nursing staff follow through with all telephone orders and in the event of a change in appointment dates, the staff need to document the reason for cancellation or rescheduling of the appointment. The facility staff is strongly advised to maintain complete documentation including the reason for all medical appointments or services that are refused, cancelled and/or rescheduled.
2. Although the inmate-patient was discharged from the hospital on 3/5/15 and the discharging provider had prescribed Depakote (anti-seizure medication), the medication was not documented in the inmate-patient's MAR until 3/9/15. Although LPCC utilizes mail order pharmacy on a regular basis, since this is an essential medication, it should have been ordered through a local pharmacy and provided to the inmate-patient on the day of his discharge.
3. The nursing staff did not fully address the inmate-patient's compliant as documented on the sick call slip. Although the inmate-patient documented on the sick call slip he had not received his anti-seizure medication, per the inmate-patient's MAR, the medication was listed under the "current list of medications" that were being administered at that time. The nurse did not crosscheck the inmate-patient's complaint against the MAR and did not document this discrepancy. The recommendation is that nursing document responses to all the issues described on the sick call slip to ensure the inmate-patient's concerns are fully addressed.

Section 5: Physician Chart Review

The CCHCS clinician reviews a predetermined number of inmate-patient medical records completed by each of the facility's providers (physician, nurse practitioner, physician assistant). The purpose of this review is to evaluate the standard of care provided by the facility physicians/mid-level provides, which also serves as a peer review of the providers. The CCHCS clinician will assess the facility provider(s) on the six clinical competencies which include patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice.

Physician Chart Review Results

At the time of the audit, LPCC had three providers on staff; one supervising physician, one licensed independent provider (LIP), and one mid-level provider. The LIP is employed in one of the other CCA facilities, Florence Correctional Center. He is currently dividing his time between the two facilities since LPCC is short of one LIP and one mid-level provider. He is providing assistance to the facility's chief physician and the mid-level provider to prevent a backlog. LPCC currently has no backlog on medical appointments, specialty services, imaging, or labs. The mid-level provider and the supervising physician appeared to be working cohesively in providing care to the inmate-patients.

Thirty inmate-patient medical encounters/charts completed by three providers at LPCC were reviewed and 16 provider encounters were directly observed. Of the 30 medical encounters reviewed, six were attributed to sick call, 10 were attributed to chronic care, five to follow-up appointments and two related to the Triage Treatment Area (TTA)/emergency department. All 30 provider encounters reviewed demonstrated adequate to proficient assessment and sound medical decision-making. However, there were some minor issues noted with the mid level provider encounters as stated below:

1. Inmate-patient education not consistently provided.
2. Sufficient history and physical exam not completed.
3. Inmate-patient vitals not typed out during encounter, just abbreviated as "vss".
4. No consistent documentation of physical exam findings.

Even though the clinical observations, chart reviews and interviews suggested the overall health care provided to the inmate-patient population to be adequate and the physicians' assessments and diagnoses appeared to be appropriate, the facility's substandard performance in the quantitative section of the audit, especially in the area of chronic care, clearly indicate that the facility has repeatedly failed to provide adequate care to the inmate-patients.

SUMMARY OF QUANTITATIVE AND QUALITATIVE FINDINGS

This portion of this audit is designed to specifically capture the efficiency of facility processes which impact access and quality of care. By their very nature, such processes often defy objective measurement, but are nonetheless worthy of attention and discussion. It bears repeating, although *this portion of the audit is not rated*, any concerning issues identified during the quantitative or qualitative process may result in additional CAP items.

The audit team conducted additional qualitative analysis primarily via interview of key facility personnel. At LPCC the personnel interviewed included the following:

J. MacDonald – Warden
J. Giovino – Supervising Physician
N. Boru – Licensed Independent Provider
J. Spizzirri – Physician's Assistant
W. Wier – Health Services Administrator (HSA)
C. Fernandes – Clinical Nursing Supervisor (CNS)
M. Surrell – CNS
J. Young – ADA Coordinator
J. McGough – Registered Nurse (CQI)
A. Snyder – Health Information Specialist

The following narrative represents a summary of the information gleaned through interviews of the above-listed personnel, as well as conclusions and inferences drawn from correlating observations and data collected during other portions of the audit. The findings are categorized into four major areas: Operations, Recent Operational Changes, Prior CAP Resolution, and New CAP Items.

As stated earlier in the report, subsequent to the previous audit, major revisions and updates have been made to the *Contract Facility Health Care Audit Monitoring Tool* and assessment processes. Several questions have been removed where clear policy support does not exist, or where related processes have changed making such questions immaterial to measuring the quality of health care services provided to inmate-patients. A number of questions have also been added in order to separate multiple requirements formerly measured by a single question, or to measure an area of health care services not previously audited. Additionally, case review sections have been added to better assess and evaluate the timeliness and quality of care provided by nurses and physicians at the contract facilities.

Taking into consideration the revisions to the audit instrument, this audit may produce ratings that appear inconsistent with previous ratings, and may require corrective action for areas not previously identified or addressed. As such, it is imperative that facility management staff and clinical supervisors thoroughly review the deficiencies and areas of non-compliance identified in this audit report and take action to expediently resolve the deficiencies.

OPERATIONS

During the tour of the facility, the audit team observed all the clinic areas and the housing units. Although the facility appeared to be fairly clean and well maintained from the outside, the auditors did identify some of the clinic areas that were not cleaned on a regular basis. This is identified and

described under the quantitative findings section. Both custody and health care staff were receptive and accommodating when approached by the audit team.

Administrative

The administrative component of this audit, the facility received a rating of 61.2% compliance which was a direct result of the facility's local operating procedures not being in full compliance with IMSP&P guidelines. In April 2015, the Corrections Corporations of America (CCA) management team met with Private Prison Compliance and Monitoring Unit (PPCMU), for the annual revision of CCA's corporate policies. A thorough review of CCA's policies was completed by PPCMU staff identifying any areas of non-compliance with IMSP&P guidelines. Subsequent to this meeting, PPCMU sent a letter to CCA listing the changes that CCA management needs to make to their corporate policies in order to bring the policies of CCA into compliance with IMSP&P guidelines. To date, PPCMU has not received the updated policies from CCA and the updated policies were not on site during the audit. Therefore, most of the policy related questions were rated as non-compliant.

Prior to the onsite audit, the audit team reviewed the sick call, chronic care, specialty services, initial intake screening, and hospital stay/emergency department monitoring logs that the facility continues to submit to PPCMU on a weekly and monthly basis. The review of these logs revealed the facility is not consistently recording accurate dates of service that were provided to the inmate-patient population at LPCC. This was validated via review of the various documents and reports filed in the facility's inmate-patient Electronic Medical Record (EMR) system. This will be monitored during subsequent audits to ensure improvements have been made in the accuracy of the data reported on these logs.

During the onsite audit, while inspecting the Release of Information (ROI) log, the auditor noticed that some of the dates of receipt of the ROI requests documented in the log were incorrect making it difficult for the auditor to track the progress of these requests. Upon further inquiry, the medical record staff (MRS) clarified that the incorrect dates were documented by one of the MRS who is no longer employed at the facility. In order to avoid such discrepancies, the auditor recommended the MRS utilize a date stamp to mark the date they receive the original request from the nursing staff and document the stamped date on the ROI log and the 13-74B form. The MRS agreed to implement the process immediately. Auditors were informed later on the same day that the MRS had implemented the date stamps for marking the dates of receipt of ROI requests. This will be monitored during subsequent audits to ensure this process is utilized by the MRS at all times.

LPCC Health Care Staff – Nursing

Several health care components and processes in the facility's four major clinics, main medical, clinics located in compound one, two and three, two Administrative Segregation (ASU) areas, and seven observation cells were observed. The NCPRs inspected 14 examination rooms and observed 10 pill passes, which were conducted between 0400 to 1630 hours. Additionally, through observation, inspection and interviews of nursing staff, the NCPRs evaluated health care processes such as continuous quality improvement (CQI), medical emergency management/response, infection control, observation cell call system, medication management, and sick call.

With regards to CQI, LPCC conducts CQI meetings quarterly; The CCA management was informed in April 2015 that IMSP&P requires these meetings to be conducted monthly.

Emergency Medical Response Review Committee (EMRRC) holds regular monthly meetings. However, when emergency medical response documentation is submitted to the EMRRC for review, Emergency Medical Drills/Incident Report forms (*Form 837* or similar forms) are not submitted to the EMRRC for review. The CCHCS auditors noted vital deficiencies related to the facility's maintenance of emergency medical response (EMR) bags and crash carts. The facility maintains four crash carts and four EMR bags. Crash carts and EMR bags in the facility do not contain standard medical equipment and supplies. All EMR bags have extra supplies that crowd the bags which may act as a barrier when trying to locate emergency supplies. This is a repeat finding from the previous audit conducted in December 2014. The EMR bags also are not uniformly organized; all bags have equipment and supplies placed in different pockets that do not match the arrangement in other bags. Oxygen tanks are not emergency-ready since majority of them do not have oxygen tubing attached. This can potentially lead to delay in responding effectively during emergencies and possibly may result in loss of life.

With regards to the infection control process, nursing staff rendering sick call services do not disinfect re-usable medical equipment such as blood pressure cuff and pulse oximeter after each inmate-patient use. During pill passes, some of the nursing staff was observed placing medications in the inmate-patient's hand, which is not a standard practice and not in compliance with infection control procedures. The auditors also observed that most of the nurses administering oral medications did not conduct mouth and cup checks and did not wash hands after touching cups used by inmate-patients. During accucheck (blood sugar checks), nurses do not sanitize the glucometers after each inmate-patient use. In the previous audit, environmental cleaning of clinic areas was not being completed at least once daily, especially in the ASU exam rooms. The facility failed to correct this deficiency. The month of May 2015 cleaning logs for all clinics indicated the clinics were not being cleaned consistently on a daily basis. ASU exam rooms did not have cleaning logs until May 2015. Although the facility started maintaining cleaning logs in June, the exam rooms in ASU still appeared unclean and disorganized. The rooms were also not adequately equipped for patient examination and care.

During the previous audit, when the CCHCS nurse auditor had observed nurses administering medications in the ASU areas, the nurses had not brought their laptops with them for immediate documentation of medications administered. However, during this audit, the nurse auditors found the facility has corrected this deficiency and this is a significant improvement from the previous audit. CCHCS nurse auditors observed that the medical staff do not check the temperatures of refrigerators, used for storing medications, in the required frequency. Temperatures should be checked once on each shift on a daily basis (twice daily). The facility medical staff checks the temperature only once daily. However, in June, the facility began to check refrigerator temperatures twice a day.

Lastly, in the ASU, access to care is a vital issue for inmate-patients since there was no documentation specifically indicating sick call slips were picked up daily by nursing staff. Since newly arriving inmate-patients are temporarily held in the ASU following initial intake screening, these inmates may not have adequate access to care as there is no documented proof that sick call slips are being picked up daily. Some of the newly arrived inmate-patients were interviewed and some stated they hand over the sick call slips to the nurses who make rounds and some others stated they would leave the slips by the window of the ASU pod for the nurses to pick up as they entered the pod. When the auditors questioned the facility administrators regarding this process, the administrators stated the nurses pick up the completed sick call forms daily when making their rounds. However, since there was no documentation available to support the facility's statement, the audit team was unable to validate this process is actually occurring and being completed by nursing staff daily. The audit team recommended to the facility management that they maintain a log in all of the ASUs to track the days and times the nursing staff make rounds to collect sick call slips. The facility warden expressed his consent to

implement the process. This will be monitored during subsequent audits to ensure compliance in this area.

LPCC Health Care Staff – Physician

During the onsite audit, the CCHCS clinician found the medical staff demonstrated an eagerness to work, and they all appeared engaged in addressing the medical needs of the inmate-patient population housed at LPCC. Although, the staff appeared eager, there were critical issues identified under the quantitative section and in Section 5 of this report, that are not in parity with the eagerness demonstrated by the facility staff. These issues require the facility's immediate attention since these deficiencies are detrimental to the well being of the inmate-patients. The facility is strongly encouraged to address and resolve these issues expediently.

As mentioned previously in Section 5, the clinical case reviews revealed some key issues in the medical services provided and there were some documentation issues as well. One of the issues identified during one of the case reviews, regarded a CT scan report not scanned into the medical record promptly. The provider should have contacted medical records and/or the hospital to obtain the report for the inmate-patient's records. This inmate-patient was transferred back to California prior to obtaining the official report. It is recommended that the facility ensures timely receipt and scanning of inmate-patient diagnostic test results into the inmate-patients' medical charts to reduce duplicate physician referrals/studies that can drive up unnecessary medical costs and potentially delay care.

Another issue was that the provider not ordering aspirin or nitroglycerin to be administered to the inmate-patient in light of concern for acute coronary syndrome. It is recommended the facility review the nursing and physician protocols for chest pain and ensure that it includes the administration of aspirin or nitroglycerin for acute coronary syndrome. These medications would help a patient experiencing an acute myocardial infarction (heart attack) and potentially save a life.

The third issue that was identified was regarding the nurse practitioner (NP) not ordering anti-seizure medications prescribed by the hospital neurologist. It is recommended that the facility providers read and follow the hospital consultants' recommendations and administer any and all medications prescribed within the timeframe specified by the prescribing provider. If there is a valid reason for not following hospital physicians' recommendations, they must be stated in the health records with written explanations. As a provider, it is important to know what medications inmate-patients are taking and to provide the correct medication(s) at all times. This will ensure that continuity of care is maintained for all inmate-patients and avoid an adverse event, in this case, seizure and potential complications of seizures.

One of the key issues identified in relation to the nursing staff was inadequate documentation. There were several occasions where there was inadequate documentation in regards to the time that vital signs were taken. It is recommended that the nursing staff document the time of vitals each time it is taken. It is important to see what trends are taking place with vital signs. It also reflects response times to medications and treatment rendered.

The CCHCS clinician auditor met with the representatives of the Inmate Advisory Council and the representatives expressed their general concern that Hepatitis and Human Immunodeficiency Virus (HIV) screening are not done when requested. The inmate-patients are required to justify with symptoms. The inmate-patients also claimed that physicians in CDCR prisons order these tests upon request. The CCHCS clinician auditor raised this issue with the facility's chief physician. The physician stated that they do order Hepatitis B & C screening and HIV screening upon request, some inmate-

patients request screening every three months. For those cases, the providers conduct screening on an annual basis, if inmate-patients do not show any symptoms. They also provide education to inmate patients on sexually transmitted diseases. The inmate-patients also inquired if they could be prescribed transitional sunglasses if they paid for them and auditor informed them that they will be prescribed by the physician only if it was considered medically necessary. The auditor also informed the inmate-patients that some facilities may differ in their practices in prescribing transition lenses since *DOM Ch.5, Article 43* states that inmate-patients can obtain non-prescription sunglasses.

One of the inmate-patient representatives complained he was charged $5 for his flu shot. This issue was discussed with the facility HSA. Upon confirming this to be true, the HSA reversed the charges to the inmate-patient's account. The inmate-patients also inquired about treatment of toe nail fungus. They stated they are not given oral medications to treat the fungus like they do in CDCR, since topical creams are not effective in treating the condition. The auditor informed them even though some CDCR providers may have provided treatment with oral medications, per *Title 15, Section 3350, subsections (a), (b)-1, 4 and 5,* physicians are required to treat medical conditions based on medical necessity. Therefore, it is left to the physician's discretion as to the type of medication or treatment that should be administered to address diagnosed clinical symptoms. The inmate-patients were content with the medical services provided and expressed that the LIP had a good rapport with the inmate-patients and he was thorough, efficient and an effective physician. They had no issues about getting their prescription medications and did not have any issues with chronic care services provided at the facility.

The chief physician expressed his concern to the clinician auditor about the delay getting reports from the outside hospitals. Often times the reports are received only after the inmate-patients are seen for their discharge or ER follow up appointments. It is suggested that LPCC track all inmate-patients sent to the outside hospitals and follow up with the hospitals regularly to ensure timely receipt of the inmate-patients' reports. If this situation persists in spite of facility's attempts to resolve the issue, the facility is encouraged to bring this issue to the attention of CCA executive management for corporate resolution.

RECENT OPERATIONAL CHANGES

Nothing to report during this audit.

PRIOR CAP RESOLUTION

During the December 2014 audit, LPCC received an overall compliance rating of 89.5% resulting in a total of 26 CAP items. The December 2014 audit CAP items are as follows:

1. *THE INMATE-PATIENTS' CHRONIC CARE (CC) FOLLOW UP VISITS ARE NOT CONSISTENTLY COMPLETED WITHIN THE 90-DAY TIMEFRAME, OR AS ORDERED BY THE LICENSED INDEPENDENT PROVIDER (LIP). (Formerly Chapter 5, Question 1)* During the previous audit in December 2014, the facility received a rating of 60.0% compliance in this area. During the current audit, the facility received a rating of 100% compliance. This corrective action item is considered resolved.

2. ***THE INMATE-PATIENTS WHO ARE A NO-SHOW OR THOSE THAT REFUSE CHRONIC CARE MEDICATIONS HALF OF THE TIME OR MORE, IN A ONE WEEK PERIOD ARE NOT BEING REFERRED TO THE LIP. (Formerly Chapter 5, Question 3)* During the previous audit in December 2014, the facility received a rating of 0.0% compliance in this area. The facility's CAP stated that The Clinical Nursing Supervisors (CNSs) will instruct the Night RN (llpm-7am)**

to print the Missed Meds report every Monday, Wednesday and Friday. The Night RN will be instructed to schedule for counseling, on nurse's line the following day, each inmate-patient that has missed either (1) three consecutive scheduled doses or (2) more than half of prescribed doses within a one week period. The Senior MD will instruct the LIPs to, upon receiving their notification of an inmate-patient missing/refusing prescribed medications, perform a chart review and update plan of care as needed. All instructions will be documented on a 4-2A, Training Roster. These efforts have proved 0 out of 25 inmate-patient medical records reviewed during the current audit indicated that the inmate-patients who are a no-show or those that refuse chronic care medications half of the time or more, in a one week period are not being referred to the LIP, resulting in a compliance rating of 0.0%. As this issue has not yet reached an acceptable level of compliance, this corrective action item is considered unresolved and will continue to be monitored in subsequent audits.

3. *IN THE CQI MEETING MINUTES, THE FACILITY DID NOT IDENTIFY A QUORUM PER THE APPROVED CQI PLAN. (Formerly Chapter 6, Question 2)* This specific requirement is no longer rated by the Private Prison Compliance and Health Care Monitoring Audits.

4. *THE DIAGNOSTIC TESTS FOR INMATE-PATIENTS ARE NOT CONSISTENTLY COMPLETED WITHIN THE TIMEFRAME SPECIFIED BY THE LIP. (Formerly Chapter 7, Question 1)* During the previous audit in December 2014, the facility received a rating of 40.0% compliance in this area. The facility's CAP stated that The Clinical Nursing Supervisors (CNSs) will review CCA Policy 13-31, Diagnostic Services with the Certified Medical Assistants (CMAs) and the designated Licensed Practical Nurse (LPN) and instruct them to complete diagnostic tests within the timeframe specified by the ordering provider. The designated LPN will continue to utilize the Lab Draw Report from Allscripts to generate a spreadsheet of all lab draws that are due or past due and submit to the CNSs and CQI weekly and the CQI Nurse will monitor reports for trending and will perform monthly audits for compliance with this standard. Failure to achieve compliance will result in further corrective action, which may include advanced individual training and/or progressive disciplinary action for staff with proven deficiencies. These efforts proved effective as 18 out of 20 inmate-patient medical records reviewed during the current audit indicated that diagnostic tests are being provided to the inmate-patients within the specified timeframes, resulting in a rating of 90.0% compliance. This corrective action item is considered resolved.

5. ***THE LICENSED INDEPENDENT PROVIDER (LIP) ON A CONSISTENT BASIS IS NOT REVIEWING, INITIALING AND DATING ALL INMATE-PATIENT DIAGNOSTIC REPORTS WITHIN THE SPECIFIED TIME FRAME. (Formerly Chapter 7, Question 2)*** **This issue was initially identified during the May 2014, audit where the facility received a rating of 52.6% compliance. During the December 2014, audit the facility's rating slightly improved to 80.0% compliance in this area. The CAP produced by facility stated that the Senior MD will instruct all LIPs to verify lab results within two business days of availability. The Clinical Nursing Supervisors (CNSs) will instruct the Night RN (llpm-7am) to continue to update the Diagnostic Results Verification Log nightly. If the ordering provider is not anticipated to be available within seven (7) days of receipt of results, the task of lab verification will be re-assigned to another provider. The assigned clinical Nursing Supervisor (CNS) will continue to review the Diagnostic Results Verification Log a minimum of twice weekly and report any deficiencies in the timeliness of provider verification to the HSA and the Senior MD. To validate and ensure compliance, The CQI Nurse will monitor the Diagnostic Results Verification Log for accuracy and will utilize the log to generate statistical data to be reported to the HSA a minimum of once monthly for**

further action. These efforts proved ineffective as 7 of the 20 inmate-patient medical records reviewed during the current audit indicated that the provider does not consistently review, initial, and date the inmate-patient diagnostic results within two days, resulting in a rating of 65.0% compliance. As this issue has not yet reached an acceptable level of compliance, this corrective action item is considered unresolved and will continue to be monitored in subsequent audits.

6. ***INMATE-PATIENTS ARE NOT CONSISTENTLY RECEIVING WRITTEN NOTIFICATION OF DIAGNOSTIC TEST WITHIN THE SPECIFIED TIME FRAME. (Formerly Chapter 7, Question 4)*** **This issue was initially identified during the June 2014 audit where the facility received a rating of 31.6% compliance. During the December 2014 audit, the facility's rating marginally increased to 50.0% compliance in this area. The facility's CAP indicated that The Clinical Nursing Supervisors (CNSs) will instruct the Night RN (llpm-7am) to review the Diagnostic Results Verification, generate notifications for all verified results and forward to the Medical Administrative Clerk nightly for distribution. The Medical Administrative Clerk will distribute the 13-31A, Notification of Diagnostic Test Results to the inmate-patient via inmate mail. To validate and ensure compliance, the assigned Clinical Nursing Supervisor (CNS) will continue to monitor the Diagnostic Results Verification Log for compliance a minimum of twice weekly x 4 weeks, then CQI will monitor monthly through the CQI process. These efforts proved ineffective as 4 of the 20 inmate-patient medical records reviewed during the current audit showed the inmate-patients did not consistently receive written notification of diagnostic test results within two business days, resulting in a rating of 80.0% compliance. Even though the facility has shown marginal improvement in this area, it has failed to achieve an acceptable level of compliance, this corrective action item is considered unresolved and will continue to be monitored in subsequent audits.**

7. *THE INMATE-PATIENTS ARE NOT CONSISTENTLY RECEIVING AN INITIAL INTAKE SCREENING BY LICENSED HEALTH CARE STAFF UPON ARRIVAL AT THE FACILITY. (Formerly Chapter 12, Question 1)* During the previous audit in December 2014, the facility received a rating of 66.7% compliance in this area. During the current audit, the facility received a rating of 100% compliance. This corrective action item is considered resolved.

8. ***INMATE-PATIENTS WHO ARE REFERRED TO A LIP BY NURSING STAFF DURING THE INITIAL INTAKE SCREENING ARE NOT BEING SEEN WITHIN SPECIFIED TIME FRAMES. (Formerly Chapter 12, Question 2)*** **During the previous audit in December 2014, the facility received a rating of 50.0% compliance in this area. The facility's CAP stated The Clinical Nursing Supervisors (CNSs) will instruct all nursing staff on proper procedures for completing an initial health screening, to include referral process in accordance with CCA policy 13-50. For tracking purposes nurses will be instructed to notify the CNSs and CQI of any inmate-patient requiring non-routine referrals during intake. The Clinical Nursing Supervisors (CNSs) will instruct designated staff (Certified Medical Assistants and D. Miller, LPN) to complete the scheduling function for each ordered appointment no later than one business day following order entry. To validate and ensure compliance, the CQI Nurse will review the EMR of 100% of inmate-patients referred to the LIP upon arrival at LPCC for 30 days and then will monitor compliance monthly as part of the CQI process. These efforts proved ineffective as 2 of the 3 inmate-patient medical records reviewed during the current audit showed that inmate-patients who are referred to a LIP by nursing staff during the Initial Intake Screening are not being seen within specified time**

frames, resulting in a rating of 33.3% compliance. As this issue has not yet reached an acceptable level of compliance, this corrective action item is considered unresolved and will continue to be monitored in subsequent audits.

9. *INMATE-PATIENTS ARRIVING AT THE FACILITY WITH EXISTING MEDICATION ORDERS ARE NOT CONSISTENTLY BEING SEEN BY THE LIP OR THEIR MEDICATIONS ARE NOT BEING ORDERED WITHIN EIGHT HOURS OF THEIR ARRIVAL. (Formerly Chapter 12, Question 3)* During the December 2014 audit, the facility received a rating of 83.3% compliance in this area. The facility did not provide a corrective action plan for this deficiency. During the current audit, the facility received a rating of 85.7% compliance, a marginal improvement from the previous audit. Due to this standard having been brought above the compliance benchmark/threshold of 85.0% compliance, this corrective action item is considered resolved.

10. *INMATE-PATIENTS ARE NOT CONSISTENTLY RECEIVING A COMPLETE HEALTH APPRAISAL BY THE LIP WITHIN 14 DAYS OF ARRIVAL AT THE FACILITY. (Formerly Chapter 12, Question 5)* During the December 2014 audit, the facility received a rating of 50.0% compliance in this area. The facility did not provide a corrective action plan for this deficiency. However, during the current audit the facility received a rating of 100% compliance. This corrective action item is considered resolved.

11. ***INMATE-PATIENTS, WHO WERE ENROLLED IN A CHRONIC CARE (CC) CLINIC AT A PREVIOUS FACILITY, ARE NOT CONSISTENTLY REFERRED BY THE REGISTERED NURSE (RN) TO THE LIP FOR A CC FOLLOW-UP. (Formerly Chapter 12, Question 6)*** **During the December 2014 audit, the facility received a rating of 50.0% compliance in this area. The facility's CAP stated that in accordance with CCA Policy 13-6, the Clinical Nursing Supervisors (CNSs) will instruct all nurses to screen each inmate-patient for chronic conditions during the intake screening process and refer as necessary for enrollment in a Chronic Care Clinic. To validate and ensure compliance, the Chronic Care Nurse will continue to add inmate-patients referred to or enrolled in the Chronic Care Clinic to the Chronic Care log for long-term monitoring. These efforts proved ineffective as 2 of the 5 inmate-patient medical records reviewed during the current audit showed that the inmate-patients are not consistently referred by the RN to the LIP for a chronic care follow-up, resulting in a rating of 60.0% compliance. As this issue has not yet reached an acceptable level of compliance, this corrective action item is considered unresolved and will continue to be monitored in subsequent audits.**

12. *INMATE-PATIENTS ARE NOT CONSISTENTLY RECEIVING A COMPLETE SCREENING FOR THE SIGNS AND SYMPTOMS OF TUBERCULOSIS UPON THEIR ARRIVAL AT THE FACILITY. (Formerly Chapter 12, Question 7)* During the December 2014 audit, the facility received a rating of 73.3% compliance in this area. During the current audit, the facility received a rating of 100% compliance. This corrective action item is considered resolved.

13. ***THE PRESCRIBING LIP IS NOT DOCUMENTING THAT THEY EXPLAINED THE MEDICATION TO THE INMATE-PATIENT. (Formerly Chapter 14, Question 2)*** **This issue was initially identified during May 2014 audit and the facility had scored 78.6% compliance. During the December 2014 audit, the facility received a rating of 33.3% compliance in this area. The facility's CAP stated The Senior MD will instruct all LIPs to document education given to inmate-patients regarding new medications. CQI will audit for compliance with this standard by reviewing a minimum of 10 applicable charts (physician encounter resulting in new medication orders) weekly x 4**

weeks and report findings to HSA and Senior MD. These efforts proved ineffective as 7 of the 22 inmate-patient medical records reviewed during the current audit indicated that the prescribing LIP is not consistently documenting that they provided education on the newly prescribed medication to the inmate-patient, resulting in a rating of 68.2% compliance. As this issue has not yet reached an acceptable level of compliance, this corrective action item is considered unresolved and will continue to be monitored in subsequent audits.

14. *INMATE-PATIENTS, WHO DO NOT SHOW OR REFUSE THEIR PRESCRIBED MEDICATION 50% OF THE TIME OR MORE, ARE NOT CONSISTENTLY BEING REFERRED TO THE LIP. (Formerly Chapter 14, Question 3)* During the December 2014 audit, the facility received a rating of 50.0% compliance in this area. The facility's CAP stated that the Clinical Nursing Supervisors (CNSs) will instruct the Night RN (11pm-7am) to print the Missed Meds report every Monday, Wednesday and Friday. The Night RN will be instructed to schedule for counseling on nurse's line the following day, each inmate-patient that has missed either (1) three consecutive scheduled doses or (2) more than half of prescribed doses within a one week period. The CNSs will provide instruction to all RNs regarding proper documentation of medication counseling appointments and process for notifying the provider. Instruction will be documented on a 4-2A, Training Roster. These efforts proved ineffective as all 3 inmate-patient medical records reviewed during the current audit showed that the inmate-patients are not referred by the RN to the LIP for if the inmate-patients are a no-show or refuse their prescribed medications 50% of the time or more resulting in a rating of 0.0% compliance. As this issue has not yet reached an acceptable level of compliance, this corrective action item is considered unresolved and will continue to be monitored in subsequent audits.

15. *INMATE-PATIENTS, REFERRED TO THE LIP FOR MEDICATION NON-COMPLIANCE, ARE NOT SEEN BY THE LIP WITHIN THE SPECIFIED TIMEFRAME. (FORMERLY CHAPTER 14, Question 4)* During the December 2014 audit, the facility received a rating of 0.0% compliance in this area. The facility's CAP stated that the Clinical Nursing Supervisors (CNSs) will instruct the Night RN (11pm-7am) to print the Missed Meds report every Monday, Wednesday and Friday. The Night RN will be instructed to schedule for counseling on nurse's line the following day, each inmate-patient that has missed either (1) three consecutive scheduled doses or (2) more than half of prescribed doses within a one week period. The CNSs will provide instruction to all RNs regarding proper documentation of medication counseling appointments and process for notifying the provider. Instruction will be documented on a 4-2A, Training Roster. These efforts proved ineffective as all 3 inmate-patient medical records reviewed during the current audit showed that the inmate-patients who were referred by the RN to the LIP for medication non-compliance were not seen by the LIP within the specified timeframe resulting in a rating of 0.0% compliance. As this issue has not yet reached an acceptable level of compliance, this corrective action item is considered unresolved and will continue to be monitored in subsequent audits.

16. *THE LICENSED PRACTICAL NURSE (LPN)/RN) IS NOT CONSISTENTLY DOCUMENTING THE MEDICATION ADMINISTERED ON THE MEDICATION ADMINISTRATION RECORD ONCE THE MEDICATION IS GIVEN TO THE INMATE-PATIENT. (Formerly Chapter 14, Question 7)* During the December 2014 audit, the facility received a rating of 75.0% compliance in this area. During the curreNt audit, the facility received a rating of 100% compliance. This corrective action item is considered resolved.

17. ***THE NURSING STAFF IS NOT CONSISTENTLY REVIEWING THE SICK CALL SLIPS WITHIN ONE DAY OF RECEIPT. (Formerly Chapter 18, Question 2)*** **During the December 2014 audit, the facility received a rating of 75.0% compliance in this area. The facility's CAP stated that in accordance with CCA Policy 13-80, the Clinical Nursing Supervisors (CNSs) will instruct all nursing staff to continue nightly collection and triaging of sick call slips. Once weekly x 4 weeks, the CNSs will perform a random "spot check" of a medical drop box on their assigned compound. They will create a list of all sick call forms awaiting pick-up, sign and date the list, and submit to CQI. To validate and ensure compliance, The CQI Nurse will utilize lists submitted by CNSs to determine timeliness of the collection/triage process and submit a report of findings to the HSA. These efforts proved ineffective as 4 of the 25 inmate-patient medical records reviewed during the current audit indicated that the nursing staff do not consistently review the sick call slips on the day it was received, resulting in a rating of 84.0% compliance. As this issue has not yet reached an acceptable level of compliance, this corrective action item is considered unresolved and will continue to be monitored in subsequent audits.**

18. *THE NURSING STAFF IS NOT FOLLOWING THE PATIENT CARE PROTOCOL TO ADDRESS AN INMATE-PATIENT'S CHIEF COMPLAINT AND IS NOT CONSISTENTLY DOCUMENTING THE CHIEF COMPLAINT IN THE PROGRESS NOTE ON THE INMATE-PATIENT'S SICK CALL FORM. (Formerly Chapter 18, Question 5)* This specific requirement is no longer rated by the Private Prison Compliance and Health Care Monitoring Audits.

19. *INMATE-PATIENTS REFERRED BY THE RN TO THE LIP FOR FOLLOW-UP ARE NOT CONSISTENTLY SEEN BY THE LIP WITHIN THE SPECIFIED TIMEFRAMES. (Formerly Chapter 18, Question 7)* During the December 2014 audit, the facility received a rating of 28.6% compliance in this area. The facility's CAP stated the Clinical Nursing Supervisors (CNSs) will instruct designated staff (Certified Medical Assistants and D. Miller, LPN) to complete the scheduling function for each ordered appointment no later than the business day following order entry. To ensure and validate compliance, the CQI Nurse will utilize the Sick Call Log to identify NSC appointments resulting in provider referrals and will review 10 charts weekly x 4 weeks. A report of findings will be submitted to the HSA. These efforts proved effective as 9 of the 10 inmate-patient medical records reviewed during the current audit indicated the inmate-patients are seen by the LIP within the specified timeframes when they are referred by the RN to the LIP for follow-up, resulting in a rating of 90.0% compliance. Due to this standard having been brought above the compliance benchmark/threshold of 85.0% compliance, this corrective action item is considered resolved.

20. *INMATE-PATIENTS WHO PRESENT TO SICK CALL THREE OR MORE TIMES IN A MONTH FOR THE SAME COMPLAINT ARE NOT BEING REFERRED BY THE RN TO THE LIP. (Formerly Chapter 18, Question 9)* During the December 2014 audit, the facility received a rating of 0.0% compliance in this area. The facility's CAP stated that In accordance with CCA Policy 13-80, Sick Call, the CNSs will instruct all Registered Nurses to refer inmate-patients presenting to sick call three or more times for the same complaint to the LIP. Prior to weekly submission of the Sick Call Log, the CQI nurse will audit 100% of charts of inmate-patients having three or more sick call visits within the preceding 30 days. Any charts lacking appropriate LIP referral will be forwarded to the CNSs and HSA. These efforts proved effective as 3 of the 3 inmate-patient medical records reviewed during the current audit indicated that the all inmate-patients who present to sick call

three or more times in a month for the same compliant are referred by the RN to the LIP, resulting in a rating of 100% compliance. This corrective action item is considered resolved.

21. *WHEN INMATE-PATIENTS RETURN FROM A COMMUNITY HOSPITAL EMERGENCY DEPARTMENT, RN IS NOT CONSISTENTLY DOCUMENTING THAT THEY REVIEWED THE INMATE-PATIENT'S DISCHARGE PLAN. (Formerly Qualitative Action Item #1 – Chapter 8, Question 4)* This issue was initially identified during May 2014 audit and the facility had scored 75.0% compliance. During the December 2014 audit, the facility received a rating of 57.1% compliance in this area. The facility's CAP stated that the CNSs will instruct all RNs to specifically include in their documentation on inmate-patients returning from a hospital visit/stay a brief summary of hospitalization, review of discharge plans with inmate-patient and any changes in plan of care. A sample 13-58B,Progress Note containing proper documentation of discharge plan review will be generated and discussed with all RNs. Instructions will be documented on a 4-2A, Training Roster. In order to ensure continued compliance, the CQI Nurse will audit 100% of hospital returns x 4 weeks. A report of findings will be submitted to the HSA. During the current audit, 11 out of 13 inmate-patient medical records reviewed indicated the RNs document that they reviewed the inmate-patient's discharge plan upon their return from the community hospital emergency department resulting in 84.6% compliance. Even though the facility has shown significant improvement in this area, this issue has not yet attained an acceptable level of compliance. Therefore, this corrective action item is considered unresolved and will continue to be monitored in subsequent audits.

22. *THE EMERGENCY MEDICAL RESPONSE REVIEW COMMITTEE MEETING MINUTES INDICATE THAT THE ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFIED HEALTH CARE STAFF IS NOT CONSISTENTLY ARRIVING ON-SITE WITHIN EIGHT MINUTES OF SOUNDING THE EMERGENCY MEDICAL ALARM. (Formerly Qualitative Action Item #2 – Chapter 8, Question 11)* During the December 2014 audit, the facility received a rating of 81.8% compliance in this area. During the current audit, the facility received a rating of 100% compliance. This corrective action item is considered resolved.

23. ***OXYGEN TANK IN COMPOUND THREE WAS ONLY ONE FOURTH FULL, RENDERING IT NON-OPERATIONAL. (Formerly Qualitative Action Item #3 – Chapter 9, Question 12)* During the December 2014 audit, the facility received a rating of 80.8% compliance in this area. The facility's CAP stated that In accordance with CCA Policy 13-7,"Clinic Space, Equipment and Supplies," the Clinical Nursing Supervisors (CNSs) will instruct all nurses to check and log oxygen levels at the beginning of each shift and to replace emergency tanks when less than three-quarters full. The CNS will continue to check for completeness of logs in assigned compound weekly and report any deficiencies to the HSA and the CQI Nurse will review logs monthly for compliance as part of the CQI process. These efforts proved ineffective because when the oxygen tanks were checked for operational readiness during the onsite audit, 11 out of 13 oxygen tanks did not have nasal tubing attached and one tank was only one fourth full, resulting in a rating of 13.3% compliance. As this issue has not yet reached an acceptable level of compliance, this corrective action item is considered unresolved and will continue to be monitored in subsequent audits.**

24. ***ENVIRONMENTAL CLEANING OF ALL "HIGH TOUCH SURFACES" IS NOT BEING COMPLETED AT LEAST ONCE PER DAY IN THE MEDICAL CLINICS. (Formerly Qualitative Action Item #4 – Chapter 11, Question 12)* During the December 2014 audit, the facility received a rating of 28.6%**

compliance. The facility's CAP stated that in accordance with CCA Policy 13-47, "Clinic, Space, Equipment and Supplies", the CNSs will instruct all medical staff to maintain a clean working environment, CCA 13-47CC, "Cleaning Schedule-Health Services" will be posted in all clinic areas and the CQI nurse will perform random "spot-checks" bi-weekly x four weeks and will submit a report of findings to the HSA. The medical administrative clerk will develop a log for inmate porters to track compliance with 13-47CC. These efforts proved ineffective because when the cleaning logs for four clinics and two ASU exam rooms were checked, the logs indicated the clinics were not cleaned for 73 days out of a total of 113 days, resulting in a rating of 60.8% compliance. As this issue has not yet reached an acceptable level of compliance, this corrective action item is considered unresolved and will continue to be monitored in subsequent audits.

25. *ONE OF THE NEWLY HIRED RN DID NOT HAVE A CURRENT ACLS CERTIFICATION. PER THE CCA CONTRACTUAL GUIDELINES, ALL RNS HIRED AT THIS FACILITY ARE REQUIRED TO MAINTAIN THEIR ACLS CERTIFICATIONS CURRENT. (Formerly Qualitative Action Item #5 – Chapter 13, Question 3)* This specific requirement is no longer rated by the Private Prison Compliance and Health Care Monitoring Audits.

26. *DOCUMENTATION IN THE CHRONIC CARE MONITORING LOG SHOWS THAT THE INMATE-PATIENTS ARE NOT CONSISTENTLY SEEN BY THE LIP WITHIN THE SPECIFIED TIMEFRAMES SET FORTH IN THE CHRONIC CARE POLICY. (Formerly Qualitative Action Item #6 – Chapter 15, Question 4)* This specific requirement is no longer rated by the Private Prison Compliance and Health Care Monitoring Audits.

NEW CAP ISSUES

As stated earlier in the report, the current audit instrument applies a more targeted approach for many of the questions and both the sample sizes and compliance requirements have increased. As a result of the current audit, there are 78 new quantitative CAP items that are fully discussed where necessary in the comments of the relevant section(s) of this report, nine CAP items that remain unresolved from the previous audit, and seven items that are no longer rated by the Private Prison Compliance and Health Care Monitoring Audits.

CONCLUSION

As indicated by the overall quantitative compliance score of **73.3%** and several areas of concern identified on the nursing and clinical case reviews, LPCC has a number of deficiencies that will require immediate attention and resolution in a timely manner. The current findings are not acceptable. The audit revealed that LPCC is struggling to provide health care meeting IMSP&P standards as it relates to; chronic care management, diagnostic services, medical emergency management, health appraisal/transfers, inmate-patient refusals/no shows for medical services, preventative services, staffing and continuous quality improvement.

A number of repeat deficiencies have been identified during the previous and current audits; specifically the facility's process for handling inmate-patient refusal/no shows for medical services; chronic care follow-ups; completing, reviewing and providing results of diagnostic tests to the inmate-patients within the specified timeframes; maintenance of emergency equipment and supplies; infection control procedures and documentation in inmate-patient medical records. As an example, there were a total of 26 corrective action items requiring follow up and resolution from the last audit dated Dec 2014. Of the 26 items listed, 7 are no longer being measured due to reconstruction of the audit tool, leaving the facility with 19 corrective action items to complete. Of those 19 items, 9 are still unresolved. The lack of commitment and follow-through by the vendor represents a serious threat to the health care of the inmates for whom they are being compensated. Many of these failures involve direct patient care delivery and follow-up.

Poor performance scores in numerous operational areas is a direct result of the lack of the facility's ability to meet established standards and achieve compliance. The facility is encouraged to work diligently towards improving the quality of health care services provided to CDCR inmate-patients, develop and implement all policies and/or procedures identified as deficient, address and resolve all CAP items in a timely manner, and strive to attain at least 85.0% compliance.

STAFFING UTILIZATION

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

A review of the health care positions revealed the facility had one vacant position for a Licensed Independent Provider, one vacant position for a mid level provider, one vacant position for a clinical nurse supervisor and 4 vacant positions for a Registered Nurse during the audit review period. The following table is a summary of the staffing and findings of the review.

LPCC Total Population: 3,146

Primary Care	Original Contract FTE	Current Required FTE
Senior Physician	1.0	1.0
Physician	1.0	0.0
ARNP/PA	2.0	1.0
ARNP/PA (contract)	0.0	0.0
Total Primary Care	**4.0**	**2.0**
CCA Management		
Deputy Director/Senior Health Services Administrator	0.0	0.0
Health Services Administrator	1.0	1.0
Clinical Nurse Supervisor	3.0	2.0
Total CCA Management	**4.0**	**3.0**
Nursing Services		
Staff RN (7 day)	9.0	5.0
Staff RN (5 day)	5.0	5.0
Staff LPN/LVN (7 day)	9.0	9.0
Staff LPN/LVN (5 day)	5.0	5.0
Nursing Total	**28.0**	**24.0**
Clinical Support Staff		
RN, Continuous Quality Improvement	[1.0]	[1.0]
Coordinator, Infectious Disease	[0.0]	[0.0]
Pharmacy Tech/LPN	[2.0]	[2.0]
LPN, Health Information Specialist	[1.0]	[1.0]
Phlebotomist	[0.0]	[0.0]
Certified Medical Assistant	[3.0]	[3.0]
Clinical Support Staff Total	**[7.0]**	**[7.0]**
Total Nursing & Clinical Support	**28.0**	**24.0**

Note: Bracketed positions indicate additional nursing positions which are not providing direct patient care. These positions are not included in the total count of nursing and clinical support positions as these are not required positions per contract.

INMATE INTERVIEWS

The intent of this portion of the audit is to elicit substantive responses from the inmate 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. In general population facilities, this is accomplished via interview of the Inmate Advisory Council (IAC) executive body. In segregated or reception facilities, this is accomplished via interview of a random sampling of at least 10 inmates housed in those buildings. 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.

Inmate 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 inmate-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:

1. Regarding questions 1 through 8 – No negative responses. None of the ten inmate-patients interviewed regarding the sick call and health care appeal processes voiced any concern. On the contrary, the inmate-patients were quite pleased and content with the health care services that are provided to them by LPCC health care staff.

2. Regarding questions 9 through 21 – At the time of the audit, LPCC had 16 inmate-patients on the DPP list. All 16 DPP inmate-patients were interviewed. Most of the DPP inmate-patients interviewed did not voice any major concerns and were quite content with the health care services and accommodations provided to them. Two inmate-patients required translator services to achieve effective communication as they did not speak English. The facility employs a telephone interpreter service and sometimes bilingual facility staff to assist those inmate-patients requiring these services.

   One inmate-patient with hearing disability complained that he had not had a hearing test in more than a year and he wanted to know when he was going to be tested. The auditors inquired about his appointment with the facility medical staff and were told that the appointment for the hearing test was already scheduled for the inmate-patient; however, for security reasons, they were not allowed to disclose the date of appointments to the inmate-patients.

   Another inmate-patient, who had hearing disability in both ears and required two hearing aids, claimed he never received his hearing aid battery even though he had verbally requested them from staff the previous week during the pill line. The auditors inquired with the nursing staff regarding his complaint and upon checking this inmate-patient's medical record, it was found that the inmate-patient had not submitted a written request for the batteries. The nursing staff informed the auditors that inmate-patients need to submit a written request in order to get replacement batteries. They also stated the facility currently provides the inmate-patients with a pack of batteries instead of single units. The inmates are required to return the used batteries in order to get a fresh pack of batteries. The facility nursing staff had the inmate-patient brought into the main medical and asked him fill out a request form for batteries. The batteries were then provided to the inmate-patient in the auditors' presence. They also informed him that he is required to submit a written request for batteries whenever he is in need of replacement batteries.

   It should be noted that all of the DPP inmate-patients were aware who their ADA Coordinator is. All stated that the ADA Coordinator sees them at least once every six weeks to address any questions or concerns they may have.