

March 4, 2016

Fred Figueroa, Warden  
Tallahatchie County Correctional Facility  
415 U.S. Highway 49 North  
Tutwiler, MS 38963

Dear Warden Figueroa:

The staff from California Correctional Health Care Services (CCHCS) completed an onsite health care monitoring audit at Tallahatchie County Correctional Facility (TCCF) on December 1-3, 2015. The purpose of this audit was to ensure that TCCF is meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006.

On February 12, 2016, a draft report was sent to your management providing the opportunity to review and dispute any findings presented in the draft report. On February 26, 2016, your facility submitted a response disputing eight of the audit team's findings. The attached document reflects five of the eight items disputed which have been reconsidered. Acceptance of these questions has resulted in the removal of three items from the list of Outstanding Critical issues. Refer to the attached document for the CCHCS's detailed response to questions and items disputed by TCCF.

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

The audit findings reveal that during the audit review period, TCCF failed to provide adequate health care to CDCR patients housed at the facility. The facility's continued struggle with internal monitoring, specifically the completion of the weekly and monthly monitoring logs, chronic care management, diagnostic services, medication management, and preventative services has resulted in significant impediments to patient care. With only 30 percent of the previous deficiencies resolved, efforts to overcome these issues must be redoubled. These deficiencies require the facility's immediate attention and resolution.

The deficient areas listed above can be brought to compliance by the facility's strict adherence to the established policies and procedures outlined in the Inmate Medical Services Policies and Procedures and the contract.



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



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

Enclosure



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**CALIFORNIA CORRECTIONAL  
HEALTH CARE SERVICES**

**PRIVATE PRISON COMPLIANCE  
AND HEALTH CARE MONITORING AUDIT**



**Tallahatchie County Correctional Facility**

**December 1-3, 2015**

## TABLE OF CONTENTS

INTRODUCTION.....	3
EXECUTIVE SUMMARY .....	3
BACKGROUND AND PROCESS CHANGES .....	5
OBJECTIVES, SCOPE, AND METHODOLOGY .....	6
IDENTIFICATION OF CRITICAL ISSUES.....	11
1. ADMINISTRATIVE OPERATIONS .....	13
2. INTERNAL MONITORING & QUALITY MANAGEMENT .....	14
3. LICENSING/CERTIFICATIONS, TRAINING, & STAFFING.....	16
4. ACCESS TO CARE .....	17
5. CHRONIC CARE MANAGEMENT .....	20
6. COMMUNITY HOSPITAL DISCHARGE .....	22
7. DIAGNOSTIC SERVICES.....	23
8. EMERGENCY SERVICES.....	25
9. HEALTH APPRAISAL/HEALTH CARE TRANSFER .....	26
10. MEDICATION MANAGEMENT .....	28
11. OBSERVATION CELLS.....	31
12. SPECIALTY SERVICES.....	32
13. PREVENTIVE SERVICES .....	34
14. EMERGENCY MEDICAL RESPONSE/DRILLS & EQUIPMENT .....	36
15. CLINICAL ENVIRONMENT .....	38
16. QUALITY OF NURSING PERFORMANCE.....	39
17. QUALITY OF PROVIDER PERFORMANCE .....	41
PRIOR CRITICAL ISSUE RESOLUTION .....	45
NEW CRITICAL ISSUES .....	57
CONCLUSION.....	57
PATIENT INTERVIEWS.....	59

## DATE OF REPORT

March 4, 2016

## INTRODUCTION

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

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

This report provides the findings associated with the onsite audit conducted between December 1-3, 2015, at Tallahatchie County Correctional Facility (TCCF), which is located in Tutwiler, Mississippi, in addition to the findings associated with the review of various documents and patient medical records for the audit review period of May through October 2015. At the time of the audit, CDCR's *Weekly Population Count*, dated December 4, 2015, indicated TCCF has a design capacity of 2,682 beds, of which 2,380 were occupied with CDCR inmates.

## EXECUTIVE SUMMARY

From December 1 through 3, 2015, the CCHCS audit team conducted an onsite health care monitoring audit at TCCF. The audit team consisted of the following personnel:

Ralph Delgado, Medical Doctor, Regional Physician Advisor  
Bruce Barnett, Medical Doctor, JD, MBA, CCHP, Chief Medical Consultant  
Luzviminda Pareja, RN, MSN, Nurse Consultant Program Review  
Donna Heisser, Health Program Manager II  
Susan Thomas, Health Program Specialist I

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

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

Based on the quantitative reviews and clinical case reviews completed for the 17 operational areas/quality indicators during the audit, TCCF achieved an overall point value of **0.9** which resulted in an overall audit rating of **inadequate**.

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

### Executive Summary Table

Operational Area/Quality Indicator	Case Review Rating	Quantitative Review Score	Quantitative Review Rating	Overall Indicator Rating	Points Scored
1. Administrative Operations	N/A	100.0%	Proficient	<b>Proficient</b>	2.0
2. Internal Monitoring & QM	N/A	82.3%	Inadequate	<b>Inadequate</b>	0.0
3. Licensing/Certification, Training & Staffing	N/A	100.0%	Proficient	<b>Proficient</b>	2.0
4. Access to Care	Adequate	89.6%	Adequate	<b>Adequate</b>	1.0
5. Chronic Care Management	Inadequate	19.8%	Inadequate	<b>Inadequate</b>	0.0
6. Community Hospital Discharge	Adequate	85.3%	Adequate	<b>Adequate</b>	1.0
7. Diagnostic Services	Adequate	66.5%	Inadequate	<b>Inadequate</b>	0.0
8. Emergency Services	Adequate	N/A	N/A	<b>Adequate</b>	1.0
9. Health Appraisal/Health Care Transfer	Proficient	91.4%	Proficient	<b>Proficient</b>	2.0
10. Medication Management	Inadequate	85.8%	Adequate	<b>Inadequate</b>	0.0
11. Observation Cells	Adequate	81.3%	Inadequate	<b>Adequate</b>	1.0
12. Specialty Services	Inadequate	99.2%	Proficient	<b>Adequate</b>	1.0
13. Preventive Services	N/A	70.0%	Inadequate	<b>Inadequate</b>	0.0
14. Emergency Medical Response/Drills & Equipment	N/A	81.9%	Inadequate	<b>Inadequate</b>	0.0
15. Clinical Environment	N/A	97.0%	Proficient	<b>Proficient</b>	2.0
16. Quality of Nursing Performance	Adequate	N/A	N/A	<b>Adequate</b>	1.0
17. Quality of Provider Performance	Adequate	N/A	N/A	<b>Adequate</b>	1.0
<b>Average</b>					<b>0.9</b>
<b>Overall Audit Rating</b>					<b>Inadequate</b>

NOTE: For specific information regarding any non-compliance findings indicated in the tables above, please refer to the Identification of Critical Issues (located on page 14 of this report), or to the detailed audit findings by quality indicator (located on page 17) sections of this report.

## BACKGROUND AND PROCESS CHANGES

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

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

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

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

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

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

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

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

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

## OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

### **Quantitative Review**

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

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

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

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

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

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

The compliance score for each question is expressed as a percentage rounded to the nearest tenth. For example, a question scored 13 ‘Yes’, 3 ‘N/A’, and 4 ‘No’.

Compliance Score = 13 ‘Yes’ / 17 (13 ‘Yes’ + 4 ‘No’) = .764 x 100 = 76.47 rounded up to 76.5%.

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

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

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

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

Chapter 1 – 75.0% = Inadequate

Chapter 2 – 92.0% = Proficient

Chapter 3 – 89.0% = Adequate

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

## **Qualitative Review**

The *qualitative* portion of the audit consists of physician and nurse case reviews which evaluate areas of clinical access and the provision of clinically appropriate care which tends to defy numeric definition, but which nonetheless have a potentially significant impact on performance. The intention of utilizing the case reviews is to determine how the various medical system components inter-relate and respond to stress, exceptionally high utilization, or complexity. Individual patient cases are selected and reviewed on an individual basis similar to well established methods utilized by the Joint Commission on Accreditation of Healthcare. This type of review focuses on processes instead of outcomes.

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

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

### **1. Nurse Case Review**

The CCHCS nursing staff performs two types of case reviews:

- a. Detailed reviews - A retrospective review of ten selected patient health records is completed in order to evaluate the quality and timeliness of care provided by the facility's nursing staff during the audit review period. A majority of the patients selected for retrospective review are the ones with a high utilization of nursing services, as these patients are most likely to be affected by timely appointment scheduling, medication management, and referrals to health care providers.
- b. Focused reviews – Five cases are selected from the audit review period of which three cases consist of patients who were transferred into the facility. The cases are reviewed for appropriateness of initial nurse health screening, referral, timeliness of provider evaluations and continuity of care. The remaining two cases selected for review are patients, who were transferred out of the facility with pending specialty or chronic care appointments. These cases are reviewed to ensure that transfer forms contain all necessary documentation.

### **2. Physician Case Review**

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

## Overall Quality Indicator Rating

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

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

## Overall Audit Rating

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

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

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

- **Proficient** - Since the cut-off value for a proficient rating in the quantitative review is 90.0% and the highest available point value for quality rating is 2 , the threshold value range is calculated by multiplying the highest available points by 90.0%, which is:  $2 \times 90.0\% = 1.8$ . This value is a *constant* and has been determined to be the minimum value required to achieve a rating of *proficient*. Therefore, any overall score/value of 1.8 or higher will be rated as *proficient*. This is designed to mirror the performance standard established in the quantitative review (i.e., 90% of the maximum available point value of 2).
- **Adequate** - A threshold value of 1.0 has been determined to be the minimum value required to achieve a quality rating of *adequate*. Therefore, any value falling between 1.0 and 1.7 will be rated as *adequate*.

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

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

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

### **Scoring for Non-Applicable Questions and Double-Failures:**

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

### **Resolution of Critical Issues**

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

## IDENTIFICATION OF CRITICAL ISSUES

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

<b>Critical Issues – Tallahatchie County Correctional Facility</b>	
Question 2.4	The facility did not consistently submit the Sick Call, Specialty Services, Hospital Stay/Emergency Department, Chronic Care and Initial Intake Screening monitoring logs within the specified time frames.
Question 2.5	The facility did not consistently document the accurate dates for primary care provider (PCP) appointments in the Sick Call monitoring log.
Question 2.6	The facility did not consistently document the accurate dates for PCP referrals, specialist appointments, and registered nurse (RN) assessments in the Specialty Services monitoring log.
Question 2.8	The facility did not consistently document correct patient CDCR numbers, accurate dates for chronic care appointments, and patient refusals in the Chronic Care monitoring log.
Question 2.9	The facility did not consistently document the accurate dates for initial intake screening and initial health appraisal in the Initial Intake Screening monitoring log.
Question 4.6	The facility RN did not consistently document nursing diagnoses based on the documented subjective/objective assessment data in the patient medical records.
Question 4.9	Patients referred to the PCP based on RN assessments, were not consistently seen within the specified time frame.
Question 4.11	The facility RN did not consistently refer patients who presented to sick call three or more times for the same medical complaint to the PCP.
Question 5.2	The patients did not consistently receive their chronic care medications without interruption within the specified time frame.
Question 5.3	The facility did not document patient refusals of chronic care medications on the CDCR Form 7225, <i>Refusal of Examination and/or Treatment</i> , or similar form.
Question 5.4	The facility RN failed to refer patients to the PCP when they did not show or refused nurse administered/Direct Observation Therapy (DOT) medications for three consecutive days or 50 percent or more doses in a week.
Question 5.5	The PCP failed to see patients who were a no-show or refused nurse administered/DOT medications for three consecutive days or 50 percent or more doses in a week, within seven days of their referral.
Question 5.6	The facility RN failed to refer patients to the PCP when they did not show or refused their insulin.
Question 6.1	The facility RN did not consistently review the discharge plan upon patients' return following their discharge from a community hospital admission.
Question 6.4	The facility did not consistently administer/deliver all prescribed medications to the patients per policy or as ordered by the PCP upon their return following discharge from a community hospital admission.
Question 7.2	The PCP did not consistently review, sign, and date all patients' diagnostic test

	reports within two business days of receipt of results.
Question 7.3	The facility did not consistently provide the patients a written notification of their diagnostic test results within two business days of receipt of results.
Question 7.4	The PCP did not consistently see the patients for clinically significant/abnormal diagnostic test results within 14 days of the provider's review of the test results.
Question 9.2	The facility nursing staff did not consistently document that an assessment was completed for all patients who answered "YES" to any of the medical problems listed on the <i>Initial Health Screening form</i> (CDCR 7277/7277A) or similar form.
Question 9.8	The patients did not consistently receive a complete screening for the signs and symptoms of tuberculosis upon their arrival.
Question 9.9	The patients did not consistently receive a complete health appraisal within seven calendar days of their arrival at the facility.
Question 10.1	The PCP did not consistently provide education to the patients on their newly prescribed medications.
Question 10.2	The initial dose of the newly prescribed medication was not consistently provided to the patients as ordered by the provider.
Question 10.3	The facility nursing staff did not consistently confirm the identity of the patient prior to the delivery and/or administration of medications.
Question 10.5	The facility nursing staff did not consistently observe patients taking DOT medications.
Question 11.1	The facility nursing staff did not consistently assess the patients housed in the observation cell every eight hours or more as ordered by the PCP.
Question 11.3	A licensed clinician did not consistently conduct daily face-to-face rounds on patients housed in observation cell for suicide precaution/watch or awaiting transfer to a Mental Health Crisis Bed.
Question 13.5	The facility did not consistently provide annual screening of patients for signs and symptoms of tuberculosis.
Question 13.6	All patients were not offered an influenza vaccination for the most recent influenza season.
Question 14.7	The facility did not consistently re-supply and re-seal the emergency medical response (EMR) bags following their use during medical emergencies and/or drills.
Question 14.9	One of the facility's EMR bags did not contain all supplies identified on the EMR bag checklist in compliance with IMSP&P requirements.
Question 14.13	The facility's crash cart did not contain all the medications as required/approved per IMSP&P.
Question 14.14	The facility's crash cart did not have all the supplies identified on the facility's crash cart checklist.
Question 14.15	The facility did not consistently service all of the Automated External Defibrillators.
Question 14.16	The facility did not consistently calibrate the electrocardiogram machines.
Question 15.2	One of the facility's dental clinics did not have documentation showing that a spore testing had been completed for their autoclaving unit.

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

## AUDIT FINDINGS – DETAILED BY QUALITY INDICATOR

### 1. ADMINISTRATIVE OPERATIONS

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

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

The facility’s staff has access to the facility’s health care policies and procedures through the company’s website. The CCHCS auditors interviewed facility health care staff and staff was able to demonstrate how to access the facility’s/corporate health care policies and procedures.

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

#### Quantitative Review Results

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

<b>Administrative Operations</b>		<b>Yes</b>	<b>No</b>	<b>Compliance</b>
1.1	Does health care staff have access to the facility’s health care policies and procedures and know how to access them?	5	0	100%
1.2	Does the facility have written health care policies and/or procedures that are in compliance with <i>Inmate Medical Services Policies and Procedures</i> guidelines?	15	0	100%
1.3	Does the facility have current contracts/agreements for routine oxygen tank maintenance service, hazardous waste removal, and repair, maintenance, inspection, and testing of biomedical equipment?	3	0	100%
1.4	Does the patient orientation handbook/manual or similar document explain the sick call and health care grievance/appeal processes?	2	0	100%
1.5	Does the facility’s health care staff access the California Department of Corrections and Rehabilitation patient’s electronic medical record?	4	0	100%
1.6	Does the facility maintain a Release of Information log that contains all the required data fields?	1	0	100%
1.7	Are all patients’ written requests for health care information documented on a CDCR Form 7385, <i>Authorization for Release of Information</i> , and scanned/filed into the patient’s medical record?	10	0	100%

1.8	Are all written requests from third parties for release of patient medical information accompanied by a CDCR Form 7385, <i>Authorization for Release of Information</i> , from the patient and scanned/filed into the patient's medical record?	Not Applicable
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**Overall Quantitative Review Score: 100%**

**Comments:**

1. Question 1.8 – Not Applicable. There were no third party requests for patient health care information received during the audit review period; therefore, this question could not be evaluated.

## 2. INTERNAL MONITORING & QUALITY MANAGEMENT

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

**Case Review Rating:**  
*Not Applicable*  
**Quantitative Review Score [Rating]:**  
*82.3% [Inadequate]*  
**Overall Rating:**  
*Inadequate*

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

The facility only submitted the monitoring logs on time 50 percent of the time. In addition, the dates documented on the chronic care, specialty services, initial intake, and sick call monitoring logs consistently did not match the dates on records found in the electronic medical record. This is a systemic issue that continues to be problematic for the facility.

### Quantitative Review Results

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

<b>Internal Monitoring &amp; Quality Management</b>		<b>Yes</b>	<b>No</b>	<b>Compliance</b>
2.1	Does the facility hold a Quality Management Committee a minimum of once per month?	6	0	100%

2.2	Does the Quality Management Committee’s review process include documented corrective action plan for the identified opportunities for improvement?	1	0	100%
2.3	Does the Quality Management Committee’s review process include monitoring of defined aspects of care?	1	0	100%
2.4	Does the facility submit all monitoring logs (sick call, specialty care, hospital stay/emergency department, chronic care and initial intake screening) by the scheduled date per Private Prison Compliance and Monitoring Unit program standards?	45	45	50.0%
2.5	Are the dates documented on the sick call monitoring log accurate?	34	16	68.0%
2.6	Are the dates documented on the specialty care monitoring log accurate?	26	22	54.2%
2.7	Are the dates documented on the hospital stay/emergency department monitoring log accurate?	36	5	87.8%
2.8	Are the dates documented on the chronic care monitoring log accurate?	31	28	52.5%
2.9	Are the dates documented on the initial intake screening monitoring log accurate?	25	19	56.8%
2.10	Are the CDCR Forms 602-HC, <i>Patient-Inmate Health Care Appeals</i> , readily available to patients in all housing units?	23	0	100%
2.11	Are patients able to submit the CDCR Forms 602-HC, <i>Patient-Inmate Health Care Appeals</i> , on a daily basis in all housing units?	23	0	100%
2.12	Does the facility maintain a CCHCS Health Care Appeals log and does the log contain all the required information?	1	0	100%
2.13	Are the first level health care appeals being processed within specified time frames?	36	0	100%
<b>Overall Quantitative Review Score:</b>				<b>82.3%</b>

**Comments:**

1. Question 2.4 – The facility was required to submit 90 monitoring logs during the audit review period. The facility submitted the monitoring logs late 50% of the time. The three weekly logs were received late on May 5, 12, 19, 26; June 2, 9, 23, 30; July 7, 14, 21, 28; and on August 25, 2015. The two monthly logs were submitted late in May, June and July 2015. This equates to 50.0% compliance.

Type of Monitoring Log	Required Frequency of Submission	Number of Required Submissions for the Audit Review Period	Number of Timely Submissions	Number of Late Submissions
Sick Call	weekly	26	13	13
Specialty Care	weekly	26	13	13
Hospital Stay/Emergency Department	weekly	26	13	13
Chronic Care	monthly	6	3	3
Initial Intake Screening	monthly	6	3	3
<b>Totals:</b>		<b>90</b>	<b>45</b>	<b>45</b>

2. Question 2.5 – Fifty encounters on the Sick Call log were reviewed. Thirty four of the encounters had accurate documentation of dates; sixteen of the encounters were non-compliant based on the actual dates the patient saw the PCP; according to information found in the medical record. This equates to 68.0% compliance.
3. Question 2.6 – Forty-eight encounters on the Specialty Services log were reviewed. Twenty-six of the encounters had accurate documentation of dates; twenty-two of the encounters were not in compliance for the date documented on log. For example, the PCP Referral date is different than the date on progress note; incorrect documentation of dates when patient was seen by the specialist and date RN

completed assessments upon patient's return from a specialty appointment; and there was missing information (dates) on the log. This equates to 54.2% compliance.

4. Question 2.7 – Forty-one encounters on the Hospital Stay/Emergency Department were reviewed. Thirty-six of the encounters had accurate documentation of dates; five of the encounters were not in compliance as the facility documented incorrect dates. For example there were errors in the dates of hospital admission; return from hospital/emergency department and date of RN and PCP assessments upon patient's return from a hospital/emergency department. This equates to 87.8% compliance.
5. Question 2.8 – Fifty-nine encounters on the Chronic Care log were reviewed. Thirty-one of the encounters had accurate documentation of dates; twenty-eight of the encounters were not in compliance as the facility documented the incorrect date for the patient's last assessment. Additionally, the log contained wrong CDCR numbers and incorrect appointment dates (actual PCP appointment date). This equates to 52.5% compliance.
6. Question 2.9 – Forty-four encounters on the Initial Intake Screening log were reviewed. Twenty-five of the encounters had accurate dates documented. Nineteen of the encounters were not in compliance as the facility documented incorrect dates for Initial Health Screening and the Initial Health Appraisal. This equates to 56.8% compliance.

### 3. LICENSING/CERTIFICATIONS, TRAINING, & STAFFING

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

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

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

The facility is currently fully staffed per contractual requirements; the facility staffing consists of two physicians, two physician assistants, twenty-one registered nurses, ten licensed practical nurses, two certified medical aides, one health services administrator and two clinical nursing supervisors. The CCHCS Health Program Specialist I (HPS I) auditor reviewed all health care staff's professional licenses, cardiopulmonary resuscitation (CPR) certifications along with five random custody staffs' CPR certifications and found all licenses and certifications to be current. The HPS I reviewed the facility's training logs and found that all health care staff training on the facility's corporate revised policies and procedures were current.

## Quantitative Review Results

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

<b>Licensing/Certifications, Training, &amp; Staffing</b>		<b>Yes</b>	<b>No</b>	<b>Compliance</b>
3.1	Are all health care staff licenses current?	37	0	100%
3.2	Are health care and custody staff current with required medical emergency response certifications?	42	0	100%
3.3	Did all health care staff receive training on the facility's policies based on Inmate Medical Services Policies and Procedures requirements?	37	0	100%
3.4	Is there a centralized system for tracking licenses, certifications, and training for all health care staff?	1	0	100%
3.5	Does the facility have the required provider staffing complement per contractual requirement?	4	0	100%
3.6	Does the facility have the required nurse staffing complement per contractual requirement?	31	0	100%
3.7	Does the facility have the required clinical support staffing complement per contractual requirement? (COCF Only)?	8	0	100%
3.8	Does the facility have the required management staffing complement per contractual requirement? (COCF Only)	3	0	100%
3.9	Are the peer reviews of the facility's providers completed within the required time frames?	4	0	100%
<b>Overall Quantitative Review Score:</b>				<b>100%</b>

### Comments:

No deficiencies identified.

## 4. ACCESS TO CARE

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

**Case Review Rating:**  
*Adequate*  
**Quantitative Review Score [Rating]:**  
*89.6% [Adequate]*  
**Overall Rating:**  
*Adequate*

The CCHCS auditors reviewed 25 patient medical records for access to care and an additional 25 records during case reviews. Medical record reviews show the RN fails to document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data. Nursing staff fails to refer

patients who present to sick call three or more times for the same medical complaint, to the PCP. Additionally the patient is not seen within the specified time frame if the RN determines a referral to the primary care provider is necessary.

### Case Review Results

There were 126 encounters that were reviewed related to access to care; 112 encounters found to be adequate, and 14 were found with minor deficiencies which did not greatly impact access to care for the patients housed at TCCF.

- In Case 2, a patient with low back pain, sent to neurosurgery with incomplete neurological exam. PCP cut and pasted prior progress note into a current progress note; Laboratory test was ordered but not obtained; Magnetic Resonance Imaging of the spine was ordered stat (medical term which means “with immediate effect”) but was not completed until 9 days later.
- In Case 5, a patient is allowed by custody and medical unit to refuse medical observation cell placement as ordered by the medical provider. Also coronary risk factors were not reviewed, inadequate nursing assessment, and no documentation of site and level of pain.
- In Case 7, patient with twisted ankle sent out for x-ray unnecessarily without indication of significant risk for fracture, also with unnecessary clinic visits and delayed specialist report. Additionally patient seen for dizziness for six months with normal neurological exam and orthostatic vitals not assessed during visit.
- In Case 14, patient with seizures returning from the emergency room and emergency room reports not reviewed by PCP.

Based on their case review findings, the CCHCS auditors determined the access to care services provided by the facility to be adequate.

### Quantitative Review Results

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

<b>Access to Care</b>		<b>Yes</b>	<b>No</b>	<b>Compliance</b>
4.1	Does the registered nurse review the CDCR Form 7362, <i>Health Care Services Request</i> , or similar form on the day it is received?	25	0	100%
4.2	Following the review of the CDCR Form 7362, or similar form, does the registered nurse complete a face-to-face evaluation of a patient within the specified time frame?	23	2	92.0%
4.3	Does the registered nurse document the patient's chief complaint in the patient's own words?	25	0	100%
4.4	Does the registered nurse document the face-to-face encounter in Subjective, Objective, Assessment, Plan, and Education (SOAPE) format?	25	0	100%

4.5	Is the focused subjective/objective assessment conducted based upon the patient's chief complaint?	23	2	92.0%
4.6	Does the registered nurse document a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data?	15	10	60.0%
4.7	Does the registered nurse implement a plan based upon the documented subjective/objective assessment data that is within the nurse's scope of practice or supported by the nursing sick call protocols?	24	1	96.0%
4.8	Did the registered nurse document that effective communication was established and that education was provided to the patient related to the treatment plan?	22	3	88.0%
4.9	If the registered nurse determines a referral to the primary care provider is necessary, is the patient seen within the specified time frame?	14	4	77.8%
4.10	If the registered nurse determines the patient's health care needs are beyond the level of care available at the facility, does the nurse contact or refer the patient to the hub institution? (MCCF Only)	Not Applicable		
4.11	If the patient presented to sick call three or more time for the same medical complaint, does the registered nurse refer the patient to the primary care provider?	1	1	50.0%
4.12	Does nursing staff conduct daily rounds in segregated housing units? (COCF only)	119	1	99.2%
4.13	Does nursing staff conduct daily rounds in segregated housing units to collect CDCR Forms 7362, <i>Health Care Services Request</i> , or similar forms? (COCF only)	119	1	99.2%
4.14	Are CDCR Forms 7362, <i>Health Care Services Request</i> , or similar forms readily accessible to patients in all housing units?	1	0	100%
4.15	Are patients in all housing units able to submit the CDCR Forms 7362, <i>Health Care Services Request</i> , or similar forms on a daily basis?	23	0	100%
<b>Overall Quantitative Review Score:</b>				<b>89.6%</b>

### **Comments:**

*For questions 4.1 through 4.11, random sample of 25 medical records were reviewed for the audit review period.*

1. Question 4.2 –Twenty-three medical records had documentation that the registered nurse completes a face-to-face evaluation of a patient within the specified time frame following the review of the CDCR 7362, or similar form and two were non-compliant. This equates to 92.0% compliance.
2. Question 4.5 – Twenty-three medical records had documentation that the registered nurse conducted a focused subjective/objective assessment based upon the patient's chief complaint and two were non-compliant. This equates to 92.0% compliance.
3. Question 4.6 – Fifteen medical records had documentation that the RN documents a nursing diagnosis related to/evidenced by the documented subjective/objective assessment data and 10 were non-compliant. This equates to 60.0% compliance.
4. Question 4.7 –Twenty-four medical records had documentation that the registered nurse implements a plan based upon the documented subjective/objective assessment data that is within the nurse's scope of practice or supported by the nursing sick call protocols and one was non-compliant. This equates to 96.0% compliance.
5. Question 4.8 – Twenty-two medical records had documentation that the registered nurse documented that effective communication was established and that education was provided to the patient related to the treatment plan and three were non-compliant. This equates to 88.0% compliance.
6. Question 4.9 – Seven of the 25 medical records were not applicable to this question. Of the remaining 18 medical records, 14 had documentation showing if the RN determines a referral to the PCP is necessary,

the patient was seen within the specified time frame and 4 were non-compliant. This equates to 77.8% compliance.

7. Question 4.10 – Not Applicable. This question pertains to the in-state Modified Community Correctional Facilities only and does not apply to the out-of-state correctional facilities.
8. Question 4.11 – Twenty-three of the records reviewed were not applicable. Only one of the two remaining records had documentation that when a patient presented to sick call three or more times for the same medical complaint, the RN referred the patient to the PCP and the other record was non-compliant. This equates to 50.0% compliance.
9. Question 4.12 – The auditors reviewed the Nursing Daily Rounds Logs in all four Administrative Segregation Units (ASU) for the entire month of November 2015. Three ASUs had documentation that nursing staff conducted daily rounds on all 30 days. However, one ASU, H19, had documentation that nursing conducted daily rounds only 29 of the 30 days in November 2015. Of the total 120 (30 days X 4 ASUs) days requiring daily rounds to be conducted in ASU, 119 days had documentation that nursing staff conducted daily rounds in the segregated housing units. One day on the ASU, H19, Nursing Daily Round Log was missing documentation. This equates to 99.2% compliance.
10. Question 4.13 – As stated in question 12 above, the auditors reviewed all four ASUs Nursing Daily Round Logs for the month of November 2015. Of the total 120 (30 days X 4 ASUs) days requiring daily rounds to be conducted in ASU, 119 days had documentation that nursing staff conducted daily rounds in the segregated housing units to collect CDCR 7362, *Health Care Services Request* form, or similar forms. In one of the ASU's, H19, Nursing Daily Round Log was missing documentation for one day. This equates to 99.2% compliance.

## 5. CHRONIC CARE MANAGEMENT

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

CCHCS auditor's reviewed 25 electronic medical records for chronic care management and an additional 25 records were reviewed for case reviews. The medical record reviews showed the facility scored 19.8% compliance when it came to providing adequate medication management to their chronic care patients. Patients who refused their chronic care medication or missed doses were not referred to the PCP for medication non-compliance and refusals were not documented on the *Refusal of Examination and/or Treatment* or similar form.

**Case Review Rating:**  
*Inadequate*  
**Quantitative Review**  
**Score [Rating]:**  
*19.8% [Inadequate]*  
**Overall Rating:**  
*Inadequate*

### Case Review Results

During the chronic care case reviews, 16 encounters were reviewed with 8 encounters found to be adequate, and 2 encounters were found to have nursing deficiencies which involved medication management and those deficiencies are detailed in Chapter 10, *Medication Management*.

- In Case 12, patient followed for high blood pressure who refused his chronic care visit/vitals check. Provider failed to document potential complications on refusal form.
- In Case 14, a patient with seizures returned from the emergency room and PCP failed to document review of the emergency room discharge packet.
- In Case 15, obese patient with diabetes not monitored per protocols, no foot or skin examination documented and received insufficient dietary counseling for weight loss.

Based on their case review findings, the CCHCS auditors determined the chronic care services provided by the facility to be *inadequate*.

## Quantitative Review Results

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

<b>Chronic Care Management</b>		<b>Yes</b>	<b>No</b>	<b>Compliance</b>
5.1	Is the patient's chronic care follow-up visit completed as ordered?	27	3	90.0%
5.2	Are the patient's chronic care medications received by the patient without interruption within the required time frame?	8	20	28.6%
5.3	If a patient refuses his/her chronic care keep-on-person medications, is the refusal documented on the CDCR Form 7225, <i>Refusal of Examination and/or Treatment</i> , or similar form?	0	3	0.0%
5.4	If a patient does not show or refuses the nurse administered/direct observation therapy chronic care medication for three consecutive days or 50 percent or more doses in a week, is the patient referred to a primary care provider?	0	4	0.0%
5.5	If a patient does not show or refuses the nurse administered/direct observation therapy (NA/DOT) chronic care medication for three consecutive days or 50 percent or more doses in a week, is the patient seen by a primary care provider within seven calendar days of the referral?	0	3	0.0%
5.6	If a patient does not show or refuses his/her insulin, is the patient referred to a primary care provider for medication non-compliance?	0	7	0.0%
<b>Overall Quantitative Review Score:</b>				<b>19.8%</b>

### Comments:

*For the following questions a random sample of 30 medical records for the audit review period were reviewed.*

1. Question 5.1 – Twenty-seven of the records had documentation that the patient's chronic care follow-up visit were completed as ordered and three records were non-compliant as the patient was not seen within the time frame ordered by the PCP. This equates to 90.0% compliance.
2. Question 5.2 – Two records were not applicable. Of the 28 applicable records reviewed, 8 records had documentation that the patient's chronic care medications were received by the patient without interruption within the required time frame and 20 were filled only after the patients had run out of their previously filled medications, thus resulting in missed doses. This equates to 28.6% compliance.

3. Question 5.3 – Twenty-seven of the records reviewed were not applicable. Of the three applicable records, none contained documentation that the patient signed the CDCR Form 7225, *Refusal of Examination and/or Treatment*, or similar form when a he refused his/her chronic care keep-on-person medications. This equates to 0.0% compliance.
4. Question 5.4 – Twenty-six of the records reviewed were not applicable. Of the four applicable records, none contained documentation that the patient is referred to a PCP if the patient does not show or refuses the nurse administered/direct observation therapy chronic care medication for three consecutive days or fifty percent or more doses in a week. This equates to 0.0% compliance.
5. Question 5.5 – Twenty-seven of the records reviewed were not applicable. Of the three applicable records, none contained documentation the patient was seen by a PCP within seven days of being referred when a patient does not show or refuses the NA/DOT chronic care medications for three consecutive days or fifty-percent or more doses in a week. This equates to 0.0% compliance.
6. Question 5.6 – Twenty-three of the records reviewed were not applicable. Of the seven applicable records, none contained documentation of the patient being referred to a PCP for medication non-compliance if the patient does not show or refuses his/her insulin. This equates to 0.0% compliance.

## 6. COMMUNITY HOSPITAL DISCHARGE

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

CCHCS auditors reviewed 25 electronic medical records for community hospital discharge and an additional 25 records were reviewed for case reviews. The medical record review revealed TCCF nursing staff is not consistently documenting they are reviewing the discharge plans upon a patient's return from the emergency department or hospital visit and there is a lack of documentation that the patient is receiving his medication as ordered by the PCP upon return from the community hospital.

**Case Review Rating:**  
*Adequate*  
**Quantitative Review**  
**Score [Rating]:**  
85.3% [Adequate]  
**Overall Rating:**  
*Adequate*

### Case Review Results

Twenty-seven community hospital/discharge encounters were reviewed with 22 encounters found to have provided adequate care, and 5 encounters were found to have minor deficiencies which did not greatly impact health care provided to these patients. Nursing staff failed to administer or delivered all prescribed medications to the patient upon his return from a community hospital admission.

- In Case 6, a 37 year old patient with ongoing abdominal pain, tightness, bloating and belching with no documentation on medication administration record that medication was given as ordered and no documentation effective communication was confirmed.

Based on their case review findings, the CCHCS auditors determined the facility is providing adequate care to the patients upon their return from a community hospital visit.

### Quantitative Review Results

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

<b>Community Hospital Discharge</b>		<b>Yes</b>	<b>No</b>	<b>Compliance</b>
6.1	<i>For patients discharged from a community hospital or returned from the hub:</i> Does the registered nurse review the discharge plan upon patient's return?	11	6	64.7%
6.2	<i>For patients discharged from a community hospital or returned from the hub:</i> Does the registered nurse complete a face-to-face assessment prior to the patient being re-housed?	17	0	100%
6.3	<i>For patients discharged from a community hospital or returned from the hub:</i> Is the patient seen by the primary care provider for a follow-up appointment within five calendar days of return?	17	0	100%
6.4	<i>For patients discharged from a community hospital:</i> Are all prescribed medications administered/delivered to the patient per policy or as order by the primary care provider?	13	4	76.5%
<b>Overall Quantitative Review Score:</b>				<b>85.3%</b>

### Comments:

*For the following questions a random sample of 17 medical records for the audit review period were reviewed.*

1. Question 6.1 – Eleven of the medical records reviewed had documentation that the registered nurse reviewed the discharge plan upon patient's return from the community hospital and six did not have documentation the discharge plan was reviewed as required. This equates to 64.7% compliance.
2. Question 6.4 – Thirteen of the medical records reviewed had documentation all prescribed medications were administered/delivered to the patient per policy or as ordered by the PCP. Four records were non-compliant. This equates to 76.5% compliance.

## 7. DIAGNOSTIC SERVICES

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

CCHCS auditors reviewed 20 electronic medical records for community hospital discharge and an additional 25 records were reviewed during case reviews. The medical record reviews found patients did not consistently receive written notification of diagnostic test results within two business days of receipt of result; were not seen timely by the PCP for clinically significant/abnormal diagnostic test results; PCP failed to consistently review, sign, and date all patient’s diagnostic test reports within specific time frames; and diagnostic tests were not performed on the patient within the time frame specified by the PCP.

**Case Review Rating:**  
*Adequate*

**Quantitative Review Score [Rating]:**  
66.5% [*Inadequate*]

**Overall Rating:**  
*Inadequate*

### Case Review Results

During the case reviews, 48 encounters for diagnostic services were reviewed. There were 38 encounters found to have provided adequate care, and 10 encounters were found to have deficiencies.

- In Case 2, patient failed to receive his laboratory service in a timely manner although the test was ordered to be completed STAT.
- In Case 2, the patient refused laboratory services and nursing staff failed to have patient sign a refusal form and failed to document in the nursing progress note which laboratory services were refused.
- In Case 8, patient with orthostatic light headedness failed to receive an assessment of orthostatic vitals; inadequate EKG was not repeated; nursing failed to document what laboratory specimen was obtained.

The deficiencies found during the nursing and physician case reviews were minor in nature and did not greatly impact health care provided to these patients, the medical record review revealed the facility’s failure to consistently provide diagnostic tests and review test reports/results within the required time frames.

Based on their case review findings, the CCHCS auditors determined the quality of diagnostic services the facility is providing to the patient population is *inadequate*.

### Quantitative Review Results

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

<b>Diagnostic Services</b>		<b>Yes</b>	<b>No</b>	<b>Compliance</b>
7.1	Is the diagnostic test completed within the time frame specified by the primary care provider?	17	3	85.0%
7.2	Does the primary care provider review, sign, and date all patients’ diagnostic test report(s) within two business days of receipt of results?	13	6	68.4%

7.3	Is the patient given written notification of the diagnostic test results within two business days of receipt of results?	12	8	60.0%
7.4	Is the patient seen by the primary care provider for clinically significant/abnormal diagnostic test results within 14 days of the provider's review of the test results?	10	9	52.6%
<b>Overall Quantitative Review Score:</b>				<b>66.5%</b>

**Comments:**

*For the following questions a random sample of 20 medical records for the audit review period were reviewed.*

1. Question 7.1 – Seventeen of the medical records reviewed had documentation that diagnostic tests were completed within the time frame specified by the PCP and three were not completed within the required timeframe. This equates to 85.0% compliance.
2. Question 7.2 – One of the medical records reviewed for this question was not applicable. Thirteen of the applicable records had documentation that the PCP reviewed, signed, and dated all patients' diagnostic test report(s) within two business days of receipt of the results and six did not have documentation of the primary care provider's review, signature, and date within the required time frame. This equates to 68.4% compliance.
3. Question 7.3 – Twelve of the medical records reviewed had documentation that the patient was given written notification of the diagnostic test results within two business days of receipt of results and eight did not have documentation the patient was given written notification with-in the required time frame. This equates to 60.0% compliance.
4. Question 7.4 – One of the medical records reviewed for this question was not applicable. Ten of the applicable questions had documentation that the patient is seen by the PCP for clinically significant/abnormal diagnostic test results within 14 days of the provider's review of the test results and nine did not have documentation that the patient was seen by the primary care provider for clinically significant/abnormal diagnostic test results within the required time frame. This equates to 52.6% compliance.

## 8. EMERGENCY SERVICES

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

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

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

## Case Review Results

The CCHCS auditors reviewed 33 encounters related to Emergency Services indicator. Twenty seven of the encounters revealed adequate care was provided to the patients and 6 had minor deficiencies that did not greatly impact health care provided to these patients.

- In Case 5, patient who injured his back while in the shower, was sent to the emergency room (ER). During a follow-up visit, nursing failed to document a nursing assessment or diagnosis. Upon return from the ER, patient was allowed by custody and medical department to refuse placement in the observation cell, even though it had been ordered by the PCP. Additionally, there was a delay in administering medication.
- In Case 7, patient presented with vomiting and diarrhea for one day. Nursing staff failed to document a nursing diagnosis. Medication Administration Record (MAR) shows medication failed to be given as ordered and other medications were not documented as given.
- In Case 8, patient returned from emergency department and nursing note failed to document if discharge instructions or medications were noted. Nursing failed to complete and sign a refusal form when patient refused to be seen by the PCP and declined to sign the refusal form.

Based on their case review findings, the CCHCS auditors determined the facility is providing adequate emergency services to the patient population.

## 9. HEALTH APPRAISAL/HEALTH CARE TRANSFER

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

**Case Review Rating:**  
*Proficient*  
**Quantitative Review**  
**Score [Rating]:**  
*91.4% [Proficient]*  
**Overall Rating:**  
*Proficient*

CCHCS auditors reviewed 18 electronic medical records for *health appraisal/ health care transfer* indicator and an additional 25 records were evaluated for case reviews. During the medical record review, CCHCS nursing staff found facility nursing failed to document patient's assessment related to the medical problems identified during the initial health screening and whether patients were receiving initial health screenings or screenings for signs and symptoms of tuberculosis (TB) upon arrival to TCCF.

## Case Review Results

During the CCHCS auditors case reviews, 15 encounters for health appraisal/health care transfer services were reviewed. Of the 15 encounters reviewed, only one case was found to have a deficiency related to failure to document a nursing diagnosis.

- In Case 13, nursing staff failed to document a nursing diagnosis or assessment during the initial intake screening for a patient with a history of multiple drug abuse.

The deficiencies found during the medical record and case reviews did not significantly affect patient care; therefore, the CCHCS auditors found overall the facility is providing proficient initial health screenings and health appraisal services to the patients.

### Quantitative Review Results

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

<b>Health Appraisal/Health Care Transfer</b>		<b>Yes</b>	<b>No</b>	<b>Compliance</b>
9.1	Does the patient receive an initial health screening upon arrival at the receiving facility by licensed health care staff?	16	2	88.9%
9.2	If "YES" is answered to any of the medical problems on the <i>Initial Health Screening</i> form (CDCR 7277/7277A or similar form), does the registered nurse document an assessment of the patient?	7	3	70.0%
9.3	If a patient presents with emergent or urgent symptoms during the initial health screening, does the registered nurse refer the patient to the appropriate provider?	Not Applicable		
9.4	If a patient is not enrolled in the chronic care program but during the initial health screening was identified as having a chronic disease/illness, does the registered nurse refer the patient to the primary care provider to be seen within the required time frame??	1	0	100%
9.5	If a patient was referred to an appropriate provider during the initial health screening, was the patient seen within the required time frame?	3	0	100%
9.6	If a patient was enrolled in a chronic care program at a previous facility, is the patient scheduled and seen by the receiving facility's primary care provider within the time frame ordered by the sending facility's chronic care provider?	1	0	100%
9.7	If a patient was referred by the sending facility's provider for a medical, dental, or a mental health appointment, is the patient seen within the time frame specified by the provider?	2	0	100%
9.8	Does the patient receive a complete screening for the signs and symptoms of tuberculosis upon arrival?	14	4	77.8%
9.9	Does the patient receive a complete health appraisal within seven calendar days of arrival?	5	1	83.3%
9.10	If a patient had an existing medication order upon arrival at the facility, were the nurse administered medications administered without interruption and keep-on-person medications received within one calendar day of arrival?	6	1	85.7%

9.11	When a patient transfers out of the facility, are the scheduled specialty services appointments that were not completed, documented on a Health Care Transfer Information Form (CDCR 7371) or a similar form?	1	0	100%
9.12	Does the Inter-Facility Transfer Envelope contain all the patient's medications, current Medication Administration Record and Medication Profile?	4	0	100%
<b>Overall Quantitative Review Score:</b>				<b>91.4%</b>

**Comments:**

*For the following questions a random sample of 18 medical records were reviewed for the audit review period.*

1. Question 9.1 – Sixteen of the medical records reviewed had documentation that patients receive an initial health screening upon arrival at the receiving facility by licensed health care staff and two did not have documentation of an initial health screening being completed within the required time frame. This equates to 88.9% compliance.
2. Question 9.2 – Eight of the medical records reviewed for this question were not applicable. Seven of the medical records reviewed had documentation that the RN documented an assessment of the patient and three did not have documentation that the RN completed an assessment of a patient who answered yes to a history of drug or alcohol abuse and one who answered yes to having dental issues.. This equates to 70.0% compliance.
3. Question 9.3 – Not applicable. None of the medical records reviewed had encounters where a patient presented with emergent or urgent symptoms during the initial health screening and needed to be referred by the registered nurse to an appropriate provider.
4. Question 9.8 – Fourteen of the medical records reviewed had documentation the patient received a complete screening for the signs and symptoms of TB upon arrival and four records did not have documentation that the inmate received a complete screening for signs and symptoms of TB upon arrival. This equates to 77.8% compliance.
5. Question 9.9 – Twelve of the medical records reviewed for this question were not applicable as the patient received his health appraisal at a previous CCA facility. Five of the medical records reviewed had documentation that the patient received a complete health appraisal within seven calendar days of arrival and one record did not have documentation that the patient received a complete health appraisal within the required time frame. This equates to 83.3% compliance.
6. Question 9.10 – Eleven of the medical records reviewed for this question were not applicable as the patient did not have an existing medication order upon arrival at TCCF. Six of the medical records reviewed had documentation that if the patient had an existing medication order upon arrival at the facility, their prescription medications were administered without interruption and keep-on-person medications received within one calendar day of arrival and one record did not have documentation to show that the patient had received his medication without interruption upon their arrival. This equates to 85.7% compliance.

## 10. MEDICATION MANAGEMENT

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

indicator also factors in the appropriate storing and maintenance of refrigerated drugs and vaccines and narcotic medications.

During the onsite audit CCHCS physician auditors found that providers followed best practices when prescribing medications to patients. CCHCS physician auditors discussed prescribing practices and prescription of non-essential therapies with the facility's PCPs; and CCHCS auditors advised the facility to use the medication Narcan for all suspected drug overdoses and to create a nursing protocol to allow nursing staff to administer Narcan without waiting for PCP orders. Nursing protocols were established prior to the completion of the onsite audit which allows nursing staff to administer Narcan for any suspected drug overdoses without waiting for a PCP's order. This will increase patients' chance of survival if found suffering from a possible drug overdose.

**Case Review Rating:**

*Inadequate*

**Quantitative Review**

**Score [Rating]:**

85.8% [Adequate]

**Overall Rating:**

*Inadequate*

During the onsite audit, the CCHCS NCPR auditor observed six medication administrations (pill passes) performed by five nurses on both shifts in different areas of the facility. Two of the six nurses observed did not consistently confirm the identity of the patient receiving medications. During four pill passes, three nurses did not consistently conduct a mouth and cup check to ensure medications were taken (one nurse conducted pill pass twice at two different locations). The medication nurse at the ASU handed medication cups directly to the patient. While IMSP&P does not require nursing staff to refrain from handing medication directly to patient, the nurse auditor recommended that nursing staff adopt a safer practice when delivering medications to ASU patients such as placing the medication cup on the small window ledge rather than handing it directly to the patient.

CCHCS nursing staff reviewed 20 electronic medical records which revealed the PCP is not consistently documenting he/she is providing education to the patient for newly prescribed medication and that the initial dose of newly prescribed medication is not being administered to the patient as ordered.

## Case Review Results

The NCPR and physician auditors completed an additional 25 case reviews for the audit review period for Medication Management to determine compliance. During the case review, CCHCS auditors reviewed 34 encounters. Of those encounters, 12 were found to be adequate, and 22 were found to be deficient. CCHCS auditors case reviews found nursing staff consistently failed to document on the MAR; medications were administered as ordered; that medication were refilled; and medications were dispensed and administered as ordered by the PCP.

- In Cases 2, 3, 4, 5, 6, 7, 8, and 10, the patients' MARs do not document that prescribed medication were administered as ordered. For example, the MAR had documentation that medication was given late, medication was not refilled timely; or documentation that medications that were ordered were not administered.

Due to the numerous deficient findings associated with documentation of medication administration, the CCHCS auditors determined the facility is providing *inadequate* medication management services to the patients.

## Quantitative Review Results

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

<b>Medication Management</b>		<b>Yes</b>	<b>No</b>	<b>Compliance</b>
10.1	Does the prescribing primary care provider document that the patient was provided education on the newly prescribed medications?	11	9	55.0%
10.2	Is the initial dose of the newly prescribed medication administered to the patient as ordered by the provider?	15	5	75.0%
10.3	Does the nursing staff confirm the identity of a patient prior to the delivery and/or administration of medications?	4	2	66.7%
10.4	Does the same medication nurse who administers the nurse administered/direct observation therapy medication prepare the medication just prior to administration?	6	0	100%
10.5	Does the medication nurse directly observe a patient taking direct observation therapy medication?	2	4	33.3%
10.6	Does the medication nurse document the administration of nurse administered/direct observation therapy medications on the Medication Administration Record once the medication is given to the patient?	6	0	100%
10.7	Are medication errors documented on the Medication Error Report form?	1	0	100%
10.8	Are refrigerated drugs and vaccines stored in a separate refrigerator that does not contain food and/or laboratory specimens?	2	0	100%
10.9	Does the health care staff monitor and maintain the appropriate temperature of the refrigerators used to store drugs and vaccines twice daily?	2	0	100%
10.10	Does the facility employ medication security controls over narcotic medications assigned to its clinic areas?	4	0	100%
10.11	Are the narcotics inventoried at the beginning and end of each shift by licensed health care staff?	3	0	100%
10.12	Do patients, housed in Administrative Segregation Unit, have immediate access to the Short Acting Beta agonist inhalers and/or nitroglycerine tablets? (COCF only)	4	0	100%
<b>Overall Quantitative Review Score:</b>			<b>85.8%</b>	

### Comments:

For questions 10.1 and 10.2, a random sampling of 20 medical records were reviewed for the audit review period.

1. Question 10.1 – Eleven of the medical records reviewed had documentation that the prescribing primary care provider documented that the patient was provided education on the newly prescribed medications and nine did not have documentation of education being provided. This equates to 55.0% compliance.
2. Question 10.2 – Fifteen of the medical records reviewed had documentation that the initial dose of the newly prescribed medication was administered to the patient as ordered by the provider and five did not have documentation the initial dose was administered as ordered. This equates to 75.0% compliance.
3. Question 10.3 – A total of six pill passes were observed by the CCHCS nurse auditor during the onsite audit. Four pill passes observed were in compliance with nursing staff confirming the identity of a patient prior to the delivery and/or administration of medications and during two pill passes the nurse failed to

confirm the identity of patients prior to delivery and/or administered of medications. This equates to 66.7% compliance.

4. Question 10.5 – Of the six pill passes observed by the CCHCS nurse auditor, two pill passes were in compliance with the medication nurse directly observing a patient taking DOT medication and during four pill passes, the medication nurse failed to consistently conduct a mouth-cup check to ensure medications were taken. This equates to 33.3% compliance.

## 11. OBSERVATION CELLS

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

During the onsite audit, the CCHCS auditors found the facility's observation cells to be adequate, with one cell being unused due to maintenance issues. A custody officer is placed outside the door of the observation cell when a patient is housed inside.

CCHCS auditors found that the PCP did not conduct daily face-to-face rounds on patients housed in observation cells for suicide precaution or awaiting transfer to a Mental Health Crisis Bed. In some instances, the PCP failed to document the need for patient's placement in the observation cell and did not conduct a brief history and physical examination within 24 hours of placement; and occasionally patients were not consistently assessed by a RN every eight hours or more frequently as ordered by the PCP when housed in an observation cell.

***Case Review Rating:***

*Adequate*

***Quantitative Review***

***Score [Rating]:***

*81.3% [Inadequate]*

***Overall Rating:***

*Adequate*

### Case Review Results

CCHCS auditors reviewed 106 observation bed encounters in which 100 were found adequate and 6 were found deficient.

- In Case 4, patient involved in altercation with multiple injuries placed in an observation cell, however was not seen daily by PCP.
- In Case 5, patient who injured back while in the shower was sent to the emergency department (ED). Upon return from the ED, patient was allowed by custody and medical department to refuse placement in the observation cell as ordered by PCP.

Since the deficiencies identified during the case reviews did not significantly impact patient care, the CCHCS auditors determined the facility is providing adequate monitoring services to patients housed in the observation cells at TCCF.

### Quantitative Review Results

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

<b>Observation Cells (COCF only)</b>		<b>Yes</b>	<b>No</b>	<b>Compliance</b>
11.1	Is the patient assessed by a registered nurse every eight hours or more frequently as ordered by the primary care provider when housed in an observation cell?	16	4	80.0%
11.2	Does the primary care provider document the need for the patient's placement in the observation cell and a brief admission history and physical examination within 24 hours of placement?	19	1	95.0%
11.3	Does a licensed clinician conduct daily face-to-face rounds on patients housed in observation cell for suicide precaution/watch or awaiting transfer to a Mental Health Crisis Bed?	3	3	50.0%
11.4	Is there a functioning call system or a procedure in place where the patient housed in an observation cell has the ability to get the attention of health care staff immediately?	1	0	100%
<b>Overall Quantitative Review Score:</b>				<b>81.3%</b>

**Comments:**

*For the following questions a random sample of 20 medical records were reviewed for the audit review period.*

1. Question 11.1 – Sixteen of the medical records reviewed had documentation that the patient was assessed by a registered nurse every eight hours or more frequently as ordered by the primary care provider when housed in an observation cell; four did not have documentation the patient was assessed as ordered by the primary care provider. That equates to 80.0% compliance.
2. Question 11.2 – Of the 20 medical records reviewed, 19 had documentation by the PCP stating the need for the patient's placement in the observation cell and a brief admission history and physical examination within 24 hours of placement. One did not have the required documentation. That equates to 95.0% compliance.
3. Question 11.3 – Of the 20 medical records reviewed, 14 were non-applicable to this question as the patient was not housed the observation cell for suicide watch or awaiting transfer to the Mental Health Crisis Bed. Of the remaining six medical records reviewed, three had documentation that the patient was seen by a licensed clinician for a daily face-to-face encounter while housed in an observation cell for suicide precaution/watch or awaiting transfer to a mental health crisis bed; three did not have documentation they were seen for a daily face-to-face by a licensed clinician as required.. That equates to 50.0% compliance.

## **12. SPECIALTY SERVICES**

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

During the onsite audit the Health Services Administrator stated the facility rarely denies any referral for specialty services to determine compliance. The documentation of care from outside sources found to be inefficient or unreliably recorded in the medical record. In some cases only a brief handwritten note from the specialist was in the medical record, with no dictated note from specialty services appointment found in the medical record. The CCHCS physician auditor discussed his concern regarding the communication between facility PCP and outside sources of care.

**Case Review Rating:**  
*Inadequate*  
**Quantitative Review**  
**Score [Rating]:**  
99.2% [*Proficient*]  
**Overall Rating:**  
*Adequate*

### Case Review Results

Physician and nurse auditors reviewed 24 specialty services encounters. The auditors found 20 of the encounters to be adequate, while four were found to be inadequate due to the following:

- In Case 2, patient referred for a stat MRI of the spine failed to receive the service until nine days after the order.
- In Case 7, patient referred to the community hospital for a specialty consult; however, there was only a brief handwritten report from the consultant in the medical record stating dictation to follow, however there was no dictation found in the medical record.

The CCHCS auditors found that overall the facility is providing adequate specialty services to the patient population at TCCF.

### Quantitative Review Results

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

<b>Specialty Services</b>		<b>Yes</b>	<b>No</b>	<b>Compliance</b>
12.1	Is the primary care provider's request for specialty services approved or denied within the specified time frame? (COCF Only)	30	0	100%
12.2	Is the patient seen by the specialist for a specialty services referral within the specified time frame? (COCF Only)	30	0	100%
12.3	Upon return from the hub, a specialty consult appointment or community emergency department visit, does a registered nurse complete a face-to-face assessment prior to the patient's return to the assigned housing unit?	30	0	100%
12.4	Upon return from the hub, a specialty consult appointment or community emergency department visit, does a registered nurse notify the primary care provider of any immediate orders or follow-up instructions provided by the hub, a specialty consultant, or emergency department physician?	23	1	95.8%

12.5	Does the primary care provider review the specialty consultant's report, hub provider's report or the community emergency department provider's discharge summary and complete a follow-up appointment with the patient within the required time frame?	30	0	100%
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**Overall Quantitative Review Score: 99.2%**

**Comments:**

*For the following questions a random sample of 30 medical records for the audit review period were reviewed.*

1. Question 12.4 – Of the 30 medical records reviewed, 6 were non-applicable. Of the remaining 24 records reviewed, 23 contained documentation a registered nurse notified the PCP of any immediate orders or follow-up instructions provided by the specialty consultant, hospital or ER physician upon the patient's return from a specialty consult appointment, community hospital or ER visit. One record did not contain documentation. This equates to 95.8% compliance.

### 13. PREVENTIVE SERVICES

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

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

**Case Review Rating:**  
*Not Applicable*

**Quantitative Review Score [Rating]:**  
*70.0% [Inadequate]*

**Overall Rating:**  
*Inadequate*

CCHCS nursing staff reviewed 20 medical records for the audit review period relative to Preventative Services to determine compliance. The review revealed the facility failed to provide adequate preventative services to their patient population. There was no documentation to confirm if the patients were screened annually for signs and symptoms of TB; were offered influenza vaccinations for the most recent influenza season; the facility monitored patients monthly while on TB medications; or that the facility administered TB medications to patient as prescribed. There was no documentation to indicate if patients aged 50-75 years of age were offered colorectal screening. Nursing staff did not notify the PCP or public health nurse when the patient missed or refused anti-TB medications and there was no documentation found to show that the patients received a Tuberculin Skin Test annually.

#### Quantitative Review Results

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

<b>Preventive Services</b>		<b>Yes</b>	<b>No</b>	<b>Compliance</b>
13.1	<i>For patients prescribed anti-Tuberculosis medication(s):</i> Does the facility administer the medication(s) to the patient as prescribed?	8	0	100%
13.2	<i>For patients prescribed anti-Tuberculosis medication(s):</i> Does the nursing staff notify the primary care provider or a public health nurse when the patient misses or refuses anti-TB medication?	1	0	100%
13.3	<i>For patients prescribed anti-Tuberculosis medication(s):</i> Does the facility monitor the patient monthly while he/she is on the medication(s)?	7	1	87.5%
13.4	Do patients receive a Tuberculin Skin Test annually?	18	1	94.7%
13.5	Are the patients screened annually for signs and symptoms of tuberculosis?	1	19	5.0%
13.6	<i>For all patients:</i> Were the patients offered an influenza vaccination for the most recent influenza season?	3	17	15.0%
13.7	<i>For all patients 50 to 75 years of age:</i> Are the patients offered colorectal cancer screening?	21	3	87.5%
13.8	<i>For female patients 50 to 74 years of age:</i> Is the patient offered a mammography at least every two years?	Not Applicable		
13.9	<i>For female patients 21 to 65 years of age:</i> Is the patient offered a Papanicolaou test at least every three years?	Not Applicable		
<b>Overall Quantitative Review Score:</b>				<b>70.0%</b>

### **Comments:**

1. Question 13.3 – A random sample of eight records for patients who were taking anti-TB medications were reviewed. Seven records contained documentation showing the facility monitored the patient monthly while he was on anti-TB medication(s), one was non-compliant in showing the facility monitored the patient monthly while on the medication. This equates to 87.5% compliance.
2. Question 13.4 – Nineteen medical records were reviewed for patients who were required to receive annual Tuberculin skin test. Eighteen records had documentation that the patients received their annual Tuberculin Skin test. One record did not have the required documentation to show if the patient received his test. This equates to 94.7% compliance.
3. Question 13.5 – Twenty medical records were reviewed of patients required to receive annual TB screening. One medical record had documentation the patient was screened annually for signs and symptoms of TB, 19 cases did not have documentation of the inmates being screened annually for signs and symptoms of TB. This equates to 5.0% compliance.
4. Question 13.6 – A random sample of 20 medical records were reviewed to determine if the patient had been offered the influenza vaccine. Three medical records had documentation that the patients were offered an influenza vaccination for the most recent influenza season; seventeen did not have documentation that the patient was offered an influenza vaccination for 2014-2015 influenza season. This equates to 15.0% compliance.
5. Question 13.7 – Twenty-five medical records were reviewed. One record was non-applicable as he had previously received a colonoscopy in 2014. Twenty-one medical records had documentation that the patients were offered colorectal cancer screening; three did not have documentation that the patient was offered the screening. This equates to 87.5% compliance.
6. Questions 13.8 and 13.9 – Not Applicable as TCCF is a male prison and these questions pertain to the female population only.

## 14. EMERGENCY MEDICAL RESPONSE/DRILLS & EQUIPMENT

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

This indicator is evaluated by CCHCS nurses entirely through the review of emergency medical response documentation, inspection of emergency medical response bags (EMR) and crash carts (COCF only), and inspection of medical equipment located in the clinics.

No clinical case reviews are conducted for this indicator and therefore, the overall rating is based on the results of the quantitative review.

**Case Review Rating:**  
*Not Applicable*  
**Quantitative Review**  
**Score [Rating]:**  
81.9% [Inadequate]

**Overall Rating:**  
*Inadequate*

During the onsite audit the CCHCS nurse auditor found that while the facility has improved in this indicator since the previous audit in May 2015, there are still deficiencies related to the facility's maintenance of EMR bags, crash carts, and compliance with emergency medical response/drill procedures. Both crash carts maintained at the facility lacked some supplies listed on the crash cart checklist. Following instances where EMR bags were used during EMR drills or actual emergency medical responses, the facility failed to document on the EMR bag logs that the bags were opened, restocked and resealed. All six Automated External Defibrillator (AED) machines inspected were operational; however one AED machine (in the main medical clinic) was past the due date of service.

### Quantitative Review Results

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

<b>Emergency Medical Response/Drills &amp; Equipment</b>		<b>Yes</b>	<b>No</b>	<b>Compliance</b>
14.1	Does the facility conduct emergency medical response drills quarterly on each shift when medical staff is present?	22	0	100%
14.2	Does a Basic Life Support certified health care staff respond without delay after emergency medical alarm is sounded during an emergency medical response (man-down) and/or drill?	21	1	95.5%
14.3	Does a registered nurse or a primary care provider respond within eight minutes after emergency medical alarm is sounded for an emergency medical response (man-down) and/or drill?	22	0	100%
14.4	Does the facility hold an Emergency Medical Response Review Committee (EMRRC) a minimum of once per month?	6	0	100%
14.5	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required documents?	16	0	100%
14.6	Is the facility's clinic Emergency Medical Response Bag secured with a seal?	300	0	100%
14.7	If the emergency medical response and/or drill warrant an opening of the	17	4	81.0%

	Emergency Medical Response Bag, is the bag re-supplied and re-sealed before the end of the shift?			
14.8	If the emergency medical response bag has not been used for emergency medical response and/or drill, is it being inventoried at least once a month?	36	0	100%
14.9	Does the facility's Emergency Medical Response Bag contain only the supplies identified on the Emergency Medical Response Bag Checklist in compliance with Inmate Medical Services Policies and Procedures requirements?	5	1	83.3%
14.10	Is the facility's Medical Emergency Crash Cart secured with a seal? (COCF Only)	120	0	100%
14.11	If the emergency medical response and/or drill warrant an opening and use of the medical emergency crash cart, is the crash cart re-supplied and re-sealed before the end of the shift? (COCF Only)	Not Applicable		
14.12	If the medical emergency crash cart has not been used for a medical emergency and/or drill, was it inventoried at least once a month? (COCF Only)	12	0	100%
14.13	Does the facility's crash cart contain all the medications as required/approved per <i>Inmate Medical Services Policies and Procedures</i> ? (COCF Only)	0	2	0.0%
14.14	Does the facility's crash cart contain the supplies identified on the facility's crash cart checklist? (COCF Only)	0	2	0.0%
14.15	Does the facility have a functional Automated External Defibrillator with electrode pads located in the medical clinic?	5	1	83.3%
14.16	Does the facility have a functional 12-lead electrocardiogram machine with electrode pads? (COCF Only)	1	1	100%
14.17	Does the facility have a functional portable suction device?	2	0	100%
14.18	Does the facility have a portable oxygen system that is operational ready?	2	0	100%
<b>Overall Quantitative Review Score:</b>				<b>81.9%</b>

### Comments:

1. Question 14.2 – Twenty-two emergency medical drills or emergency medical responses were reviewed. Twenty one drills/responses showed documentation that a Basic Life Support certified health care staff responded without delay after the emergency medical alarm was sounded during an emergency medical response (man-down) and/or drill. This equates to 95.5% compliance.
2. Question 14.7 – Twenty-two emergency medical drills or emergency medical responses that warranted opening of the EMR bag were reviewed. For 17 of the 22 dates, the EMR Bag log had documentation that the EMR bag was re-supplied and re-sealed before the end of the shift. The remaining five dates did not reflect documentation of the EMR bag being opened, resupplied and resealed. This equates to 81.0% compliance.
3. Question 14.9 – Six EMR bags were examined. Five bags contained all the supplies identified on the EMR bag checklist in compliance with the IMSP&P requirements. One bag did not have a glucometer. This equates to 83.3% compliance.
4. Question 14.11 – Not Applicable. The EMRRC meeting minutes and the Crash Cart logs for both Main and P Medical were reviewed for the audit review period. Both had documentation that the emergency medical responses/drills during the audit review period did not warrant the opening of either Crash Cart. Therefore this question cannot be evaluated.
5. Question 14.13 – The two facility Crash Carts were examined. Both Crash Carts did not contain all the medications as required/approved per IMSP&P. Both crash carts did not contain the required epinephrine medication. This equates to 0.0% compliance.
6. Question 14.14 – The two facility Crash Carts were examined. Both crash carts did not contain all the supplies identified on the facility's crash cart checklist. Neither had all required IV catheters listed on the crash cart list. This equates to 0.0% compliance.

7. Question 14.15 – Of the facility’s six AEDs examined, five were fully operational and serviced within the past year. The remaining one was operational; however, it was not serviced was past the due date for service (July 2015). This equates to 83.3% compliance.
8. Question 14.16 – Of the facility’s two electrocardiogram (EKG) machines examined, one of the EKG machine in P Medical was not calibrated. This equates to 50.0% compliance.

## 15. CLINICAL ENVIRONMENT

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

**Case Review Rating:**  
*Not Applicable*  
**Quantitative Review Score [Rating]:**  
97.0% [*Proficient*]  
**Overall Rating:**  
*Proficient*

During the onsite audit, the CCHCS nurse auditor found the facility to be well within compliance levels for infection control with the exception of their autoclave sterilization in their dental clinic located in main medical, which shoulders the responsibility for sterilizing reusable medical equipment. The facility greatly improved their score related to daily environmental cleaning of common clinic areas with high foot traffic. The facility increased their compliance by 31.6 percentage points bringing them into compliance for this requirement. Although the facility scored well on this indicator, there was one exam room, P155, which had an ophthalmoscope that was not in working order.

The CCHCS auditors found that overall the facility is *proficient* in the cleanliness and maintenance of their clinical environment at TCCF.

### Quantitative Review Results

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

<b>Clinical Environment</b>		<b>Yes</b>	<b>No</b>	<b>Compliance</b>
15.1	Are packaged sterilized reusable medical instruments within the expiration dates shown on the sterile packaging?	2	0	100%
15.2	If autoclave sterilization is used, is there documentation showing weekly spore testing?	1	1	50.0%
15.3	Are disposable medical instruments discarded after one use into the biohazard material containers?	1	0	100%
15.4	Does clinical health care staff adhere to universal hand hygiene precautions?	5	0	100%
15.5	Is personal protective equipment readily accessible for clinical staff use?	3	0	100%

15.6	Is the reusable non-invasive medical equipment disinfected between each patient use when exposed to blood-borne pathogens or bodily fluids?	4	0	100%
15.7	Does the facility utilize a hospital grade disinfectant to clean common clinic areas with high foot traffic?	3	0	100%
15.8	Is environmental cleaning of common clinic areas with high foot traffic completed at least once a day?	59	1	98.3%
15.9	Is the biohazard waste bagged in a red, moisture-proof biohazard bag and stored in a labeled biohazard container in each exam room?	10	0	100%
15.10	Is the clinic's generated biohazard waste properly secured in the facility's central storage location that is labeled as a "biohazard" area?	2	0	100%
15.11	Are sharps/needles disposed of in a puncture resistant, leak-proof container that is closeable, locked, and labeled with a biohazard symbol?	15	0	100%
15.12	Does the facility store all sharps/needles in a secure location?	2	0	100%
15.13	Does the health care staff account for and reconcile all sharps at the beginning and end of each shift?	62	0	100%
15.14	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	8	0	100%
15.15	Is the facility's biomedical equipment serviced and calibrated annually?	41	0	100%
15.16	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	10	0	100%
15.17	Does the clinic visit location ensure the patient's visual and auditory privacy?	8	0	100%

**Overall Quantitative Review Score: 97.0%**

**Comments:**

1. Question 15.2 – The autoclave logs from the two dental clinics were reviewed (P and Main Medical) to ensure autoclave sterilization was in compliance with spore testing. The dental clinic located in P medical was in compliance with spore testing, however, the dental clinic located in main medical did not have documentation that spore testing was completed during the week of November 23-25, 2015. The dental clinics provide the autoclaving to sterile reusable medical equipment. This equates to 50.0% compliance.
2. Question 15.8 – The cleaning logs for both P medical and Main Medical were examined for the 30 days prior to the onsite audit. Of a total of 60 (2 logs X 30 day) days reviewed, Main Medical's log was missing documentation that environmental cleaning of common clinic areas with high foot traffic was completed at least once that day. This equates to 98.3% compliance.

## 16. QUALITY OF NURSING PERFORMANCE

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

**Case Review Results**

Based on the CCHCS Nurse detailed retrospective review of 10

**Case Review Rating:**  
*Adequate*

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

**Overall Rating:**  
*Adequate*

patient health records and focused review of five patient health records in which 266 encounters were reviewed, the quality of nursing performance at TCCF was *adequate*. Ten cases were found to contain 32 deficiencies related to nursing performance. The nursing services that were found to be inadequate/deficient include:

- nursing diagnosis not documented (Cases 2, 5, and 8);
- affected site and level of pain not documented (Case 5);
- refusal form not signed by two witnesses when patient refused to be seen and declined to sign consent (Case 8);
- delay of stat lab order (Case 2);
- nursing staff failed to document what labs were to be drawn on progress note, just documented labs were taken (Cases 2, 8, and 9);
- failure of nursing staff to complete and have patient sign refusal forms (Cases 2, 8, and 9);
- delay in administration of ordered medication (Cases 2, 3, 4, 5, 6, 7, and 10);
- medication not documented on MAR (Cases 3 and 5);
- no documentation that hospital/ED discharge instructions were noted (Case 8);
- medication administration record did not reflect that medications were given or filled timely (Cases 4, 5, 6, 7, and 10);
- vital signs and neurological checks were not taken at the frequency ordered by the PCP (Cases 5, 9, and 10);
- MRI of spine ordered stat but not completed until nine days later (Case 2).

<i>Case Number</i>	<i>Deficiencies</i>
<b>Case 2</b>	<b><i>Adequate.</i></b> Forty-two year old patient with low back pain, nurse failed to document a nursing diagnosis, MAR does not show medications were given as ordered, delay in diagnostic services (MRI and urine dipstick lab ordered stat, but not completed until days later), medication not given on time, and patient refused services but no refusal form completed and nursing note failed to document what laboratory exam was ordered, drawn, and/or refused.
<b>Case 3</b>	<b><i>Adequate.</i></b> Thirty-one year old patient followed-up after brain injury and for chronic facial acne. Medications were ordered by PCP; however, no documentation on the MAR that they were given to the patient.
<b>Case 4</b>	<b><i>Adequate.</i></b> Twenty-six year old patient with no chronic diagnosis involved in an altercation resulting with multiple injuries. MAR does not show medication was administered as ordered due to numerous missed doses and MAR has no documentation that medication was extended although documented on physician's orders.
<b>Case 5</b>	<b><i>Inadequate.</i></b> Fifty-six year old patient with history of asthma, possible blurry vision, chest pain, chronic obstructive pulmonary disease, depression, dry eye syndrome, esophageal reflux, indigestion, left ankle injury, left elbow joint pain, lumbago, major depressive disorder, neurodermatitis, xerosis cutis was allowed by custody and medical unit to refuse medical observation as ordered by medical providers. MAR does not have documentation to show medications were ordered or if they were refilled on time, MAR does not show that medication was administered as ordered, nursing notes fail to show that vital signs were taken every eight hours and neurological checks were done every three hours, inadequate nursing assessment, nurse failed to document the location and severity of pain, refusal form not completed and nursing staff failed to document a nursing diagnosis.
<b>Case 6</b>	<b><i>Adequate.</i></b> Thirty-seven year old patient with ongoing abdominal pain, tightness, bloating and belching. MAR shows Mylanta was not given consistently as ordered, there was a delay in

administering medications ordered, and MAR did not have documentation medication was administered.

**Case 7** **Adequate.** Thirty-five year old patient with chronic back pain and history of dyspepsia, acute gastroenteritis, abdominal pain, oral aphthous ulcers, localized osteoarthritis of multiple sites. MAR shows medication being administered late, no nursing diagnosis documented, and medication ordered by PCP not listed on MAR and nursing note does not indicate if medication was administered or not.

**Case 8** **Adequate.** Twenty-three year old patient with chronic problem of skin lesion on back and legs, headache and history of seizures. During audit review period patient had a wound on left flank area which was infected with Methicillin-resistant Staphylococcus Aureus (MRS). No nursing diagnosis documented, nursing failed to document type of laboratory specimen that was obtained, nursing failed to document if discharge instructions or medications were noted, and nursing failed to complete refusal form and did not get it signed by two witnesses when patient refused to be seen by PCP and declined to sign refusal form.

**Case 9** **Adequate.** Thirty-eight year old patient with chronic diagnoses of Hepatitis C, hypertension, hypothyroidism, and back pain. Patient was frequently non-compliant with his chronic care follow-up appointments. During the audit review period the patient had an infected wound to his left arm. Nursing staff failed to document the type of lab specimens that were obtained, vital sign flow sheets show blood pressure was not taken as frequently as ordered by the provider, nursing staff failed to have patient sign a refusal of services form and failed to document on the nursing note the type of laboratory studies the patient refused.

**Case 10** **Adequate.** Fifty-four year old patient with chronic diagnoses of chronic Hepatitis C and hypertension and history of first degree atrioventricular (AV) block, seborrheic dermatitis, skin callus and tinea pedis. MAR shows medications were delayed numerous times, MAR shows medication was not discontinued when ordered by the provider and was erroneously refilled, vital sign flow sheet shows blood pressure was not taken as frequently as ordered by the PCP.

The NCPR auditor made the following recommendations to improve nursing services provided to CDCR patient's housed at TCCF:

- While IMSP&P does not require nursing staff to refrain from handing medication directly to the patient, during medication administration in the ASU, nursing staff is encouraged to place the cup containing the medication on the small window ledge rather than handing the cup directly to the patient, thereby decreasing the chance of the patient grabbing the nurse's hand while giving the medication; and
- The facility should consider writing "Autoclave Date" or "Exp. Date" on autoclaved reusable/sterilized equipment packages to clearly state what the written date signifies.

## 17. QUALITY OF PROVIDER PERFORMANCE

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

## Case Review Results

Based on the CCHCS Physicians detailed retrospective review of 20 patient health records, the facility provider performance was *adequate*. There were a total of 201 physician encounters with 42 deficiencies identified related to provider performance. Most deficiencies were minor and unlikely to contribute to patient harm. Of the 20 provider cases reviewed, four cases (1, 3, 6 and 13), were found to be proficient in the care rendered by the providers at TCCF. The medical services provided by physician, physician extenders and nursing generally met the standards of care applied in California prisons. However, in 6 out of 20 patients reviewed, overall care was deemed inadequate.

**Case Review Rating:**  
*Adequate*

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

**Overall Rating:**  
*Adequate*

There is substantial room for improvement in oversight of physician extenders. The facility needs to improve in their process of coordinating of nursing, custodian, physician and outside specialty services; i.e. verifying the status of the patient once he has refused health care services. In a few cases significant lapses in patient care, which were identified in the onsite review, increased the risk of adverse clinical outcomes. The provider services that were found to be inadequate/deficient include:

- Failure to document review of prior medical services (Case 14)
- Failure to document consequences and/or potential complications of refusals (Case 12)
- Incomplete examination (Cases 2 and 9)
- Provider copied and pasted documentation from previous progress notes (Cases 2 and 14)
- Failure by PCP to see patient while in observation room (Case 4)
- Coronary risk factors not reviewed (Case 5)
- Patient allowed to refuse placement in medical observation as ordered by provider (Case 5)
- Diagnostic services ordered – not indicated (Cases 7 and 18)
- Lack of specialty consultant’s dictated report in medical record (Case 7)
- Orthostatic vitals not assessed (Case 8)
- Inadequate EKG not reordered (Case 8)
- Patient allowed to refuse to be taken to medical clinic (Case 11)
- Patient not seen within required time frame (Case 11)
- Patient with uncontrolled diabetes not scheduled for follow-up for three months (Case 15)
- Insufficient (weight loss) dietary counseling (Case 15)
- Medication not medically indicated prescribed (Case 16)
- Delay in clinical supervision (Case 17)
- Delay in timeliness of medical action (Case 17)
- Failure to establish a diagnosis and treatment plan (Cases 17 and 18)
- Delay of appropriateness of medical action (Case 19)

<b>Case Number</b>	<b>Deficiencies</b>
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<b>Case 2</b>	<b>Adequate.</b> Forty-two year old patient with low back pain, sent to neurosurgery with incomplete neurological exam. Provider cut and pasted subjective from prior progress note. Hemocult test was positive but the patient was not followed up.
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<b>Case 4</b>	<b>Inadequate.</b> Twenty-six year old patient not seen by physician while in observation unit.
<b>Case 5</b>	<b>Inadequate.</b> Fifty-six year old patient allowed by custody and medical unit to refuse medical observation as ordered by medical providers. Coronary risk factors not reviewed with patient.
<b>Case 7</b>	<b>Adequate.</b> Thirty-eight year old patient with twisted ankle. Sent out for x-ray unnecessarily without indication of significant risk for fracture with unnecessary clinic visits and delayed specialist report.
<b>Case 8</b>	<b>Adequate.</b> Twenty-six year old patient with orthostatic vital signs not assessed despite complaint consistent with orthostatic hypertension. Inadequate EKG not reordered.
<b>Case 9</b>	<b>Adequate.</b> Twenty-five year old patient diagnosed as having otitis externa without documented ear exam.
<b>Case 11</b>	<b>Inadequate.</b> Forty-two year old patient not seen by medical providers as required by protocols within five days following his return from community hospital/emergency department. Patient refused to be taken to medical clinic to be seen by PCP.
<b>Case 12</b>	<b>Adequate.</b> Thirty-seven year old patient followed for high blood pressure. Provider failed to document potential complications on refusal form.
<b>Case 14</b>	<b>Adequate.</b> Twenty-eight year old patient with seizures. Emergency room reports not reviewed. Provider cut and pasted subjective from prior progress note.
<b>Case 15</b>	<b>Adequate.</b> Forty-five year old obese patient with uncontrolled diabetes not monitored per protocols and insufficient dietary counseling.
<b>Case 16</b>	<b>Adequate.</b> Forty-three year old patient with chronic shoulder pain prescribed muscle rub with Benadryl for sleep. Muscle rub is inappropriate treatment in a prison setting as there is insufficient medical evidence to demonstrate its effectiveness for significant muscular disease. Patient does not have any reported impairment in activities of daily living and muscle rub can be misused to injure others in a fight by rubbing the substance in opponents or peace officer's eyes.
<b>Case 17</b>	<b>Inadequate.</b> Twenty-seven year old patient with acute testicular pain has definitive surgical treatment delayed resulting in and loss of testicle.
<b>Case 18</b>	<b>Inadequate.</b> Thirty year old patient complains of left arm weakness and muscle wasting. No measurements taken of arm circumference, no diagnoses proffered, unnecessary laboratory tests ordered, follow-up delayed.
<b>Case 19</b>	<b>Inadequate.</b> Thirty-nine year old patient admitted for emergency treatment of severe narcotic overdose and was not provided Narcan. No follow-up care in prison after return from hospital as patient was allowed to refuse physician care without safety checks or mental health referral/consultation.
<b>Case 20</b>	<b>Adequate.</b> Twenty-two year old patient with follow-up for atypical chest pain and recurrent externa otitis. Investigation into chest pain seemed to not consider the patient's young age, history and lack of risk factors for heart disease.

The CCHCS physician auditors recommended the following to improve provider services at TCCF:

- Monthly meetings with TCCF PCP staff to review challenging cases and provide continuing education. The physician auditors also recommended CCHCS physicians be included, electronically, in the meetings;
- Consistent review of logs to identify patients needing further consideration by the medical director;

- Peer review to be completed among the four PCP;
- Creation and use of a log to document after hours phone call contact with providers;
- Medical director to encourage nursing staff to seek contemporaneous advice or physical examination of patients with new symptoms or worsening condition;
- Licensed providers to perform daily rounds of patients housed in observation cells;
- Request follow-up by custody safety report for patients who refuse offered health care appointments and consider mental health referral/evaluation when a patient's refusal places his health/life at risk;
- PCP to document phone calls to specialists, and emergency room physicians who have seen patients to ensure PCP and specialist/ER physicians communication; and
- Outside services (specialty consultants, emergency departments and community hospitals) should be required to e-mail or fax their reports to TCCF PCP the same day as service is rendered.

## PRIOR CRITICAL ISSUE RESOLUTION

The previous audit during May 2015 resulted in the identification of 45 quantitative critical issues. It should be noted that some of the critical issues previously identified may no longer be measured in the new audit instrument. Some of the questions that measured those requirements have been merged with questions that address a similar requirement, or are currently measured by new questions; some have been completely eliminated as a result of revisions to some of the policies and procedures in IMSP&P and other CCHCS standards that govern the delivery of inmate health care services. Although some of the critical issues are not directly measured by the audit instrument, they will most definitely be measured by the physician, nurse and NCPR auditors during medical record reviews, case reviews and during site visits.

During the current audit, auditors found 16 of the 45 issues resolved, 3 issues are no longer evaluated as they will be measured during nurse case review or through chart reviews and the remaining 26 not resolved to within the established compliance threshold. Below is a discussion of each previous critical issue:

1. *THE FACILITY'S PATIENT ORIENTATION HANDBOOK/MANUAL DOES NOT ADDRESS THE HEALTH CARE GRIEVANCE/APEAL PROCESS. (Formerly Section 1, Chapter 1, Question 18).*

Prior Compliance	Current Compliance	Status
0.0%	100%	<b>Resolved</b>

CCHCS HPS I auditor's review of the facility's inmate handbook/manual (Revised 8/2014) showed the handbook/manual failed to fully explain the health care grievance/appeal process, specifically the various levels of appeal. During the current audit the HPS I auditor found the handbook/manual had been revised (11/2015) and now fully explains the health care grievance/appeal process. This deficiency is considered resolved.

2. *THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE SICK CALL MONITORING LOGS TIMELY. (Formerly Section 1, Chapter 3, Question 1).*

Prior Compliance	Current Compliance	Status
35.3%	50.0%	<b>Unresolved</b>

The facility previously submitted 6 out of 17 (35.3%) sick call monitoring logs on time. The facility submitted 13 of the 26 sick call monitoring logs on time during the current audit period. This issue remains a deficiency and will be monitored during subsequent audits until resolved.

3. *THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE SPECIALTY CARE MONITORING LOGS TIMELY. (Formerly Section 1, Chapter 3, Question 4).*

Prior Compliance	Current Compliance	Status
41.2%	50.0%	<b>Unresolved</b>

The facility only submitted 7 out of 17 (41.2%) specialty services monitoring logs on time previously. The facility submitted 13 of the 26 specialty services monitoring logs on time during the current audit period. This issue remains a deficiency and will be monitored during subsequent audits until resolved.

4. *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATES ON THE SPECIALTY CARE MONITORING LOG(S). (Formerly Section 1, Chapter 3, Question 6).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
22.1%	54.2%	<b>Unresolved</b>

The facility previously accurately documented 17 out of 77 entries accurately on the specialty care monitoring log. The facility accurately documented 26 of 48 entries correctly on the specialty care monitoring log during the current audit period. This issue remains a deficiency and will be monitored during subsequent audits until resolved.

5. *THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE HOSPITAL STAY/EMERGENCY DEPARTMENT MONITORING LOGS TIMELY. (Formerly Section 1, Chapter 3, Question 7).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
41.2%	50.0%	<b>Unresolved</b>

The facility previously submitted 7 out of 17 hospital stay/emergency department monitoring logs on time. The facility submitted 13 of the 26 logs on time on the hospital stay/emergency department monitoring log during the audit review period. This issue remains a deficiency and will be monitored during subsequent audits until resolved.

6. *THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE CHRONIC CARE MONITORING LOGS TIMELY. (FORMERLY SECTION 1, CHAPTER 3, QUESTION 10).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
75.0%	66.7%	<b>Unresolved</b>

Previously the facility submitted three out of four chronic care monitoring logs on time. The facility submitted 4 of the 6 chronic care monitoring logs on time during the audit review period. This issue remains a deficiency and will be monitored during subsequent audits until resolved.

7. *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATES ON THE CHRONIC CARE MONITORING LOG(S). (FORMERLY Section 1, Chapter 3, Question 12).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
52.5%	52.5%	<b>Unresolved</b>

For the previous audit review period, the facility accurately documented 42 out of 80 entries. The facility accurately documented 31 out of 59 entries reviewed on the chronic care monitoring log for the current audit review period. This issue remains a deficiency and will be monitored during subsequent audits until resolved.

8. *THE FACILITY DOES NOT CONSISTENTLY SUBMIT THE INITIAL INTAKE SCREENING MONITORING LOGS TIMELY. (Formerly Section 1, Chapter 3, Question 13).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
75.0%	66.7%	<b>Unresolved</b>

The facility previously submitted three out of four (75%) initial intake screening monitoring logs on time. The facility submitted four of the six logs initial intake screening monitoring logs on time during the audit review period. This issue remains a deficiency and will be monitored during subsequent audits until resolved.

9. *THE FACILITY DOES NOT ACCURATELY DOCUMENT ALL THE DATES ON THE INITIAL INTAKE SCREENING MONITORING LOG(S). (Formerly Section 1, Chapter 3, Question 15).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
46.7%	56.8%	<b>Unresolved</b>

The facility accurately documented 28 out of 60 entries correctly on the initial intake screening monitoring logs during the previous audit period. The facility accurately documented 25 of 44 of the entries reviewed on the initial intake screening monitoring log correctly for the current audit review period. This issue remains a deficiency and will be monitored during subsequent audits until resolved.

10. *THE FACILITY DOES NOT CONSISTENTLY PROCESS THE FIRST LEVEL HEALTH CARE APPEALS WITHIN THE REQUIRED TIME FRAME. (Formerly Section 1, Chapter 6, Question 4).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
52.9%	100%	<b>Resolved</b>

The facility processed 9 out of 17 first level health care appeals within 30 days during the previous audit period. CCHCS HPS I auditor reviewed 20 first level appeals submitted during the audit review period. The auditor found that all 20 appeals were processed within the 30 day time frame. The facility is currently compliant with this requirement. Since TCCF has been successful in addressing and correcting this deficiency, this item is considered to be resolved

11. *FOLLOWING THE EXPOSURE TO CHEMICAL AGENTS AND REFUSING DECONTAMINATION, THE PATIENT IS NOT BEING MONITORED BY HEALTH CARE STAFF EVERY 15 MINUTES FOR NOT LESS THAN A TOTAL OF 45 MINUTES. (Formerly Section 2, Chapter 1, Question 1).*

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

12. *FOLLOWING EXPOSURE TO CHEMICAL AGENTS, THE FACILITY PROVIDERS DO NOT CONSISTENTLY ASSESS AND MEDICALLY CLEAR THE MEDICALLY UNSTABLE PATIENTS PRIOR TO THEIR RETURN TO THE HOUSING UNIT. (Formerly Section 2, Chapter 1, Question 2).*

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

13. *THE PATIENT'S CHRONIC CARE KEEP ON PERSON (KOP) MEDICATIONS ARE NOT CONSISTENTLY BEING RECEIVED BY THE PATIENT WITHOUT INTERRUPTION. (Formerly Section 2, Chapter 2, Question 2).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
35.7%	28.6%	<b>Unresolved</b>

During the previous audit, the review showed that 5 out of 14 medical records had documentation that the patient received their KOP medication without interruption. The medical record review for the current audit period showed that 8 out of 28 patients received their chronic care medications without interruption. In the new audit instrument, this requirement is being measured by Question 5.2. Since the facility has failed to address this deficiency effectively, it is considered to be unresolved and will continue to be monitored during subsequent audits until resolved.

14. *THE NURSING STAFF DOES NOT DOCUMENT THE PATIENT'S REFUSAL OF KEEP ON PERSON (KOP) CHRONIC CARE MEDICATIONS ON THE CDCR FORM 7225, OR SIMILAR FORM. (Formerly Section 2, Chapter 2, Question 3).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	0.0%	<b>Unresolved</b>

The auditors previously reviewed eight records and found that none had documentation that nursing documented patient refusals of KOP medications on CDCR 7225 form or similar form. In the new audit instrument, this requirement is measured by question 5.3. During the current audit, three records were reviewed and none showed that nursing documented patient refusals of KOP medications on CDCR 7225 form or similar form. Since the facility has failed to address this deficiency effectively, it is considered to be unresolved and will continue to be monitored during subsequent audits until resolved.

15. *THE PATIENT'S CHRONIC CARE NURSE ADMINISTERED/DIRECT OBSERVATION THERAPY (NA/DOT) MEDICATIONS ARE NOT CONSISTENTLY ADMINISTERED WITHOUT INTERRUPTION. (Formerly Section 2, Chapter 2, Question 4).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
37.5%	28.6%	<b>Unresolved</b>

Previously, auditors found out of eight medical records reviewed, three records had documentation that patients received chronic care NA/DOT medication without interruption. In the new audit instrument, this requirement is measured by question 5.3. During the current audit, out of 28 medical records reviewed, 8 records had documentation that patients received chronic care NA/DOT medication without interruption within the required time frame. Since the facility has failed to address this deficiency effectively, it is considered to be unresolved and will continue to be monitored during subsequent audits until resolved.

16. *THE 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. (Formerly Section 2, Chapter 2, Question 5).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	0.0%	<b>Unresolved</b>

Previously auditors reviewed 3 records and found that none had documentation to show that those patients who do not show or refuse their chronic care NA/DOT medications for 3 consecutive days or 50% or more doses in a week are referred to the provider for medication

non-compliance. Of the 4 medical records reviewed during the current audit, none had documentation to confirm that the requirement for referring patients to providers for chronic care medication was met. Since the facility has failed to address this deficiency effectively, it is considered to be unresolved and will continue to be monitored during subsequent audits until resolved.

17. *THE 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. (Formerly Section 2, Chapter 2, Question 6).*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	<b>Unresolved</b>

During the previous audit, auditors reviewed 4 records and found that none had documentation to show that the provider saw patients who refused their NA/DOT chronic care medication within 7 calendar days of the referral for medication non-compliance. In the new audit instrument, this requirement is measured by question 5.5. CCHCS auditors found of 3 medical records reviewed, none had documentation to show that this requirement was met. Since the facility has failed to address this deficiency effectively, it is considered to be unresolved and will continue to be monitored during subsequent audits until resolved.

18. *THE PATIENTS THAT DO NOT SHOW OR REFUSE THEIR INSULIN ARE NOT BEING REFERRED TO THE PROVIDER FOR MEDICATION NON-COMPLIANCE. (Formerly Section 2, Chapter 2, Question 7).*

Prior Compliance	Current Compliance	Status
0.0%	0.0%	<b>Unresolved</b>

CCHCS auditors reviewed 2 records during the previous audit and found that none had documentation to show that patients who do not show or refuse their insulin were referred to the provider for medication non-compliance. In the new audit instrument, this requirement is measured by question 5.6. CCHCS auditor's review of 7 medical records during the current audit found that none had documentation to show that this requirement was met. Since the facility has failed to address this deficiency effectively, it is considered to be unresolved and will continue to be monitored during subsequent audits until resolved.

19. *THE EMERGENCY MEDICAL RESPONSE REVIEW COMMITTEE (EMRRC) DOES NOT CONSISTENTLY REVIEW/EVALUATE EACH MEDICAL RESPONSE AND/OR EMERGENCY MEDICAL DRILL THAT IS SUBMITTED TO THE COMMITTEE FOR REVIEW. (Formerly Section 2, Chapter 4, Question 7).*

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

20. *THE EMERGENCY MEDICAL RESPONSE BAGS (EMR) DO NOT CONTAIN ALL THE SUPPLIES IDENTIFIED ON THE FACILITY'S EMR BAG CHECKLIST. (Formerly Section 2, Chapter 4, Question 11).*

Prior Compliance	Current Compliance	Status
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66.7%	83.3%	<b>Unresolved</b>
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Previously 4 out of the 6 EMR bags contained all the supplies identified on the facility’s EMR bag checklist. In the new audit instrument, this requirement is measured by question 14.9. Inspection of the EMR bags during the current audit found 5 out of the 6 bags contained all the supplies identified on the facility’s EMR bag checklist. Although the facility has shown marked improvement in this area, the facility has failed to achieve the required benchmark of 85.0% compliance. Since the facility has been only partially successful in addressing this deficiency effectively, it is considered to be unresolved and will continue to be monitored during subsequent audits until resolved.

21. *THE FACILITY HAS TWO CRASH CARTS; HOWEVER THE CRASH CART LOCATED IN MAIN MEDICAL MAIN MEDICAL CLINIC IS NOT INVENTORIED MONTHLY. (Formerly Section 2, Chapter 4, Question 15).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
50.0%	100%	<b>Resolved</b>

The audit team inspected the logs for the facility’s two crash carts for the audit period of four months (4X2=8 ) and found that one out of two crash carts was not inventoried on all 4 months when they were not used for a medical emergency or emergency drill. Currently, the facility’s two crash carts were inspected during the onsite audit the Crash Cart Logs had documentation that both carts were inventoried monthly (2 crash carts x 6 months = 12) when they were not used for a medical emergency or emergency drill. The findings show that TCCF has successfully addressed this deficiency, this item is considered resolved.

22. *THE FACILITY’S CRASH CARTS DO NOT CONTAIN ALL THE REQUIRED MEDICATIONS AS LISTED IN THE IMSP&P. (Formerly Section 2, Chapter 4, Question 16).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
50.0%	0.0%	<b>Unresolved</b>

During the last audit, one of the facility’s two crash carts contained all the required medications as listed in the IMSP&P. During the current audit, both crash carts were missing the medication Epinephrine. Inspection of the facility’s two crash carts found both were missing the medication Epinephrine. The facility ordered the medication while CCHCS auditors were on-site, however, this deficiency is considered unresolved and will continue to be monitored during subsequent audits as Question 14.13 until resolved.

23. *THE FACILITY’S CRASH CARTS DO NOT CONTAIN ALL THE SUPPLIES IDENTIFIED ON THE FACILITY’S CRASH CART CHECKLIST. (Formerly Section 2, Chapter 4, Question 17).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	0.0%	<b>Unresolved</b>

Neither of the facility’s crash carts contained all the supplies identified on the crash cart checklist during the previous audit. Currently, upon inspection of the two facility crash carts, it was found that both facility crash carts did not contain all required IV catheters listed on the crash cart checklist. This deficiency is considered unresolved and will continue to be monitored during subsequent audits as Question 14.14 until resolved.

24. ONE OF THE FACILITY'S PORTABLE OXYGEN SYSTEMS WAS MISSING A REQUIRED PIECE OF EQUIPMENT. (Formerly Section 2, Chapter 4, Question 20).

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
83.3%	100%	<b>Resolved</b>

On the previous audit, six portable oxygen systems were inspected and one of them was missing a nasal cannula. On the currently audit seven portable oxygen systems were inspected and all systems were found to be operationally ready. The facility is currently 100% compliant with this requirement. Since TCCF has been successful in addressing and correcting this deficiency, this issue is considered to be resolved.

25. THE ENVIRONMENTAL CLEANING OF FACILITY'S ADMINISTRATIVE SEGREGATION (AD SEG) UNIT CLINIC/EXAM ROOM IS NOT COMPLETED DAILY. (Formerly Section 2, Chapter 6, Question 8).

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
66.7%	NA	<b>Unresolved</b>

Previously TCCF failed to maintain a cleaning log for the Ad Seg. Unit clinic/exam room, however, during the current audit, the facility provided the CCHCS Nurse auditor with logs for all medical clinics', P Medical, Main Medical and Ad Seg clinic/exam room. Since the Ad/Seg clinic had not been utilized during the audit review period, the auditors did not evaluate this item based on current methodology. Therefore, this issue is considered to be unresolved and it will be monitored during subsequent audits until resolved.

26. THE PATIENTS ARRIVING AT THE FACILITY WITH EXISTING MEDICATION ORDERS ARE NOT CONSISTENTLY RECEIVING THEIR NA/DOT AND/OR KOP MEDICATION WITHOUT INTERRUPTION. (Formerly Section 2, Chapter 7, Question 6).

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
50.0%	85.7%	<b>Resolved</b>

Out of six medical records reviewed during the previous audit, three had documentation that the patients arriving at the facility with existing medication orders are consistently receiving their NA/DOT and/or KOP medication without interruption. During the current audit, six records were reviewed and five records contained documentation that patients who arrived at TCCF with existing medication orders received their NA/DOT and/or KOP medication without interruption. Since the findings show that TCCF has been successful in addressing and bringing compliance above the required 85% benchmark compliance, this issue is considered to be resolved.

27. THE PATIENTS ARRIVING AT THE FACILITY WITH AN EXISTING REFERRAL OR A SCHEDULED MEDICAL, DENTAL, OR MENTAL HEALTH APPOINTMENT ARE NOT SEEN BY THE FACILITY'S PROVIDER WITHIN THE SPECIFIED TIME FRAME. (Formerly Section 2, Chapter 7, Question 7).

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
0.0%	100%	<b>Resolved</b>

During the previous audit, only one medical record met the criteria for review. However, the review showed that the patient who had an existing referral or a scheduled medical, dental or mental health appointment was not seen by the facility's provider within the specified time frame. During the current audit, two medical records were found applicable for this requirement. Both records contained documentation that the patient was seen within the required time frame. Since the findings show that TCCF has been successful in addressing and resolving this deficiency, this issue is considered to be resolved.

28. *THE PROVIDERS DO NOT CONSISTENTLY COMPLETE A HEALTH APPRAISAL WITHIN FOURTEEN CALENDAR DAYS OF PATIENT'S ARRIVAL AT THE FACILITY. (Formerly Section 2, Chapter 7, Question 8).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
25.0%	83.3%	<b>Unresolved</b>

One out of the four medical records reviewed during the previous audit had documentation that the patient received a complete health appraisal within 14 calendar days of arrival at the facility. The current requirement is that the facility provides an initial health appraisal to the patient within seven calendar days of the patient's arrival. This change is in accordance with recent revisions to the *IMSP&P policy - Volume 4: Medical Services, Chapter 4.2.2: Reception Health Care Procedure*. In the new audit instrument, this requirement is measured by question 9.9. During the current audit, five out of six medical records that were reviewed showed that the patient received an initial health appraisal within seven days of their arrival at the facility. Since the facility has been only partially successful in addressing this deficiency effectively and failed to achieve the benchmark of 85% compliance, this issue is considered to be unresolved and it will continue to be monitored during subsequent audits until resolved.

29. *THE FACILITY DOES NOT CONSISTENTLY DOCUMENT ANY SCHEDULED SPECIALTY APPOINTMENTS ON CDCR FORM 7371 OR SIMILAR FORM FOR PATIENTS WHO TRANSFER OUT OF THE FACILITY. (Formerly Section 2, Chapter 7, Question 11).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
50.0%	100%	<b>Resolved</b>

On the previous audit, two out of the four qualifying medical records reviewed showed documentation that the staff documented all scheduled specialty appointments on a CDCR Form 7371 or similar form for those patients transferring out of the facility. During the current audit, only one medical record met the criteria for review and it was found to contain documentation on the CDCR 7371 form or similar form of the patient's scheduled specialty appointments. Since the findings show that TCCF has been successful in addressing and resolving this deficiency, this issue is considered to be resolved.

30. *THE PROVIDERS DO NOT CONSISTENTLY EDUCATE THE PATIENTS ON THE NEWLY PRESCRIBED MEDICATIONS. (Formerly Section 2, Chapter 8, Question 1).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
50.0%	55.0%	<b>Unresolved</b>

Previously 10 out of 20 medical records reviewed had documentation showing the providers educated the patients on newly prescribed medications. In the new audit instrument, this requirement is measured by question 10.1 in the new audit instrument, this requirement is measured by question 10.1. During the current audit, 11 out of 20 medical records had documentation the provider educated the patients on newly prescribed medications. Since TCCF has failed to address this deficiency effectively, it is considered to be unresolved and will continue to be monitored during subsequent audits until resolved.

31. THE NURSING STAFF DOES NOT CONSISTENTLY ADMINISTER THE INITIAL DOSE OF THE NEWLY PRESCRIBED MEDICATION TO THE PATIENT AS ORDERED BY THE PROVIDER. (Formerly Section 2, Chapter 8, Question 2).

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
50.0%	75.0%	<b>Unresolved</b>

Previously, 10 out of 20 medical records reviewed had documentation showing patients were administered the initial dose of newly prescribed medication as ordered by the provider. In the new audit instrument, this requirement is measured by question 10.2. During the current audit, 15 out of 20 medical records had documentation that the provider educated the patients on newly prescribed medications. Since TCCF has failed to address this deficiency effectively, it is considered to be unresolved and will continue to be monitored during subsequent audits until resolved.

32. *THE FACILITY'S NURSES THAT DISTRIBUTE MEDICATION ARE NOT TOTALLY VERSED ON THE PROCESS OF DOCUMENTING MEDICATION ERRORS. (Formerly Section 2, Chapter 8, Question 8).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
50.0%	100%	<b>Resolved</b>

There were no medication errors reported during the previous audit period; however, when the auditors interviewed four medication nurses regarding facility's procedure for reporting medication errors, it was found that only two out of the four could accurately explain the facility's process. In the new audit instrument, this requirement is measured by question 10.7. During the current audit, the facility had one record that met the criteria for review and it was found that the facility staff documented the medication error. Since the findings show that TCCF has been successful in addressing and resolving the deficiency, this issue is considered to be resolved.

33. *THE 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. (Formerly Section 2, Chapter 9, Question 1).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
73.7%	80.0%	<b>Unresolved</b>

Previously 14 out of 19 patient records reviewed had documentation that the registered nurse checked the patient at the beginning of each shift within two hours or more frequently as ordered by the provider when they were housed in observation cells. In the current audit instrument, the question has been modified and the current requirement is that the patient is

required to be seen every eight hours or more frequently as ordered by the provider when housed in the observation unit. In the new audit instrument, this requirement is measured by question 11.1. During the current audit, 16 out of 20 records reviewed showed that patients were seen every eight hours or more frequently when housed in the observation unit. Since TCCF has been only partially successful in addressing this deficiency effectively and failed to achieve the benchmark of 85.0% compliance, this issue is considered to be unresolved and it will continue to be monitored during subsequent audits until resolved.

**34. THE PATIENTS PRESCRIBED ANTI-TB MEDICATION ARE NOT CONSISTENTLY RECEIVING THE MEDICATION AS PRESCRIBED BY PROVIDER. (Formerly Section 2, Chapter 11, Question 1).**

Prior Compliance	Current Compliance	Status
55.0%	75.0%	<b>Unresolved</b>

Eleven out of 20 patient's records reviewed during the previous audit contained documentation that the patients were consistently receiving the anti-TB medication as prescribed by the provider. During the current audit, six out of eight medical records reviewed had documentation patients prescribed anti-TB medication were consistently receiving the medication as prescribed by the provider. Since TCCF has failed to address this deficiency effectively, it is considered to be unresolved and will continue to be monitored during subsequent audits resolved.

**35. THE NURSING STAFF DOES NOT CONSISTENTLY NOTIFY THE PROVIDER WHEN A PATIENT MISSES OR REFUSES HIS ANTI-TB MEDICATION. (Formerly Section 2, Chapter 11, Question 2).**

Prior Compliance	Current Compliance	Status
11.1%	0.0%	<b>Unresolved</b>

Previously one out of nine medical records reviewed contained documentation that the provider was notified when the patient missed or refused his anti-TB medication. During the current audit, only two records met the criteria for review and it was found that both records did not have documentation to show that nursing staff notified the provider when the patient missed or refused his anti-TB medication. Since TCCF has failed to address this deficiency effectively, it is considered to be unresolved and will continue to be monitored during subsequent audits until resolved.

**36. THE FACILITY DOES NOT MONITOR THE PATIENT PRESCRIBED ANTI-TB MEDICATION EVERY MONTH WHILE THE PATIENT IS ON MEDICATION. (Formerly Section 2, Chapter 11, Question 3).**

Prior Compliance	Current Compliance	Status
60.0%	37.5%	<b>Unresolved</b>

Previously 12 out of 20 medical records contained documentation that the facility monitored the patients who are prescribed anti-TB medication every month while the patient is on the medication. In the new audit instrument, this requirement is measured by question 13.3. During the current audit, only 3 out of 8 medical records reviewed had documentation that patients were monitored monthly while on anti-TB medication. Since TCCF has failed to address this deficiency effectively, it is considered to be unresolved and will continue to be monitored during subsequent audits until resolved.

37. *THE FACILITY DOES NOT ANNUALLY SCREEN ALL THE PATIENTS FOR SIGNS AND SYMPTOMS OF TUBERCULOSIS. (Formerly Section 2, Chapter 11, Question 4).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
25.0%	5.0%	<b>Unresolved</b>

During the previous audit, 5 out of 20 medical records reviewed showed documentation that the facility screened all patients annually for signs and symptoms of tuberculosis. In the new audit instrument, this requirement is measured by question 13.5. During the current audit, only 1 out of 20 medical records showed that the patient received the annual TB screening. Since the facility has failed to address this deficiency effectively, it is considered to be unresolved and will continue to be monitored during subsequent audits resolved.

38. *NOT ALL THE PATIENTS RECEIVE A TUBERCULIN SKIN TEST ANNUALLY. (Formerly Section 2, Chapter 11, Question 5).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
62.5%	94.7%	<b>Resolved</b>

Sixteen medical records reviewed during the previous audit showed ten contained documentation that the patients received a TB skin test annually. In the new audit instrument, this requirement is measured by question 13.4. During the current audit, 18 out of 19 medical records showed documentation that patients received an annual TB skin test. Since the findings show that TCCF has been successful in addressing and resolving the deficiency, this issue is considered to be resolved.

39. *BASED UPON INCONSISTENT DOCUMENTATION IN THE MEDICAL CHART, IT CANNOT BE DETERMINED IF THE INFLUENZA VACCINATION IS CONSISTENTLY OFFERED TO THE PATIENT POPULATION OR IF THE PATIENT REFUSED THE VACCINATION. (Formerly Section 2, Chapter 11, Question 6).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
55.0%	15.0%	<b>Unresolved</b>

Eleven out of twenty medical records reviewed previously contained documentation the patient was offered the influenza vaccine. In the new audit instrument, this requirement is measured by question 13.6. During the current audit, only 3 out of 20 medical records reviewed showed that the patient was offered the influenza vaccination for the most recent Influenza season. Since TCCF has failed to address this deficiency effectively, it is considered to be unresolved and will continue to be monitored during subsequent audits until resolved.

40. *THE FACILITY DOES NOT CONSISTENTLY OFFER COLORECTAL CANCER SCREENING TO PATIENTS 50 TO 75 YEARS OF AGE. (Formerly Section 2, Chapter 11, Question 7).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
80.0%	87.5%	<b>Resolved</b>

Previous documentation showed 16 out of 20 medical records reviewed contained documentation that colorectal cancer screening was offered to qualifying patients. In the new audit instrument, this requirement is measured by question 13.7. During the current audit, 21 out of 24 medical records reviewed had documentation that the patients were offered colorectal screening. Since the findings show that TCCF has been successful in addressing and resolving the deficiency, this issue is considered to be resolved.

41. *THE NURSING STAFF DOES NOT CONSISTENTLY CONDUCT A FOCUSED SUBJECTIVE/OBJECTIVE ASSESSMENT BASED UPON THE PATIENT'S CHIEF COMPLAINT. (Formerly Section 2, Chapter 12, Question 6).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
68.4%	92.0%	<b>Resolved</b>

Previously 13 out of 18 medical records reviewed contained documentation that nursing staff completed a focused subjective/objective assessment based upon the patient's chief complaint. In the new audit instrument, this requirement is measured by question 4.5. During the current audit, 23 out of 25 medical records reviewed showed documentation of the focused subjective/objective assessment. Since the findings show that TCCF has been successful in addressing and resolving the deficiency, this issue is considered to be resolved.

42. *THE NURSING STAFF DO NOT CONSISTENTLY DOCUMENT THAT EDUCATION WAS PROVIDED TO THE PATIENT RELATED TO THE TREATMENT PLAN AND THAT EFFECTIVE COMMUNICATION WAS ESTABLISHED. (Formerly Section 2, Chapter 12, Question 9).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
68.4%	88.0%	<b>Resolved</b>

Chart review of 19 medical records during the previous audit showed that 13 records contained documentation that education was provided to the patient related to the treatment plan and that effective communication was established. In the new audit instrument, this requirement is measured by question 4.8. During the current audit, 22 out of 25 medical records reviewed had documentation that education was provided to the patient related to the treatment plan and that effective communication was established. Since the findings show that TCCF has been successful in addressing and resolving the deficiency, this issue is considered to be resolved.

43. *THE PATIENTS ARE NOT CONSISTENTLY SEEN FOR A FOLLOW-UP APPOINTMENT WITHIN THE SPECIFIED TIME FRAME. (Formerly Section 2, Chapter 12, Question 14).*

<u>Prior Compliance</u>	<u>Current Compliance</u>	<u>Status</u>
63.6%	100%	<b>Resolved</b>

Previously seven out of eleven medical records reviewed contained documentation that the patients were seen for a follow-up appointment within the specified time frame after their return to the facility from a hospital/emergency department visit. In the new audit instrument, this requirement is measured by question 6.3. During the current audit, all 17 medical records reviewed had documentation that the patient had a follow-up appointment within the specified timeframe following their return from a hospital/emergency department visit. Since the findings show that TCCF has been successful in addressing and resolving the deficiency, this

issue is considered to be resolved. The findings show that TCCF has successfully addressed this deficiency, this item is considered resolved.

44. *THERE IS NO EVIDENCE THAT THE NURSING STAFF CONDUCTS DAILY ROUNDS IN ADMINISTRATIVE SEGREGATION UNITS TO PICK-UP SICK CALL SLIPS. (Formerly Section 2, Chapter 12, Question 17).*

Prior Compliance	Current Compliance	Status
0.0%	99.2%	<b>Resolved</b>

Previously, sign-in logs for the ASU were reviewed and had documentation that sick call rounds were completed; however, there was no specific documentation of nursing staff conducting rounds to pick up sick call slips. During the current audit, sign-in logs for 4 ASUs were reviewed for a 30 day period. Out of a total of 120 (4 logs X 30 days) days of rounds reviewed, 119 days had documentation of nursing staff picking up sick call slips. Since the findings show that TCCF has been successful in addressing and resolving the deficiency, this issue is considered to be resolved.

45. *THE FACILITY DOES NOT PROVIDE ALL THE CLINICS WITH PROPER EQUIPMENT, SUPPLIES, AND ACCOMMODATIONS FOR PATIENT VISITS. (Formerly Section 2, Chapter 12, Question 20).*

Prior Compliance	Current Compliance	Status
37.5%	100%	<b>Resolved</b>

During the May 2015 audit, three out of eight exam rooms inspected during the onsite audit had the proper equipment, supplies and accommodations for the patient encounters/visits. The other five exam rooms were either missing the required equipment or the equipment was not functional. In the new audit instrument, this requirement is measured by question 15.16. During the current audit, all common areas and exam rooms contained the essential core medical equipment and supplies needed for patient encounters/visits. Since the findings show that TCCF has been successful in addressing and resolving the deficiency, this issue is considered to be resolved.

## NEW CRITICAL ISSUES

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

## CONCLUSION

During the current audit, the facility's performance was rated *inadequate*. Of the 17 quality indicators evaluated, CCHCS found 4 *proficient*, 7 *adequate*, and 6 *inadequate* (see Executive Summary Table on page 4). While the facility resolved 15 of the 45 deficiencies identified in the previous audit, 27 remain unresolved and will be monitored in subsequent audits and 3 are no longer being measured, or measured in combination with other questions. The facility's continued struggle with internal monitoring, specifically the completion of the weekly and monthly monitoring logs, chronic care

management, diagnostic, medication management, and preventative services has resulted in significant impediments to patient care. With only 30 percent of the previous deficiencies resolved, efforts to overcome these issues must be redoubled.

Two cases involving significant lapses in patient care during the onsite audit which resulted in adverse clinical outcomes for the patient were identified during the onsite audit. The facility is expected to work with and monitor health care staff (physicians, physician assistants, and nurses) to ensure they are providing appropriate health care to eliminate significant lapses in patient care, thereby reducing the risk of adverse clinical outcomes. The two cases involving significant lapses in patient care identified during the onsite audit were discussed in length during the onsite audit with health care management staff. During the facility's audit exit meeting, these cases, along with the outstanding and new deficiencies found during the audit, were again discussed with the facility's executive and health care management staff. The facility's executive and health care management team acknowledged the findings and stated they will work diligently to resolve any outstanding and new critical issues. In addition, they will ensure health care staff receive additional training and supervision where required.

## PATIENT INTERVIEWS

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

<b>Patient Interviews (not rated)</b>	
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?
<i>Questions 9 through 21 are only applicable to ADA patients.</i>	
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:**

A combination of 15 patients in both general population and ASU were interviewed by the CCHCS HPS I auditor for questions 1 through 8. At the time of the onsite audit, TCCF housed 12 Disability Placement Program (DPP) patients. The HPS I auditor interviewed 11 of the 12 DPP patients, one patient declined to be interviewed. In addition, three IAC members were interviewed. Below is a summary of the responses received during the interviews:

1. Regarding questions 1 through 4 – All patients were able to fully explain the facility’s sick call process, describe where/how to obtain a sick call request form and where to place the form when it is completed. While none of the patients stated they required assistance completing the forms, they stated if a patient needed assistance filling out the sick call form they could ask a fellow inmate, custody or health care staff. None of the 15 patients interviewed had any negative comments regarding the sick call or health services provided at TCCF.
2. Regarding questions 5 through 8 – Fourteen of the fifteen patients interviewed were able to fully explain the facility’s Health Care Grievance/Appeal process, describe where/how to obtain a Grievance/Appeal (602-HC) form and where to place the form when it is completed. While none of the patients stated they required assistance completing the form, they stated they could ask a fellow inmate, custody or health care staff for assistance. The auditor explained the Health Care Grievance/Appeal process to the one patient who stated he was not aware of the process. The patient was able to verbalize his understanding of the process.
3. Regarding question 9 – All 11 DPP patient interviewed were able to describe their documented qualifying disability.
4. Regarding question 10 –All 11 DPP patients interviewed were able to describe their documented accommodations such as lower bunk, lower tier, medical appliance, and/or accommodations for learning disability.
5. Regarding question 11 – Ten of the eleven patients interviewed were able to describe the process and identify the form used to request reasonable accommodation. The eleventh patient stated he would request reasonable accommodation by submitting a sick call request. The HPS I auditor described the process to the patient on how to request reasonable accommodation if he felt he needed it. He stated he understood the process.
6. Regarding question 12 –Ten of the eleven patients interviewed were able to describe who to contact in order to request a reasonable accommodation form if needed. The HPS I auditor informed the eleventh patient that he could request a reasonable accommodation form from the housing custody officer, facility’s ADA coordinator, or from any of the health care staff. He stated he would request the form from a housing custody officer if he needed one.
7. Regarding question 13 – All 11 patients reported they had received their reasonable accommodation while previously housed in a prison in California. All inmates indicated they had received reasonable accommodation in a timely manner at the current facility upon their arrival.
8. Regarding question 14 – Three of the eleven patients reported they have previously used the repair services or are in the process of using the medical appliance repair program. Patient number 1 reported he felt his repair was completed very promptly; Patient number 2 stated he was currently waiting for an appointment to see a specialist to have his hearing aid repaired; Patient number 3 enquired how to use the program as he needed to have his cane shortened. The HPS I auditor spoke with the facility ADA coordinator regarding patients number 2 and 3. She reported she would check into the issues for patient 2 and promptly had patient number 3 brought back to medical where his cane was shortened while he waited in the main medical clinic. Both issues were resolved the same day that the interview was conducted.
9. Regarding question 15 – Patient number 1 reported he did not receive interim accommodation while his appliance (hearing aid) was repaired since he could understand conversations due to his ability to read lips. Patient number 2 reported he had one functioning hearing aid he wears

and also had a vest provided for hearing impaired inmates. Patient number 3 did not require any accommodation as he waited in the medical clinic while his cane was shortened.

10. Regarding question 16 – All 11 patients were able to describe the process for filing a grievance/appeal for their disability related issue.
11. Regarding question 17 – All 11 patients reported they did not require any assistance obtaining or completing a CDCR 602-HC Inmate/Parolee Health Care Appeal Form, CDCR 1824 Reasonable Modification or Accommodation Request Form, or similar form, but if needed, they could ask a fellow inmate or health care staff.
12. Regarding question 18 – Six of the eleven patients reported they have submitted an ADA grievance/appeal in the past. One of the six patients reported his ADA grievance/appeal was filed while at TCCF. He reported the appeal process had taken very short time and he received his response within 48 hours. Four patients reported their grievance/appeals were filed while housed in CDCR facilities within California and only one of the patients could recollect the approximate time it took for the process. He stated it took about 45 days to receive his response. One patient reported he filed an appeal while housed at CCA's North Fork Correctional Facility (NFCF) and was still waiting on his response. The HPS I auditor encouraged the patient to speak with the HSA regarding the outstanding appeal as NFCF is now closed. One patient reported he has not yet filed an appeal regarding his disability, but reported he is planning to file one shortly. The patient has a learning disability and requires additional time to take his General Education Development (GED) test and he states the medical department cannot help him as he needs to be tested for Dyslexia before the Mississippi Department of Education will allow him to have additional time to take his GED test. The HPS I auditor provided the name of the ADA contact (Correctional Counselor II (CC II)) to the patient. This contact is located at the CDCR's Contract Beds Unit (CBU). The patient stated that he is familiar with CBU's ADA contact and had reached out to her in the past. Upon return to California, the HPS I auditor contacted the CC II and gave her the patient's information and the CC II is working to see what accommodations could be afforded to the patient.
13. Regarding question 19 – All but one of the 11 patients knew the name of the ADA coordinator at TCCF. The one patient had recently arrived from another facility (less than 30 days prior) and had not met with the ADA coordinator yet. The HPS I auditor provided the name of the ADA coordinator to the patient.
14. Regarding question 20 – Ten of the eleven patients stated they have access to licensed health care staff to address any issues regarding their disability. One patient reported he has a learning disability and medical staff is unable to assist with his learning issues.
15. Regarding question 21 – All 11 patients stated that health care staff at TCCF take their time with the patient during their medical visits and explain things in a way they understand. All of the inmates reported they were very satisfied with the health care provided to them at TCCF.