September 11, 2018

Gerald Marshall, Chief
Patricia Spiro, Health Services Administrator
Delano Modified Community Correctional Facility
2727 West Industry Road
Delano, CA 93215

Dear Chief Marshall and Ms. Spiro,

The staff from California Correctional Health Care Services (CCHCS) completed an annual Private Prison Compliance and Health Care Monitoring Audit at Delano Modified Community Correctional Facility (DMCCF) on April 24 through 26, 2018. The purpose of this audit was to ensure DMCCF is providing a level of care consistent with the standards set forth in the Federal Receiver's *Turnaround Plan of Action* dated June 8, 2006.

On July 13, 2018, a draft report was provided to allow you the opportunity to review and dispute any findings presented in the report. On July 24, 2018, we received DMCCF's response and supporting documentation disputing seven deficiencies. Upon careful review and consideration, four of the seven deficiencies were removed. Please refer to the document, CCHCS Response to DMCCF Rebuttal, for additional information.

Attached is the final audit report in which DMCCF received an overall audit rating of ***Proficient*** with a compliance score of 91.1%. This compliance score is an increase of 4.4 percentage points from the prior October 2017 annual audit score of 86.7%. The health care standards associated with this audit are grouped into 14 components. As a result of this audit, nine components were rated proficient, four were rated adequate, and one was rated inadequate. The report contains an Executive Summary, list of critical issues, findings detailed by component, prior critical issue resolution, and an explanation of the methodology behind the audit.

The facility has shown significant improvements by resolving the majority of its past critical issues. The facility implemented an efficient internal audit process and tracking mechanisms to proactively identify problems, thus ensuring the timely provision of medical services to patients.

The areas requiring improvement are Internal Monitoring and Quality Management, and Emergency Medical Response Drills and Equipment. Improvement in these areas can be achieved by employing strict adherence to the established policies and procedures outlined in the *Inmate Medical Services Policies and Procedures*, by facility QMC's monitoring of defined aspects of care to track health care process

improvements, and completion of required emergency forms during actual emergency responses.

Thank you for your assistance and please extend my gratitude to your staff for their professionalism and cooperation. Should you have any questions or concerns, you may contact Anastasia Bartle, Staff Services Manager II, Private Prison Compliance and Monitoring Unit, Field Operations, Corrections Services, CCHCS, at (916) 691-4921 or via email at Anastasia.Bartle@cdcr.ca.gov.

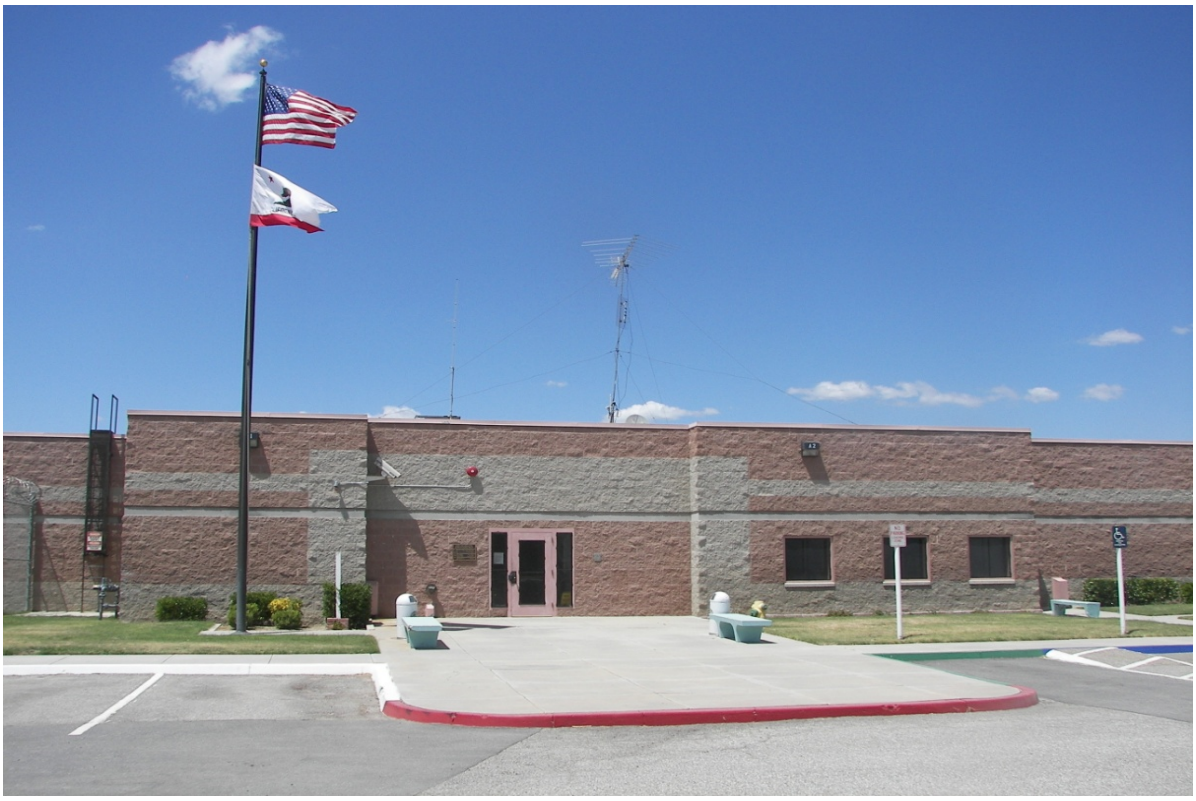
Sincerely,

Joseph (Jason) Williams
Deputy Director
Field Operations, Corrections Services

cc: Vincent S. Cullen, Director, Corrections Services, CCHCS
Joseph W. Moss, Chief, Contract Beds Unit (CBU), Division of Adult Institutions (DAI), California Department of Corrections and Rehabilitation (CDCR)
Ted Kubicki, Chief Executive Officer, North Kern State Prison, CCHCS
Edward Vasconcellos, Chief Deputy Warden, CBU, DAI, CDCR
Jay Powell, Correctional Administrator, Health Care Placement Oversight Program (HCPOP) and Private Prison Compliance and Monitoring Unit (PPCMU), Field Operations, Corrections Services, CCHCS
Brian Coates, Associate Warden, CBU, DAI, CDCR
Joseph Edwards, Captain, HCPOP and PPCMU, Field Operations, Corrections Services, CCHCS
Anastasia Bartle, Staff Services Manager II, PPCMU, Field Operations, Corrections Services, CCHCS

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT



Delano Modified Community Correctional Facility

Annual Audit

April 24 – 26, 2018

TABLE OF CONTENTS

DATE OF REPORT

September 11, 2018

INTRODUCTION

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

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

This report provides the findings associated with the audit conducted at Delano Modified Community Correctional Facility (DMCCF), located in Delano, California, for the review period of November 1, 2017 through February 28, 2018. At the time of the audit, CDCR's *Weekly Population Count* report, dated April 20, 2018, the patient population was 558, with a budgeted capacity of 578.

EXECUTIVE SUMMARY

From April 24 through 26, 2018, the audit team conducted an onsite health care monitoring audit at DMCCF. The audit team consisted of the following personnel:

R. Delgado, Medical Doctor, Retired Annuitant
L. Pareja, Nurse Consultant, Program Review (NCPR)
K. Srinivasan, Health Program Specialist I (HPS I)

The audit includes 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 DMCCF. The end product of the quantitative and qualitative reviews is expressed as a compliance score, while the overall audit rating is expressed both as a compliance score and an associated quality rating.

The audit rates each of the components based on case reviews conducted by an NCPR and physician, health record reviews conducted by registered nurses (RN), and onsite reviews conducted by a physician, NCPR, and HPS I. The compliance scores for every applicable component are derived from either the

clinical case review results, the health record and/or onsite audit results, or a combination of both as reflected in the *Executive Summary Table* below.

Based on the quantitative and/or clinical case reviews conducted for the 14 components, DMCCF achieved an overall compliance score of **91.1%**, which corresponds to a rating of ***Proficient***. Refer to Appendix A for results of the quantitative review, Appendix B for results of the patient interviews, and Appendix C for additional information regarding the methodology utilized to determine the facility's compliance for each individual component, and overall audit scores and ratings. Comparatively speaking, during the previous annual audit conducted at DMCCF on October 17 through 19, 2017, the overall compliance rating was 86.7%, indicating an increase of 4.4 percentage points.

This report includes a summary of critical issues identified during the audit through clinical case reviews, and quantitative health record and administrative reviews. The *Executive Summary Table* below lists all the operational areas by component, assessed by the audit team during the audit, and provides the facility's overall compliance score and quality rating for each area.

Executive Summary Table

Audit Component	NCPR Case Review Score	Physician Case Review Score	Overall Case Review Score	Quantitative Review Score	Overall Component Score	Overall Component Rating
1. Administrative Operations	N/A	N/A	N/A	85.0%	85.0%	Adequate
2. Internal Monitoring & Quality Management	N/A	N/A	N/A	79.6%	79.6%	Inadequate
3. Licensing/Certifications, Training & Staffing	N/A	N/A	N/A	100.0%	100.0%	Proficient
4. Access to Care	93.8%	94.4%	94.1%	98.8%	95.6%	Proficient
5. Diagnostic Services	92.3%	89.5%	90.9%	93.2%	91.7%	Proficient
6. Emergency Services & Community Hospital Discharge	80.0%	100.0%	90.0%	91.7%	90.6%	Proficient
7. Initial Health Assessment/Health Care Transfer	86.2%	80.0%	83.1%	98.2%	88.1%	Adequate
8. Medical/Medication Management	83.9%	93.8%	88.8%	94.0%	90.5%	Proficient
9. Observation Cells	N/A	N/A	N/A	N/A	N/A	N/A
10. Specialty Services	100.0%	100.0%	100.0%	80.0%	93.3%	Proficient
11. Preventive Services	N/A	N/A	N/A	91.7%	91.7%	Proficient
12. Emergency Medical Response/Drills & Equipment	N/A	N/A	N/A	88.9%	88.9%	Adequate
13. Clinical Environment	N/A	N/A	N/A	100.0%	100.0%	Proficient
14. Quality of Nursing Performance	86.8%	N/A	86.8%	N/A	86.8%	Adequate
15. Quality of Provider Performance	N/A	94.0%	94.0%	N/A	94.0%	Proficient
Overall Audit Score and Rating					**91.1%**	**Proficient**

NOTE: For specific non-compliance findings indicated in the table, please refer to the *Identification of Critical Issues* located on page 5, or to the specific component section located on pages 7 through 27.

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 described in Appendix C. The table also includes any *qualitative* critical issues or concerns identified by the audit team which rise to the level at which they have the potential to adversely affect patient's access to health care services.

Critical Issues – Delano Modified Community Correctional Facility	
Question 1.6	The facility does not consistently document all Release of Information (ROI) requests on the ROI log. ***This is a new critical issue.***
Question 2.3	The facility's Quality Management Committee's review process does not include the monitoring of defined aspects of care.
Question 2.5	The facility does not accurately document all the data on the sick call monitoring log. ***This is a new critical issue.***
Question 2.12	The facility's Health Care Grievance log does not contain all the required information. ***This is a new critical issue.***
Question 5.4	The facility does not consistently provide the patients a written notification of their diagnostic test results within the specified time frame. ***This is a new critical issue.***
Question 6.4	The facility does not consistently administer all prescribed medications to the patients per policy or as ordered by the prescribing Primary Care Provider (PCP). ***This is an unresolved critical issue since the October 2017 audit.***
Question 8.1	The facility does not consistently provide the patients their chronic care medications within the specified time frame. ***This is an unresolved critical issue since the April 2016 audit***.
Question 8.6	The facility's PCP does not consistently educate the patients on their newly prescribed medications. ***This is an unresolved critical issue since the October 2017 audit.***
Question 10.3	The facility nursing staff do not consistently notify the PCP of any immediate orders or follow-up instructions provided by the specialty consultant. ***This is an unresolved critical issue since the October 2017 audit.***
Question 11.3	The facility does not consistently offer colorectal cancer screening to the patient population 50-75 years of age. ***This is an unresolved critical issue since the October 2017 audit.***
Question 12.4	The facility's Emergency Medical Response Review Committee (EMRRC) does not consistently perform timely incident package reviews containing the required documents. ***This is an unresolved critical issue since the April 2016 audit.***
Question 12.15	The facility does not utilize a Naloxone (Narcan) log to account for each dose of intranasal Naloxone stored in the facility. ***This is a new critical issue***.
Qualitative Critical Issue # 1	The date of completion of ROI requests documented on the ROI log does not always correspond to the dates documented on the CDCR Form 7385, *Authorization for Release of Health Information* form. ***This is a new critical issue***.
Qualitative Critical Issue # 2	The facility does not consistently document the health care grievance disposition on the CDCR Form 602 HC *Health Care Grievance* by checking the appropriate box on the form. ***This is a new critical issue***.

Qualitative Critical Issue # 3	The facility does not allow patients in a holding cell to have prescribed keep-on person medications in their cell. ***This is an unresolved critical issue since the October 2017 audit.***
Qualitative Critical Issue # 4	The patients in a holding cell are not brought to the medical clinic for their non-emergent/urgent health care services. ***This is an unresolved critical issue since the October 2017 audit.***

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 COMPONENT

1. ADMINISTRATIVE OPERATIONS

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

Case Review Score: *Not Applicable*
Quantitative Review Score: *85.0%*

Overall Score: 85.0%

The compliance for this component is evaluated by the auditors through the review of patient health records and the facility's policies and LOPs. Since no clinical case reviews are conducted to evaluate this component, the overall score is based entirely on the results of the quantitative review.

Quantitative Review Results

Delano Modified Community Correctional Facility received a compliance score of 85.0% *(Adequate)* with one new quantitative and one qualitative critical issues identified. Eight questions were rated for this component; six scored 100% compliance, one scored adequate and the remaining one scored inadequate.

For question 1.2, 15 policies were reviewed and 12 were determined to be compliant with the IMSP&P guidelines. The deficiencies identified are noted below.

- In DMCCF Policy No. 801, Chapter, *Prison Medical Care System Reform*, section XVI, Healthcare Responsibilities and Limitations, subsection Licensing, there is no reference the PCP is required to maintain a current Drug Enforcement Administration license and also does not state the facility should schedule shadow training for all newly hired health care staff at the facility's hub, North Kern State Prison (NKSP).
- The facility does not have a policy for the use and storage of Narcan. The facility needs to develop a separate Narcan Use and Storage policy (per the *CCHCS memorandum #17-01, March 21, 2017, Deployment and Use of Intranasal Naloxone within California Department of Corrections and Rehabilitation Adult Institutions; and IMSP&P, Volume 4, Chapter 11.3 Medication Storage and Accountability procedure; Vol 9, Chapter 9.5 - Emergency Drug Supplies Procedure)* that states the following:
    - Narcan shall be stored in a secured locked cabinet, or in a locked container in the individual Supervising Registered Nurse's (SRN) office, or in a secured pouch in the Emergency Medical Response (EMR) bag.
    - The facility shall maintain a separate accountability log for Narcan for health care staff to account for each dose of Narcan stored in the facility at the beginning and end of the shift.
    - All health care staff will be trained.

- In section VIII. A., Medical Health Records, Release of Information (ROI), of the previously mentioned policy, the following information is missing:
    - There are no time frames (15 calendar days) stated for completion of all ROI requests.
    - The policy does not specify a charge of 10 cents per page will be deducted from the patient's Trust Account for each page copied, a CDC 193, *Trust Account Withdrawal Order,* will be completed for the amount charged, and a copy of the CDC 193 will be provided to the patient.
    - Does not state the facility's procedure for processing patient and third party ROI requests for reviewing mental health records.

The facility has shown significant improvement by updating the majority of their health care policies in order to be compliant with IMSP&P. As a result, the facility resolved the previously identified critical issue for Question 1.2 and achieved 80.0% compliance. The facility also corrected the critical issue identified during the previous audit for Question 1.7 regarding ROI requests not being completed within the 15 business day time frame. During the current audit, all 18 ROI requests received during the review period were completed within the specified time frame.

Although DMCCF was successful in resolving the two previous critical issues, one new quantitative and one new qualitative critical issue was identified for this component. The first issue resulted due to the facility failing to document the receipt of one ROI request in the ROI log. This request was identified by the HPS I auditor while conducting pre-audit review of a patient's electronic health record. The auditor found the patient submitted two separate requests on the same day; the first request was for a copy of his diagnostic test results, and the second request was for a copy of his X-ray result. The signed copies of the CDCR Form 7385, *Authorization for Release of Health Information*, for both requests were found in the patient's electronic health record. However, the patient's request for the X-ray results was not documented on the ROI log. As a result, Question 1.6 received 0.0% compliance.

The qualitative issue identified during this audit was due to the date of completion of health information requests documented on the ROI log not matching the dates documented on the CDCR Form 7385. Six of the 18 entries on the ROI log had different dates from those documented on the CDCR Form 7385. The HPS I auditor brought these discrepancies to the attention of the facility's Health Services Administrator (HSA) and the SRN. The HSA informed the auditor the discrepancy with the dates might have likely occurred due to the staff printing the completion dates on the CDCR 7385 as soon as the copies of the requested information were ready to be handed over to the patient. However, the copies were likely provided to the patient the following day, and that date was documented in the log. The HPS I auditor recommended the facility date stamp the request by utilizing a "completed" stamp and document the completed date on the same day the copies are provided to the patient. This date should be documented in the ROI log. The auditor also informed the HSA all requests for health information should be documented in the ROI log including the requests received from the same patient on the same day if the requests are for different documents, such as the one identified during the audit. The HSA confirmed understanding and agreed to implement this process and train staff as needed.

2. INTERNAL MONITORING & QUALITY MANAGEMENT

This component focuses on whether the facility completes internal reviews and holds committee meetings in compliance with the CCHCS policies. Auditors review the minutes from Quality Management Committee meetings to determine if the facility identifies opportunities for improvement; implements action plans to address the identified deficiencies; and continuously monitors the quality of health care provided to patients. Auditors review the monitoring logs utilized by the facility to document and track all patient medical encounters such as initial intake, health assessment, sick call, chronic care, emergency, and specialty care services. These logs are reviewed for accuracy and timely submission to CCHCS. Lastly, auditors evaluate whether the facility promptly processes and appropriately addresses health care grievances.

Case Review Score: *Not Applicable*
Quantitative Review Score: *79.6%*

Overall Score: 79.6%

The clinical case reviews are not conducted for this component. The overall component score is based entirely on the results of the quantitative review.

Quantitative Review Results

Delano Modified Community Correctional Facility received an overall compliance score of 79.6% (*Inadequate*) with three critical issues identified, two of which are new. This is a decrease of 12.8 percentage points from the previous score of 92.4% achieved during the annual audit in October 2017. The facility did not reach the compliance threshold of 80.0% for 3 out of 13 questions evaluated. The remaining ten questions were rated as follows: nine proficient, and one adequate.

Upon review of the facility's Quality Management Committee (QMC) Meeting Minutes, the NCPR auditor noted DMCCF did not reference any validation audits derived from corrective action plans which demonstrate monitoring and objective improvement. As a result, the facility received 0.0% for Question 2.3 during the current audit. This is an unresolved critical issue first identified during the April 2016 audit, at which time a score of 60.0% compliance. The HSA attributed the lack of validation audits to a lack of staffing. The NCPR auditor explained to the HSA the importance of conducting internal validation audits in order to measure the percentage of improvement or lack thereof, after the implementation of a corrective action plan. The NCPR auditor recommended the nursing staff maintain a log for health care related issues to submit to the QMC at the end of each month. Prior to the monthly QMC meetings, staff need to categorize the identified issues and summarize the findings into numerical percentages. Any trend or pattern of issues identified through this process may be discussed and monitored on a monthly basis during the QMC meetings.

The facility achieved 100% compliance for timely submission of weekly and monthly monitoring logs during the audit review period. A total of five questions (Questions 2.5 through 2.9) are utilized to measure the accuracy of data documented on the weekly and monthly monitoring logs, and DMCCF did not achieve the 80.0% compliance threshold for one of these questions (Question 2.5). Five of the 18 entries reviewed on the Sick Call monitoring log showed the facility staff documented incorrect information; namely, missing date, incorrect date, and incorrect patient name. Additionally, two entries could not be verified due to missing sick call request forms and/or PCP progress notes in the electronic health record.

Auditors found the facility is not using the updated version of the Health Care Grievance log (Question 2.12). The screening disposition drop down field on the log was not updated to the current disposition criteria, "intervention" and "no intervention". The log utilized by the facility lists the outdated options; "granted", "partially granted", and "denied". Additionally, not all grievance response due dates documented on the log reflect the new 45–business day time frame. The facility should review the CCHCS Health Care Grievances Operational Standards and California Code of Regulations, Title 15, Article 8.6, Health Care Grievances and make the necessary revisions to ensure compliance with this requirement.

One new qualitative critical issue was identified during the current audit which was related to DMCCF health care staff's failure to document one patient's health care grievance outcome on the CDCR Form 602 HC by not checking the appropriate box. The HPS I auditor informed the HSA and SRN about the importance of completing all applicable fields on the CDCR Form 602 HC since it is a legal document and could be potentially used as a reference in court cases. The HSA and SRN confirmed their understanding and agreed to complete the form as recommended.

3. LICENSING/CERTIFICATIONS, TRAINING & STAFFING

This component 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 certifications are current; and training requirements are met. The auditors will also determine whether clinical and custody staff are current with their emergency medical response certifications and if the facility is meeting staffing requirements specified in the contract.

Case Review Score: *Not Applicable*
Quantitative Review Score: *100.0%*

Overall Score: 100.0%

This component is evaluated by auditors through the review of facility's documentation of health care staff licenses, medical emergency response certifications, health care staff training records, and staffing information. The clinical case reviews are not conducted for this component; therefore, the overall component score is based entirely on the results of the quantitative review.

Quantitative Review Results

Delano Modified Community Correctional Facility achieved 100% compliance *(Proficient)* with one prior critical issue found resolved. Six questions for this component were reviewed; five were found 100% compliant, and one was unable to be rated.

During the previous audit in October 2017, the facility was unable to provide evidence of Cardio Pulmonary Resuscitation (CPR) certifications for all custody staff, resulting in 78.1% compliance. However, during the current audit, the facility was able to provide CPR certification information for all 59 custody staff and provided the requested copies of certifications to the HPS I auditor.

It should be noted, towards the end of the audit review period, DMCCF hired a new PCP. Therefore, some of the deficiencies described in the physician's case review sections of this report do not pertain to the services provided by the current PCP. The facility's Chief informed the auditors they are currently

struggling to retain PCPs. Although the workload is relatively less than the state and county prisons, the other prisons in the area offer higher salaries to providers. The current PCP at DMCCF was hired on a short term basis, to provide services until May 30, 2018. The facility received credentialing approval for two additional providers for short term hire, and will be submitting credentialing paperwork for one more additional providers for long term hire.

4. ACCESS TO CARE

This component 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, daily care team huddles, and timely triage of sick call requests. Additionally, the auditors perform onsite inspection of housing units and logbooks to determine if patients have a means to request medical services and to confirm there is continuous availability of CDCR Form 7362*, Health Care Services Request*.

Case Review Score: *94.1%*
Quantitative Review Score: *98.8%*

Overall Score: 95.6%

Delano Modified Community Correctional Facility received an overall compliance score of 95.6% (*Proficient*). Specific findings related to the nurse and physician case reviews, and the electronic health record and onsite quantitative reviews are documented below.

Case Review Results

The facility received an overall case review compliance score of 94.1% for this component. The clinical auditors reviewed a combined total of 66 encounters.

Nurse Case Reviews

The NCPR auditor reviewed a total of 48 nursing encounters and identified three deficiencies detailed below.

- In **Case 17**, the patient submitted a sick call request complaining of diarrhea from consuming meat at the facility. The CDCR Form 7362 was received and reviewed by the RN on November 7, 2017; however, the RN's assessment was inadequate. It did not include a subjective and objective assessment such as frequency of bowel movement, date of last bowel movement, the type of food that caused the diarrhea, nature of bowel sounds, presence of abdominal cramps, nausea, vomiting, and abdominal pain.
- In **Case 18**, the PCP ordered for weekly blood pressure (BP) checks for the patient; however the nursing staff failed to conduct the weekly BP checks.
- In **Case 23**, the patient submitted a CDCR Form 7362 complaining of reddening and itchiness of his whole face. The request was received and reviewed by the RN on the same day. The RN

documented noticing excoriation[1] from scratching. Following assessment, the RN referred the patient to the PCP to be seen on a routine priority. The auditor determined the rashes on the whole face was a new episode and different from the skin rash the patient had reported during previous visits for which treatment had been provided. Therefore, the patient should have been referred to the PCP on an urgent priority and not as a routine referral.

Physician Case Reviews

The physician auditor reviewed a total of 18 encounters for this component and identified only one deficiency.

- In **Case 6**, the 26-year old patient was transferred from Sierra Conservation Center to DMCCF and immediately upon arrival, a large abscess was noted on the patient's left thigh. It was mentioned in the notes the PCP saw the patient and ordered the patient to be transferred to the hub for treatment which was determined as appropriate. However, the physician auditor could not locate PCP's notes that described the infection, and the PCP also failed to document the patient's status and the need for an immediate transfer.

Quantitative Review Results

The facility received a quantitative compliance score of 98.8% (*Proficient*) with one prior critical issue found resolved. Nine of the ten questions reviewed in this chapter scored 100% compliant. During the October 2017 audit, the patient chronic care follow-up visits were not consistently completed timely (Question 4.7). Upon review of 24 patient health records with orders for a follow-up visit, five were found non-compliant resulting in a score of 79.2%. During the current audit, 2 out of 16 health records were found non-compliant for a score of 87.5%.

5. DIAGNOSTIC SERVICES

For this component, the clinician auditors assess several types of diagnostic services such as radiology, laboratory, and pathology. The auditors review the patient health records to determine whether radiology and laboratory services were provided timely, whether the PCP completed a timely review of the results, and whether the results were communicated to the patient within the required time frame. Information regarding the appropriateness, accuracy and quality of the diagnostic tests ordered, and the clinical response to the results is evaluated via the case review process.

Case Review Score: *90.9%*
Quantitative Review Score: *93.2%*

Overall Score: 91.7%

Delano Modified Community Correctional Facility received an overall compliance score of 91.7% (*Proficient*). Specific findings identified by the clinical auditors during case reviews, and electronic health record quantitative review are documented below.

[1] Excoriation: an injury to a surface of the body caused by trauma, such as scratching, abrasion, or a chemical or thermal burn.

Case Review Results

The facility received an overall case review compliance score 90.9% (*Proficient*). The clinician auditors reviewed a combined total of 32 encounters for this component.

Nurse Case Reviews

The NCPR auditor reviewed a total of 13 nursing encounters and identified only one deficiency.

- In **Case 18**, the 45-year old patient refused blood work and urine analysis test. A CDCR Form 7225 *Refusal of Examination and/or Treatment* was completed by nursing staff and signed by the patient; however, the nursing staff failed to document the specific lab test being refused by the patient on the refusal form.

Physician Case Reviews

The physician auditor reviewed a total of 19 PCP encounters and identified two deficiencies. Both deficiencies were related to **Case 1,** where on two separate occasions the PCP failed to review the patient's diagnostic test results within the two business day time frame.

Quantitative Review Results

The facility received a quantitative compliance score of 93.2% (*Proficient*) with one new critical issue identified. Three out of the four questions scored 100% and one scored 72.7%.

During the electronic health record review, the nurse auditor identified 3 out of 11 patients did not receive a written notification of their test results within the specified time frame (Question 5.4). During the onsite audit, the auditors discussed this issue with the HSA. The HSA informed the auditors, as a corrective measure, a box was installed the medical clinic containing the copies of patients' laboratory tests. The SRN follows up on these laboratory tests daily, prints out the copies of the results as soon as they become available, and hands over the results to the PCP for his review on the same day. Through the implementation of this new process, the facility has been successful in meeting the two business day time frame and are able to provide the diagnostic test results to the PCP for review and provide the notifications of the test results to the patients in a timely manner. The outcome of this corrective action will be measured by the auditors during subsequent audits.

6. EMERGENCY SERVICES AND COMMUNITY HOSPITAL DISCHARGE

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

Case Review Score: *90.0%*
Quantitative Review Score: *91.7%*
Overall Score: 90.6%

The auditors evaluate the emergency medical response system and the facility's ability to provide effective and timely responses. The clinician auditors 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.

Delano Modified Community Correctional Facility received an overall compliance score of 90.6% (*Proficient*) with one critical issue identified. Specific findings related to the nurse and physician case reviews, and the electronic health record quantitative review are documented below.

Case Review Results

The facility received an overall case review compliance score of 90.0% (*Proficient*). The clinician auditors reviewed a combined total of seven patient encounters.

Nurse Case Reviews

The NCPR auditor reviewed five nursing encounters for this component and identified one deficiency.

- In **Case 23**, the PCP's progress notes indicated the patient returned from the Triage and Treatment Area (TTA) at the hub. However, the NCPR auditor could not find any nursing notes to show a nursing assessment was completed upon the patient's return to DMCCF.

Physician Case Reviews

The facility received 100% compliance for the physician case reviews. The physician auditor did not identify any specific areas of concern within the two encounters reviewed.

Quantitative Review Results

The facility received a quantitative compliance score of 91.7% (*Proficient*) with one critical issue identified. Four questions were rated for this component; three received 100% compliance and one scored 66.7%. The nurse auditor reviewed three patient health records for this requirement and found two patients did not receive their prescribed medications timely upon their return from a community hospital emergency room visit or discharge (Question 6.4). This critical issue was first identified during the October 2017 audit.

During the previous October 2017 audit, three critical issues were identified for this component. The facility was successful in resolving two out of three issues; both achieving 100% compliance. The nurse auditor reviewed 11 health records and found, upon a patient's return to the facility from a community

hospital, nursing staff are consistently reviewing the discharge instructions (Question 6.1), and the PCP is seeing the patient for a follow-up within five calendar days (Question 6.3).

7. INITIAL HEALTH ASSESSMENT/HEALTH CARE TRANSFER

Case Review Score: *83.1%*
Quantitative Review Score: *98.2%*

Overall Score: 88.1%

This component 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 component reviews the facility's ability to accurately and appropriately document transfer information that includes pre-existing health conditions, pending medical, dental and mental health appointments, medication transfer packages, and medication administration prior to transfer.

Delano Modified Community Correctional Facility received an overall compliance score of 88.1% (*Adequate*). Specific findings related to the nurse and physician case reviews, and the electronic health record and onsite quantitative reviews are documented below.

Case Review Results

The facility received a case review compliance score of 83.1%. The clinician auditors reviewed a combined total of 34 encounters.

Nurse Case Reviews

The NCPR auditor reviewed 29 nursing encounters related to this component and identified four deficiencies. Two of the deficient encounters were related to the facility's intra- and inter-facility transfer process, and the other two were related to inadequate nursing assessments.

- In **Case 20**, the patient was transferred back to DMCCF from the hub and during the intake screening the patient answered "yes" to some of the questions on the intake screening form. However, the nursing staff did not conduct an adequate assessment of the patient based on the "yes" responses. The nursing staff's documentation stated "rash" without additional details.
- In **Case 21**, the patient's electronic health record showed he was transferred from NKSP to Folsom State Prison. However, the NCPR auditor could not locate nursing documentation showing the patient was transferred from DMCCF to its hub, NKSP. There were no transfer documents found in the patient's record.
- In **Case 23,** two deficiencies were identified. Initially, when the patient was transferred out to the hub, the nursing staff failed to document on the CDCR Form 7371, *Health Care Transfer Information,* about the patient's pending referral to an Eyes, Nose and Throat (ENT) specialist with a Request for Services (RFS) dated November 30, 2017. When the same patient returned from

the hub to DMCCF, the nursing staff failed to conduct a complete assessment of the patient based on the "yes" responses on the CDCR Form 7277, *Initial Health Screening,*. The nursing staff did not describe the conditions related to the Dermatology and the ENT issues the patient checked on the form.

Physician Case Reviews

The physician auditor reviewed a total of five provider encounters related to this component and identified one deficiency.

- In **Case 10**, the 45-year old morbidly obese patient with a history of Coronary Artery Disease (CAD) was transferred to DMCCF. The PCP noted the patient to have apparently new onset of unilateral edema[2] upon arrival. The PCP completed an RFS for urgent evaluation to exclude Deep Vein Thrombosis (DVT)[3]. The RFS was reviewed promptly by the Chief Medical Executive at the hub, who changed the priority to emergent. The patient had a study the following day. Following the test, DVT was excluded. The physician auditor determined the encounter to be inadequate due to the PCP not ordering a study on an emergent basis since the patient appeared to be at high risk for DVT.

Quantitative Review Results

Delano Modified Community Correctional Facility received a quantitative compliance score of 98.2% with one prior critical issue found resolved and one prior critical issue found unresolved. Eight questions were reviewed for this component; seven scored 100% compliance, and one scored 85.7% compliance.

During the previous October 2017 audit, new patients to the facility were not consistently being seen for their medical, dental or mental health appointments as specified by the sending facility provider (Question 7.4). Upon review of the health records during this audit, the nurse auditor found two out of two records compliant with this requirement.

Another deficiency identified during the previous audit was the lack of face-to-face assessments of patients scheduled to transfer to other facilities, which, according to the SRN, was due to the lack of coordination between the custody officers and nursing staff. In order to resolve this issue, the nursing staff currently print out a list of impending transfer-outs to provide to the custody officers so that they ducat these patients for a face-to-face assessment prior to their transfer to another facility. The nurse auditor will evaluate the effectiveness of this corrective action during subsequent audits.

[2] Edema - The swelling of soft tissues as a result of excess fluid accumulation.

[3] DVT - Deep vein thrombosis (DVT) is a condition that occurs when a blood clot forms in a vein deep inside a part of the body. It mainly affects the large veins in the lower leg and thigh, but can occur in other deep veins such as in the arms and pelvis.

8. MEDICAL/MEDICATION MANAGEMENT

Case Review Score: *88.8%*
Quantitative Review Score: *94.0%*

Overall Score: 90.5%

For this component, the clinicians assess the facility's health care staff performance to determine whether appropriate and medically necessary care was provided to patient population per the nursing and physician scope of practices and clinical guidelines established by the department. This includes, but is not limited to the following: proper diagnosis, appropriateness of medical/nursing action, and timeliness and efficiency of treatments and care provided related to the patient's medical complaint. The clinician auditors also assess the facility's process for medication management which includes: timely filling of prescriptions, appropriate dispensing of medications, appropriate medication administration, completeness in documentation of medications administered to patients, and appropriate maintenance of medication administration records. This component also factors in the appropriate storing and maintenance of refrigerated drugs, vaccines, and narcotic medications.

Delano Modified Community Correctional Facility received an overall compliance score of 90.5% (*Proficient*), an increase of 13.7 percentage points from the previous score of 76.8% (*Inadequate*). Specific findings related to the nurse and physician case reviews, and the electronic health record and onsite quantitative reviews are documented below.

Case Review Results

The facility received an overall case review compliance score of 88.8%. The clinician auditors reviewed a combined total of 78 encounters related to this component.

Nurse Case Reviews

The NCPR auditor reviewed a total of 62 nursing encounters and identified 10 deficiencies. Five of the deficiencies were related to the facility providing additional supply of medications to the patients, i.e., 30-day supply for an ordered 10-day supply. The SRN claimed the nurses only administered what was ordered and the 30-day supply was a routine documentation from the pharmacy. Three deficiencies were related to non-availability of a Medication Administration Record (MAR) showing medications were given as ordered. The remaining two deficiencies were due to the nursing staff not administering medications to the patients in a timely manner.

- In **Case 16**, the patient did not receive the refill of docusate sodium timely. Documentation in the patient's health record shows the patient requested a refill on January 30, 2018. The patient should have received his refill within four business days; however, the medication was received on February 22, 2018.
- In **Case 19**, the PCP ordered ibuprofen 400 mg for five days but the patient's MAR showed the patient received a 30-day supply.
- In **Case 20**, the PCP ordered a 30-day supply of Triamcinolone 0.1% ointment KOP and Vaseline petroleum jelly KOP for the patient's skin irritation. The PCP's order was to start the medications on February 12, 2018. However, the petrolatum jelly was started one day later, on

February 13, 2018. For Triamcinolone, there was no documentation in the patient's MAR to indicate this medication was given to or received by the patient.

- In **Case 21**, the PCP ordered 10 antacid packets to be given to the patient. There was no documentation in the patient's MAR to show the antacids were given as ordered.
- In **Case 22**, the PCP ordered a seven-day supply of ibuprofen 200 mg to be given every eight hours for the pain in the patient's toe. There was no documentation in the patient's MAR to show the medication was provided to the patient as ordered.
- In **Case 23**, the patient's MAR showed the nurse administered medication Prednisone was filled by the pharmacy on January 18, 2018. However, the patient's MAR did not show Prednisone was administered as a unit by unit dose. There were no nursing initials against each date the medication was supposedly given.
- In **Case 25**, four deficiencies were identified. When the dental provider ordered Amoxicillin and ibuprofen for 10 days on December 11, 2017, the nursing staff failed to specify in the MAR if the patient received only 10 days of Amoxicillin and ibuprofen as ordered. The patient's MAR showed the patient received a 30-day supply. On December 29, 2017, the patient received a 7-day supply of amoxicillin to be taken thrice a day, and also received a 10-day supply of ibuprofen to be taken thrice daily. The nursing staff again failed to specify in the MAR if the patient received these medications as prescribed. The documentation in the MAR showed the patient received a 30-day supply of both medications. On February 5, 2018, the provider ordered a 7-day supply of ibuprofen for this patient to be taken thrice a day. However, the patient's MAR showed the patient received a 30-day supply. Lastly, on February 6, 2018, the patient received a 10-day supply of ibuprofen which was documented in the MAR accurately. However, the nursing staff failed to note the patient had already received the ibuprofen on February 5, 2018. The medication was over supplied to the patient.

Physician Case Reviews

The physician auditor reviewed 16 provider encounters and identified one encounter deficient.

- In **Case 14**, a 29 year old patient, with long standing mild persistent asthma, was seen for a chronic care follow-up. The PCP diagnosed the patient to have worsening control over asthma with worsening ACT[4]. However, the progress notes showed no changes were made in the management of the patient's condition, and there was no evidence of a close follow-up. The physician auditor determined the encounter to be inadequate due to the PCP not considering a more advanced treatment for the patient, and not closely following up on the patient's condition.

Quantitative Review Results

The facility received a quantitative compliance score of 94.0% for this component with two critical issues identified. This is an increase of 10.8 percentage points from the previous October 2017 audit score of 83.2% during which time four critical issues were identified. During the current audit, 14 questions were

[4] ACT - The Asthma Control Test™ (ACT™) is a five question health survey used to measure asthma control in individuals 12 years of age and older. The survey measures the elements of asthma control as defined by the National Heart, Lung and Blood Institute (NHLBI).

reviewed; 4 were unable to be rated, 8 scored 100%, 1 scored 96.4%, and 2 questions scored below the required 80.0% threshold; 68.8% and 75.0% respectively. Three out of the four prior critical issues were found resolved.

Delano Modified Community Correctional Facility has struggled since the April 2016 audit to meet the compliance standard related to the timely refill of chronic care medications (Question 8.1). Although this issue was one of the items discussed by the DMCCF health care staff during the Daily Care Team Huddle, the critical issue remains unresolved. In order to develop a corrective action plan, the facility's SRN discussed the issue with the Central Fill pharmacist and was told that although the facility enters the request for chronic care medication refills timely in the system, it is likely the hub is not dispensing the requested medications in a timely manner. The SRN created a database to generate a list of patients with expiring medications five days prior to the expiry as a preventative measure. Once the list is generated, the nursing staff follow up with the hub pharmacy staff on these medication refills.

Per the SRN (as stated in his e-mail to the NCPR auditor on April 30, 2018), the issue appears to be associated with the autofill medications processed on Fridays by CCHCS Central Fill pharmacy. Medications processed and shipped to the hub are not received by the pharmacy staff at the hub until a couple of days later, most likely late in the afternoon. Since DMCCF staff were instructed by the hub's pharmacy staff to pick up medications at 1230 hours daily, the facility staff are unable to pick up these refills until the following day. The SRN felt this was a systemic problem within Central Fill and not due to the facility's delay in placing refill requests. The SRN also stated, all medications are administered by nursing staff the same day they are received. The SRN reiterated in his email the issue is most likely due to the autofill medications processed on Fridays by Central Fill. The NCPR auditor suggested the SRN track the receipt of medication refills closely and work with the Central Fill pharmacy staff on medications received late to identify the cause of the delay.

During the current audit, the nurse auditor reviewed 12 health records and found the prescribing PCP did not educate the patient on their newly prescribed medication in three records (Question 8.6). This is an unresolved critical issue since the October 2017 audit.

Overall, the facility showed improvement. Namely, the NCPR auditor found nursing staff are consistently confirming the identity of the patient prior to the delivery or administration of medication (Question 8.8) and are knowledgeable of the Medication Error Reporting procedure (Question 8.12). Both of these critical issues were found resolved.

After a review of health records, the RN auditor found there were no refusals of keep-on-person medications, no refusals of nurse administered/Direct Observation Therapy medications, and no patients prescribed anti-Tuberculosis medications. As a result four questions in this component were unable to be rated (Questions 8.2 through 8.5).

9. OBSERVATION CELLS (California Out of State Correctional Facilities (COCF) Only)

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

This component does not apply to the modified community correctional facilities and was not reviewed during this audit.

Case Review Score: *Not Applicable*
Quantitative Review Score: *Not applicable*

Overall Score: Not Applicable

10. SPECIALTY SERVICES

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

Case Review Score: *100.0%*
Quantitative Review Score: *80.0%*

Overall Score: 93.3%

Delano Modified Community Correctional Facility received an overall compliance score of 93.3% (*Proficient*). Specific findings related to the nurse and physician case reviews, and the electronic health record quantitative review are documented below.

Case Review Results

The facility received an overall case review compliance score of 100%. The clinician auditors reviewed a combined total of 27 encounters related to this component. The NCPR auditor reviewed 22 nursing encounters and the physician auditor reviewed 5 provider encounters. Neither auditor identified any deficiencies during their review.

Quantitative Review Results

The facility received a quantitative compliance score of 80.0% with one critical issue identified. Four questions were reviewed; two were rated proficient, one was adequate, and one question was rated inadequate.

During the previous October 2017 audit, two critical issues were identified. Nursing staff were not consistently notifying the PCP of any immediate orders or follow-up instructions from the specialty care provider (Question 10.3), and the PCP was not consistently reviewing the patient's discharge summary

and seeing the patient for a follow-up in a timely manner (Question 10.4). The electronic medical record review during the current audit revealed DMCCF was not successful in resolving the critical issue for Question 10.3, for which DMCCF received a compliance score of 50.0%. The second critical issue for Question 10.4 was found resolved.

11. PREVENTIVE SERVICES

This component assesses whether the facility offers or provides various preventive medical services to patients meeting certain age and gender requirements. These include cancer screenings, tuberculosis evaluations, and influenza and chronic care immunizations. The clinical case reviews are not conducted for this component; therefore, the overall component score is based entirely on the results of the quantitative review.

Case Review Score: *Not Applicable*
Quantitative Review Score: *91.7%*

Overall Score: 91.7%

Quantitative Review Results

Delano Modified Community Correctional Facility received a compliance score of 91.7% (*Proficient*) with one critical issue identified. This is an increase of 22.9 percentage points from the previous October 2017 compliance score of 68.8%, during which time one critical issue was identified for Question 11.3. During the current audit, out of the three questions reviewed, two scored 100%, and one scored 75.0%.

A review of 20 patient electronic health records revealed DMCCF did not offer a colorectal screening to 5 of these patients (Question 11.3). While this is an improvement over the previous audit score of 23.1%, during which ten out of 13 patients were not offered the screening, this critical issue remains unresolved.

12. EMERGENCY MEDICAL RESPONSE/DRILLS and EQUIPMENT

For this component, the nurse auditors review the facility's emergency medical response documentation to assess the response time frames of the facility's health care staff during medical emergencies and/or drills. The auditors also inspect emergency response bags and various emergency medical equipment to ensure regular inventory and maintenance of equipment is occurring. The compliance for this component is evaluated entirely through the review of emergency medical response documentation, inspection of emergency medical response bags and crash carts, and inspection of medical equipment located in the clinics. The clinical case reviews are not conducted for this component; therefore, the overall component score is based entirely on the results of the administrative record and onsite quantitative reviews.

Case Review Score: *Not Applicable*
Quantitative Review Score: *88.9%*

Overall Score: 88.9%

Quantitative Review Results

Delano Modified Community Correctional Facility received an overall compliance score of 88.9% (*Adequate*) with two critical issues identified. This is a 13.5 percentage point increase over the previous October 2017 audit score of 75.4%. Ten questions were reviewed for this component; eight received a score of 100% and two received a score of 0.0%.

During the previous October 2017 audit, the nurse auditor found the facility's EMR documentation for three out of ten incidents did not have a response time for health care staff documented (Question 12.2). During the current audit, all 12 incidents reviewed indicated an appropriate response time for staff. This critical issue is resolved.

The facility was also successful in resolving three additional prior critical issues which were related to facility not consistently resupplying and resealing the EMR bag following use in medical emergencies and/or drills (an issue initially identified during the April 2016 audit) (Question 12.6), not consistently inventorying the EMR bag on a monthly basis (Question 12.7) and the facility's oxygen tank did not have a nasal cannula or mask attached to it when checked during the previous onsite audit (Question 12.14). The NCPR auditor's review of the EMR bag logs during the current audit revealed the facility staff re-supplied and re-sealed the EMR bag following a medical emergency, the staff inventoried the EMR bag monthly during all four months of the audit review period, and NCPR auditor inspected and found all three oxygen tanks had nasal cannula or mask attached to them during the onsite audit. The facility scored 100% for all three questions thus resolving these critical issues.

The NCPR auditor found DMCCF staff do not complete the necessary documentation during emergency medical responses and drills; namely, CDCR Form 7219, *Medical Report of Injury or Unusual Occurrence*, CDCR Form 7463, *First Medical Responder Data Collection Tool*, and CDCR Form 7462, *Cardiopulmonary Resuscitation Record,* which resulted in the facility failing Question 12.4. This critical issue was first identified during the April 2016 audit and remains unresolved.

When the NCPR auditor spoke with the nursing staff regarding this issue, the SRN asserted the CDCR Form 7219 is usually completed by the custody officers. If the custody officers fail to complete this form, it is not included in the medical emergency response packet.[5] Furthermore, the SRN added, the form does not get filled out because most DMCCF patients who are transferred out for emergency services are seen in the clinic and not in the yard; therefore, nursing staff completes only the nursing progress note. The NCPR auditor informed the SRN the CDCR Form 7219 is to be completed by nursing staff, and should also be completed for all unplanned transfers to the hospital or to the hub because these are also considered medical emergencies.

The NCPR auditor spoke to Chief Marshall regarding custody officers' training in completing custody's required forms (CDCR Forms 837, *Crime/Incident Report* and 871-A-1 *Crime/Incident Report Supplement* (if necessary) as a result of an emergency medical responses and drills. The Chief confirmed his understanding and agreed to include the completion of these forms in the custody training curriculum.

[5] Since the onsite audit, the SRN contacted the NCPR to clarify his understanding of who completes the CDCR Form 7219. He indicated nursing staff does complete the form which is later used for custody purposes.

The failure of Question 12.15 resulted in a new critical issue which is related to the facility not maintaining a separate Narcan log for health care staff to account for the Narcan stored in the facility during each shift.

13. CLINICAL ENVIRONMENT

This component measures the general operational aspects of the facility's clinic(s). The 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. Evaluation of this component 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 Score: *Not Applicable*
Quantitative Review Score: *100.0%*

Overall Score: 100.0%

Quantitative Review Results

Delano Modified Community Correctional Facility received an overall compliance score of 100% (*Proficient*). Fifteen questions were reviewed; 13 questions received a 100% compliance score, and two questions were not rated because the facility does not use and/or restore medical instruments. The auditors found the clinical space was clean and organized with excellent access to hand washing, sanitizing, sharps disposal, and appropriate biohazard disposal. The medical clinic's examination rooms provided for visual and auditory privacy during patient health care encounters.

The auditors recommended during the previous audit, DMCCF staff maintain a log to document the cleaning of the receptacle placed under the sink in the PCP's exam room for collecting the waste water from the sink. During the current audit, the NCPR auditor identified DMCCF staff currently maintains a cleaning log to document the daily cleaning of the receptacle placed under the sink, and the log is included within the facility's daily cleaning log.

14. QUALITY OF NURSING PERFORMANCE

The goal of this component is to provide an 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 were the ones with high utilization of nursing services, as these patients were most likely to be affected by timely appointment scheduling, medication management, and referrals to health care providers.

Case Review Score: *86.8%*
Quantitative Review Score: *Not Applicable*

Overall Score: 86.8%

Case Review Results

Delano Modified Community Correctional Facility received a compliance score of 86.8% (*Adequate*). This determination was based upon the NCPR auditor's review of nursing services provided to ten patients housed at DMCCF during the audit review period of November 2017 through February 2018. Of the ten detailed case reviews conducted by the NCPR auditor, six cases were proficient *(*scored 90% or more), one was inadequate (scored less than 80.0%). The remaining three cases were rated as adequate (scored between 80.0 and 89.9%). Of the 166 total nursing encounters assessed within the ten detailed case reviews, 19 deficiencies were identified related to nursing care and performance, details of which are documented in the previous components; *Access to Care, Diagnostic Services, Emergency Services, Initial Health assessment/Health Care Transfer and Community Hospital Discharge, and Medical/Medication Management*.

Below is a brief synopsis of the one case for which the NCPR auditor determined the facility nursing staff's performance was inadequate.

Case Number	Deficiencies
Case 21	***Inadequate (50.0%).*** This is a 38 year-old male patient with no chronic diagnosis. During the audit review period, the patient complained of chest tightness and was later transferred to another institution. Only four nursing encounters were reviewed, and two of these encounters were found deficient. One deficient encounter was due to the lack of documentation on the MAR showing the patient received antacid as recorded on the nurse's notes. The second deficiency was due to the absence of nursing documentation related to the patient's transfer to another institution.

Recommendations

- Patients received from the hub post hospitalization or emergency services should be similarly processed as patients directly discharged from the hospital to the facility. In order to determine if a patient was previously discharged from the hospital, nursing staff should review the patient's health record and not solely rely on information sent by the hub.
- The facility should conduct internal validation audits in order to determine if the corrective action plan implemented for each critical issue is effective. The facility should maintain a log of health care related issues for documenting objective findings.
- The facility should continue collaborating and communicating with the Central Fill pharmacy and the hub pharmacy regarding timely refill of chronic care medications.
- The facility should continue monitoring the laboratory results and provide them to the PCP immediately upon receipt so the PCP is able to review the results in a timely manner.
- The facility should train all nursing and custody staff on completion of CDCR emergency forms during actual emergency medical responses and emergency medical response drills.
- The facility should continue monitoring patient transfers and conducting patient face-to-face assessments prior to transfers. Validation audits need to be conducted in order to determine if the corrective action plan is effective.

15. QUALITY OF PROVIDER PERFORMANCE

In this component, the physicians provide an 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, sick call, chronic care programs, specialty services, diagnostic services, emergency services, and specialized medical housing.

Case Review Score: 94.0%
Quantitative Review Score: *Not Applicable*

Overall Score: 94.0%

Case Review Results

Based on the detailed review of 15 cases conducted by the physician auditor, the provider performance received a score of 94.0% compliance, equating to an overall quality rating of *Proficient.* Fifteen detailed case reviews were conducted; 11 were found *proficient*, 2 were *adequate*, and 2 cases were determined to be *inadequate*. Out of a total of 65 PCP encounters/visits assessed, five deficiencies were identified.

Health care services at DMCCF are currently delivered by one PCP, who was interviewed and observed by the physician auditor while providing patient care to over four patients during the onsite audit. The prior PCP resigned from the facility on February 16, 2018. The PCP providing coverage at DMCCF at the time of the onsite audit began work on February 20, 2018, and was contracted to provide services until May 30, 2018. During the physician auditor's interview with the PCP during the onsite audit, he found the PCP to be a seasoned family practice physician who is new to correctional medicine. All patient appointments and/or walk-ins to see the RN and/or PCP are logged in by date along with the patient complaints. Health care is provided to patients in one small medical unit. There is one examination room. The physician findings and recommendations are based upon the observations made during the tour of the facility, conversations with medical staff, patient interviews, and review of selected health records.

The facility PCP has access to CCHCS policies and appeared to generally operate in accord with written guidelines and policy. As a modified community correctional facility (MCCF), DMCCF utilizes NKSP as its hub which provides telemedicine, onsite specialty services, and other clinical support. The PCP and RNs demonstrated their ability to access the CCHCS electronic Unit Health Records and the Cerner Electronic Health Record System (EHRS) upon request. The clinical space was clean and organized with excellent access to hand washing, sanitizing, sharps disposal, and appropriate biohazard disposal.

The facility conducts Daily Care Team Huddles and all patient send outs, patients seen or presented to the on-call physician, transfers to other level of care, prescriptions due to expire within three days, laboratory reconciliation, and other patient related issues are discussed by the entire medical team. The physician auditor was present for the huddle on April 25, 2018, at which time the Daily Care Team Huddle appeared well organized, appropriate, and well documented. Documentation of peer review for the current PCP was not due at the time of the audit, owing to his recent hire. On-call coverage is provided by the hub, KVSP; hence, in person coverage at DMCCF occurs 40 hours weekly, with nursing coverage available 24/7. The facility holds monthly QMC meetings which is attended by the PCP. The facility PCP gives short clinical educational talks to the clinical staff at least once weekly.

The physician auditor did not evidence any apparent back log for patient care. Access to care appears to be adequate, discussions with patients, and review of the sick call request log reveal prompt care is being delivered. Patients requiring more advanced medical care are transferred from DMCCF to the hub or

neighboring community hospital. The facility sends the patients to outside consultants for specialty service appointments. The physician auditor found the communications between the facility PCP and outside sources of care such as consultants and leadership at the hub to be excellent; the PCP doesn't hesitate to reach out for assistance or guidance. He appears motivated to provide excellent care. The auditor determined since the current PCP is new to correctional medicine and only recently began seeing patients at DMCCF, it is premature to provide an overall performance rating. However, from the review of patient records, discussions with the PCP, and onsite observations; the auditor did not find any reason to expect less than excellent medical care from the facility's PCP during the rest of his time at DMCCF.

Since the audit review period was from November 2017 through February 2018, the physician auditor primarily reviewed the care provided by the prior PCP during this period. The auditor also reviewed some of the current PCP's encounters in order to evaluate the quality of the medical care provided by him. The auditor determined the patients are seen timely and in a professional and compassionate manner. The PCP was found to be articulate and well-groomed. He took time to educate the patients and appeared to be genuinely concerned with patient care as well as wanting to practice medicine in a manner consistent with Title 15. Referrals to outside care and laboratory testing were determined to be generally appropriate, and the auditor spent a considerable amount of time discussing Title 15 and appropriate medic-legal concerns with the PCP. Prescribing overall seemed consistent with best practices. The PCP was found diligent to update or initiate a POLST[6] as well as establish and maintain a current Problem List.

The physician auditor determined the overall quality of medical services provided by the DMCCF PCP and nursing staff met the standards of care applied in California prisons. The medical team appeared to have a very good morale, is eager to learn and improve, and generally has a very positive approach to the delivery of care. The auditor determined the reviewed and observed care to range from adequate to proficient.

Below is a brief synopsis of each case for which the physician auditor determined the prior and current facility PCP's performance to be *inadequate*.

Case Number	Deficiencies
Case 1	***Inadequate (71.4%).*** This is a 46 year old patient who was seen in chronic care clinics for Diabetes Mellitus and Hypertension with thorough notes. However, the PCP failed to complete a timely review of the patient's diagnostic test results on two occasions during the audit review period which the physician auditor determined to be inadequate.
Case 14	***Inadequate (75.0%).*** This is a 29 year old patient with mild persistent long standing asthma who was seen in the chronic care clinic during the audit review period. Although the PCP noted the patient to have worsening control over asthma (per the diagnosis noted in the progress notes), the PCP did not document the reason for not considering an advanced therapy for better management of asthma and also failed to closely follow up with the patient. The physician auditor determined the patient's worsening asthma control demands consideration for more advanced treatment.

[6] POLST (Provider Orders for Life-Sustaining Treatment) is an approach to improving end-of-life care in the United States, encouraging providers to speak with patients and create specific medical orders to be honored by health care workers during a medical crisis.

Recommendations:

- Health care staff should continue holding monthly quality improvement meetings, documenting minutes of the discussions that occur, and develop plans/corrective actions to be implemented for correcting the deficiencies identified during the meetings.
- The PCP is encouraged not to accept signed "refusal" slips as sufficient; the PCP is encouraged to have the patient come to the clinic to discuss the refusal, its possible adverse effects, and to generate a personalized refusal for documenting in the patient's health record.
- The PCP should continue to encourage nurses to seek contemporaneous advice or physical examination of patients with new symptoms, persistent problem, or worsening condition.

PRIOR CRITICAL ISSUE RESOLUTION

The previous audit conducted on October 17 through 19, 2017, resulted in the identification of 21 quantitative critical issues and four qualitative critical issues. During the current audit, auditors found 16 of the 25 issues resolved, and seven quantitative critical issues not resolved within the established compliance threshold. Two qualitative critical issues were not evaluated due to unavailability of valid samples that met the criteria for evaluation. Below is a discussion of each previous critical issue:

Critical Issue	Status	Comment
Question 1.2 – *THE FACILITY'S LOCAL OPERATING PROCEDURES/POLICIES (LOP) ARE NOT ALL IN COMPLIANCE WITH THE INMATE MEDICAL SERVICES POLICIES AND PROCEDURES (IMSP&P).*	**Resolved**	This deficiency was initially identified during the April 2016 audit. At the time, five out of 15 of the facility's LOPs were not compliant with IMSP&P resulting in 66.7% compliance. During the October 2017 audit, DMCCF again failed to update all of their LOPs resulting in 21.4% compliance. A review of DMCCF's LOPs during the current audit showed DMCCF has made significant improvement by updating 12 of the 15 LOPs. As a result, DMCCF met the compliance threshold by receiving 80.0% rating. The remaining three non-compliant LOPs will be reviewed during the upcoming audits for compliance. ***This critical issue is resolved.***
Question 1.7 – *THE FACILITY DOES NOT PROVIDE REQUESTED COPIES OF MEDICAL RECORDS TO PATIENTS WITHIN 15 BUSINESS DAYS FROM THE DATE OF THE INITIAL REQUEST.*	**Resolved**	This deficiency was initially identified during the October 2017 audit. At the time, a review of 12 entries in the ROI log showed DMCCF failed to provide the requested copies of the medical records to five patients within the 15 business day time frame, which resulted in 58.3 % compliance. During the current audit, DMCCF was found 100% compliant for this requirement. ***This critical issue is resolved.***
Question 2.3 – *THE FACILITY'S QMC REVIEW PROCESS DOES NOT INCLUDE MONITORING OF DEFINED ASPECTS OF CARE FOR IDENTIFIED OPPORTUNITIES FOR IMPROVEMENT OF MEDICAL SERVICES DISCUSSED DURING THE QMC MEETINGS.*	**Unresolved**	This deficiency was initially identified during the April 2016 audit. At the time, minutes of five QMC meetings were reviewed and the minutes for two months did not include a monitoring of defined aspects of care resulting in 60.0% compliance. During the October 2017 audit, three out of six QMC meeting minutes reviewed did not contain the required data resulting in 50.0% compliance. During the current audit, none of the four QMC meeting minutes reviewed included a review process for monitoring defined aspects of care resulting in 0.0% compliance. ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***

Question 3.2 – *SOME OF THE FACILITY'S CUSTODY STAFF DO NOT HAVE THE REQUIRED CARDIO PULMONARY RESUSCITATION (CPR) CERTIFICATION.*	**Resolved**	This deficiency was initially identified during the October 2017 audit. At the time, 16 custody staff did not have a current CPR certifications which resulted in 78.1% compliance. During the current audit, DMCCF was found 100% compliant for this requirement. ***This critical issue is resolved.***
Question 4.7 – *THE PATIENT CHRONIC CARE FOLLOW-UP VISITS ARE NOT COMPLETED AS ORDERED.*	**Resolved**	The issue was initially identified during the October 2017 audit. At the time, review of 24 patient health records showed five patients' chronic care visits were not completed as ordered resulting in 79.2% compliance. During the current audit, a review of 16 electronic health records showed only four patient visits were not completed as ordered resulting in a compliance score of 87.5%. ***This critical issue is resolved.***
Question 6.1 – *THE FACILITY'S NURSING STAFF DO NOT CONSISTENTLY REVIEW THE DISCHARGE PLAN/INSTRUCTIONS UPON THE PATIENT'S RETURN FROM A COMMUNITY HOSPITAL.*	**Resolved**	The issue was initially identified during the October 2017 audit. At the time, a review of 15 patient health records showed the discharge plans of four patients were not reviewed upon their return from the community hospital resulting in 73.3% compliance. During the current audit, DMCCF was found 100% compliant for this requirement. ***This critical issue is resolved.***
Question 6.3 – *PATIENTS ARE NOT ROUTINELY SEEN BY THE PRIMARY CARE PROVIDER FOR A FOLLOW-UP APPOINTMENT WITHIN FIVE CALENDAR DAYS OF RETURN FROM A COMMUNITY HOSPITAL.*	**Resolved**	The issue was initially identified during the October 2017 audit. At the time, a review of 12 patient health records revealed four patients were not seen by the provider for a follow-up appointment within the specified time frame resulting in 66.7% compliance. During the current audit, DMCCF was found 100% compliant for this requirement. ***This critical issue is resolved.***
Question 6.4 – *PATIENTS RETURNING TO DMCCF FROM A COMMUNITY HOSPITAL OR HUB INSTITUTION WITH EXISTING MEDICATION ORDERS, DO NOT CONSISTENTLY RECEIVE THEIR PRESCRIBED MEDICATIONS TIMELY.*	**Unresolved**	The issue was initially identified during the October 2017 audit. At the time, a review of nine patient health records showed two patients did not receive their prescribed medications resulting in 77.8% compliance. During the current audit, a review of three records showed one patient did not receive the prescribed medications upon their return to DMCCF from the hub and/or community hospital discharge resulting in a compliance score of 66.7%. ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***
Question 7.4 – *THE PATIENTS ARRIVING AT DMCCF ARE NOT BEING SEEN FOR THEIR MEDICAL, DENTAL OR MENTAL HEALTH APPOINTMENTS AS SPECIFIED BY THE SENDING FACILITY'S PROVIDER.*	**Resolved**	The issue was initially identified during the October 2017 audit. At the time, a review of two patient health records showed one patient was not seen by the provider resulting in 50.0% compliance. During the current audit, DMCCF was found 100% compliant for this requirement. ***This critical issue is resolved.***
Question 8.1 – *CHRONIC CARE MEDICATIONS ARE NOT CONSISTENTLY RECEIVED BY THE PATIENT WITHIN THE REQUIRED TIME FRAME.*	**Unresolved**	This deficiency was initially identified during the April 2016 audit. At the time, a review of 29 patient health records showed nine patients did not receive their medications timely resulting in 69.0% compliance. During the October 2017 audit, a review of 23 patient health records showed DMCCF failed to provide the medications to 17 patients within the specified time frame resulting in 26.1% compliance. During the current audit, a review of 16 records showed five patients did not receive their chronic care medications indicating DMCCF has once again failed to correct this critical issue. The facility scored 68.8% compliance. ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***

Question 8.6 (*formerly Question 8.7) – THE PROVIDER DOES NOT CONSISTENTLY DOCUMENT EDUCATION WAS PROVIDED TO PATIENTS ON THEIR NEWLY PRESCRIBED MEDICATIONS.*	**Unresolved**	The issue was initially identified during the October 2017 audit. At the time, a review of 18 patient health records showed six patients were not provided education on their new prescription medications resulting in 66.7% compliance. During the current audit, 12 records were reviewed and it was found the PCP did not educate three patients on their newly prescribed medications, which resulted in a compliance score of 75.0%. ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***
Question 8.8 *(formerly Question 8.9) – NURSING STAFF DO NOT CONSISTENTLY CONFIRM THE IDENTITY OF THE PATIENT PRIOR TO THE ADMINISTRATION OF MEDICATION.*	**Resolved**	The issue was initially identified during the October 2017 audit. During the onsite audit, the NCPR auditor observed four nursing staff administering medications and saw one nurse did not confirm the identity of the patient before administering medication resulting in 75.0% compliance. During the current audit, DMCCF was found 100% compliant for this requirement. ***This critical issue is resolved.***
Question 8.12 *(formerly Question 8.13) – SOME OF THE FACILITY'S NURSING STAFF IS NOT KNOWLEDGEABLE ABOUT THE MEDICATION ERROR REPORTING PROCEDURE.*	**Resolved**	This deficiency was initially identified during the April 2016 audit. At the time, three nursing staff were interviewed by the NCPR auditor regarding the process and two of them were not knowledgeable about the medication error reporting process which resulted in 33.3% compliance. During the October 2017 audit, the nurse auditor interviewed three nursing staff and found two staff were not knowledgeable about the process. The facility again received 33.3% compliance rating. During the current audit, the NCPR auditor interviewed two nursing staff and both were knowledgeable of this process and the facility achieved 100% compliance for this requirement. ***This critical issue is resolved.***
Question 10.3 – *THE NURSING STAFF DO NOT CONSISTENTLY NOTIFY THE PROVIDER OF ANY IMMEDIATE ORDER OR FOLLOW-UP INSTRUCTIONS PROVIDED BY THE SPECIALTY CARE CONSULTANT.*	**Unresolved**	The issue was initially identified during the October 2017 audit. At the time, 12 patient records were reviewed and the nurse auditor found only one patient health record had documentation to show the nursing staff notified the PCP of immediate orders or follow-up instructions received from the specialty care consultant, resulting in 8.3% compliance. During the current audit, two out of four records reviewed had the required documentation resulting in 50.0% compliance. ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***
Question 10.4 – *THE PROVIDER DOES NOT CONSISTENTLY REVIEW PATIENT'S DISCHARGE SUMMARY OR COMPLETE A FOLLOW-UP APPOINTMENT UPON PATIENT'S RETURN FROM A SPECIALTY APPOINTMENT.*	**Resolved**	The issue was initially identified during the October 2017 audit. At the time, a review of 21 patient health records showed the PCP failed to review the discharge plans of six patients and/or complete a follow-up appointment with the patients which resulted in a compliance rating of 71.4%. During the current audit, nurse auditor reviewed ten patient health records and found eight records to be compliant. As a result, DMCCF achieved 80.0% compliance rating. ***This critical issue is resolved.***
Question 11.3 – *THE FACILITY DOES NOT CONSISTENTLY OFFER COLORECTAL CANCER SCREENING TO THE PATIENT POPULATION 50-75 YEARS OF AGE.*	**Unresolved**	The issue was initially identified during the October 2017 audit. At the time, a review of 13 records showed ten patients were not offered a colorectal screening resulting in 23.1% compliance. During the current audit, a review of 20 patient health records showed five patients were not offered the screening and facility achieved 75.0% compliance. ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***
Question 12.2 – *THE FACILITY DID NOT CONSISTENTLY DOCUMENT THE RESPONSE*	**Resolved**	The issue was initially identified during the October 2017 audit. At the time, a review of the facility's Emergency

TIMES OF THE MEDICAL STAFF TO EMERGENCY MEDICAL ALARMS DURING FACILITY'S EMERGENCY MEDICAL DRILLS/MEDICAL RESPONSES.		Medical documentation for ten incidents showed the facility did not note the response times of medical staff for three incidents resulting in 70.0% compliance. During the current audit, the facility was found to be 100% compliant for this requirement. ***This critical issue is resolved*.**
Question 12.4 – *THE FACILITY'S EMERGENCY MEDICAL RESPONSE REVIEW COMMITTEE (EMRRC) DOES NOT CONSISTENTLY PERFORM TIMELY INCIDENT PACKAGE REVIEWS CONTAINING THE REQUIRED REVIEW DOCUMENTS.*	**Unresolved**	This deficiency was initially identified during the April 2016 audit. At the time, a review of six incident packages revealed five packages did not contain the required documents resulting in 16.7% compliance. During the October 2017 audit, 10 of 12 incident packages did not meet this requirement which again resulted in 16.7% compliance rating. During the current audit, it was found DMCCF again failed to meet this requirement scoring 0.0% compliance due to the required documents missing in all 12 incident packets reviewed. ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***
Question 12.6 – *THE FACILITY DOES NOT CONSISTENTLY RESUPPLY AND RESEAL THE EMERGENCY MEDICAL RESPONSE (EMR) BAGS FOLLOWING USE DURING MEDICAL EMERGENCIES AND/OR EMR DRILLS.*	**Resolved**	This deficiency was initially identified during the April 2016 audit. During the onsite audit, auditor's review of the EMR bag log showed EMR bags were not re-stocked and resealed following two out of three EMR responses. This resulted in a compliance rating of 66.7%. During the October 2017 audit, the EMR bags were not re-stocked and resealed the following two out of four EMR responses resulting in 50.0% compliance. During the current audit, the facility was found to be 100% compliant for this requirement. ***This critical issue is resolved.***
Question 12.7 – *THE FACILITY DOES NOT CONSISTENTLY INVENTORY THE EMERGENCY MEDICAL RESPONSE BAG ON A MONTHLY BASIS.*	**Resolved**	The issue was initially identified during the October 2017 audit. During the onsite audit, NCPR auditor's review of the EMR bag log showed EMR bags were not inventoried during two out of four months reviewed resulting in 50.0% compliance. During the current audit, the facility was found to be 100% compliant for this requirement. ***This critical issue is resolved.***
Question 12.14 – *THE OXYGEN TANK DID NOT HAVE A NASAL CANNULA OR MASK ATTACHED TO THE TANK.*	**Resolved**	The issue was initially identified during the October 2017 audit. During the onsite audit, the auditor noted the clinic's portable oxygen tank was lacking a nasal cannula or mask making it non-functional for a medical emergency. During the current audit, auditor observed the facility has corrected this issue and portable oxygen tank was fully functional. ***This critical issue is resolved.***
Qualitative Issue # 1 – *THE EMERGENCY MEDICAL RESPONSE REVIEW COMMITTEE DOES NOT REVIEW ALL THE UNSCHEDULED EMERGENT/URGENT TRANSFERS TO THE HUB INSTITUTION FOR FURTHER EVALUATION FOR TIMELINESS AND APPROPRIATE RESPONSE BY CUSTODY AND HEALTH CARE STAFF.*	**Resolved**	The issue was initially identified during the October 2017 audit during the auditor's review of EMRCC meeting minutes. During the current audit, it was found the facility's EMRRC reviews all unscheduled emergency/urgent transfers to the hub to evaluate the timeliness and appropriate responses by health care staff. ***This critical issue is resolved.***
Qualitative Issue # 2 – *DMCCF DOES NOT ALLOW PATIENTS HOUSED IN THE HOLDING CELL TO HAVE PRESCRIBED KEEP-ON PERSON (KOP) MEDICATIONS IN THEIR CELL.*	**Not Rated**	The issue was initially identified during the October 2017 audit. At the time, the NCPR auditor observed the patients housed in the holding cell were not provided their KOP medications. During the current audit, the auditor could not evaluate this issue since there were no patients housed in the holding cell during the onsite audit. This requirement was not rated. ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***
Qualitative Issue # 3 – *THE PATIENTS HOUSED IN THE HOLDING CELL ARE NOT*	**Not Rated**	The issue was initially identified during the October 2017 audit. At the time, the NCPR auditor observed the health care

BROUGHT TO THE MEDICAL CLINIC FOR THEIR NON-EMERGENT/URGENT HEALTH CARE SERVICES.		staff assessed and provided the services to the patients inside their holding cells. During the current audit, the auditor could not evaluate this issue since there were no patients housed in the holding cell during the onsite audit. This requirement was not rated. ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***
Qualitative Issue # 4 – *THE EXAM TABLES IN BOTH THE NURSING AND PHYSICIAN EXAM ROOMS HAVE TEARS IN THE NON-POROUS MATERIAL.*	**Resolved**	The issue was initially identified during the October 2017 audit. During the current audit, the auditor observed the facility has replaced the torn covers on the exam tables. ***This critical issue is resolved.***

CONCLUSION

The audit findings discussed in this report are a result of a thorough evaluation of the health care services provided by DMCCF to the patient population during the audit review period of November 2017 through February 2018. The facility's overall performance during this time frame was rated as *Proficient.* Of the 14 components evaluated, the auditors found 9 components to be *Proficient*, 4 *Adequate,* and 1 *Inadequate* (refer to the *Executive Summary Table* on page 4). The facility resolved 16 of the 25 prior critical issues. Nine issues remain unresolved of which three issues were initially identified during the April 2016 audit, and six were identified during the October 2017 audit. In addition, five new quantitative critical issues and two new qualitative critical issues were identified during the current audit.

The facility made significant improvements by resolving the majority of its past critical issues through implementation of an internal audit process and tracking mechanisms to proactively identify problems with provision of timely medical services to patients and by providing essential training to all incumbent health care staff. The facility periodically checks nursing staff's knowledge on nursing protocols, conducts regular internal review on the clinic's health care processes, and was successful in updating 12 of the 15 policies which currently meet IMPS&P guidelines. However, the current audit identified five critical issues which the facility has struggled with resolving since August 2014. These are listed in the table below and explained in the individual component sections.

Critical Issues	Full Audit August 2014	Full Audit March 2015	Limited Review November 2015	Full Audit April 2016	Full audit October 2017	Full Audit April 2018
Question 2.3 – The Quality Management Committee's review process does not include monitoring of defined aspects of care for identified opportunities for improvement.	Fail	Fail	Pass	Fail	Fail	Fail
Question 2.5 – The facility does not accurately document all data in the sick call monitoring log.	Fail	Pass	N/A	Fail	Pass	Fail
Question 8.1 – The facility does not consistently provide the patients their chronic care medications within the specified time frame.	Fail	Pass	N/A	Fail	Fail	Fail
Question 8.6 – The facility's provider does not consistently educate the patients on their newly prescribed medications.	Fail	Fail	Pass	Pass	Fail	Fail
Question 12.4 – The facility's EMRRC does not consistently perform timely incident package reviews containing the required review documents.	N/A	Fail	Fail	Fail	Fail	Fail

N/A - Questions with a documented N/A score in the above table is either due to the question not having been evaluated due to the unavailability of samples that met the criteria, was not required to be reviewed during that audit per the audit methodology, or the question had not been a part of the audit tool at the time of the corresponding audit.

The facility's QMC is not monitoring defined aspects of care to track health care process improvements. Although DMCCF conducts regular monthly QMC meetings, the facility has not implemented an efficient internal tracking mechanism to measure process improvements following the implementation of corrective action plans to mitigate identified deficiencies. During May 2017, the facility implemented a log/process to identify the corrective action plans taken to improve various processes; however, this

process failed to document the steps to be taken to determine the effectiveness of the action plans. Shortly thereafter, DMCCF also implemented a medical ducat process, which again failed to identify when or if a follow-up would occur to determine effectiveness of this process. During the current audit, the NCPR auditor explained to the HSA the importance of conducting and recording performance trends periodically following the implementation of corrective action plans (CAP). The staff should conduct weekly checks and record data, and use it to create a statistical report that provides a percentage value for changes/improvements that resulted following the CAP implementation. This report should then be discussed during the monthly QMC meetings. Based on the data presented, strategies to improvise the existing CAP should be discussed and executed.

The second consistent critical issue identified is the timely provision of chronic care medications to patients. This has been an ongoing struggle for DMCCF since August 2014 audit. During the current audit, the facility staff stated they currently track all medication refills diligently and ensure auto refills are received in a timely manner. The SRN attributed the late administration of medications to the late receipt of medications refilled on Fridays. They believe the Central Fill pharmacy processes these orders the following Monday causing a delay in hub receiving these medications. This was discussed previously in the *Medication Management* component of this report along with the recommendations made by the NCPR auditor to address this problem.

The third consistent critical issue is related to DMCCF staff not completing the required emergency forms during actual emergency responses. This facility has continuously failed five times to meet this requirement since the March 2015 audit. This critical issue was discussed previously in the *Emergency Medical Response/Drills and Equipment* component of this report. The NCPR auditor had an in-depth conversation with the HSA and the SRN on this issue; the auditor reiterated facility staff have to complete these forms during medical emergencies and when patients are transported to an emergency room. The SRN stated the nurses are not required to complete these forms and these cannot be included in the incident package if the custody staff do not provide them the completed forms. Following the audit, NCPR auditor researched this issue further and found the current CDCR Form 7219 does not state custody officers are required to complete the form. The NCPR auditor informed the SRN via email that the nursing staff should complete the required emergency forms and place in the incident package for EMRRC's review in order to meet compliance for this requirement.

At the conclusion of the audit, the auditors held an Exit Conference and discussed the preliminary audit findings and recommendations with DMCCF facility and health care management. The health care staff at DMCCF were extremely receptive to the findings, suggestions, and recommendations presented by the audit team and expressed their dedication to implementing new processes to improve health care services for California patients in the areas that fell deficient during this audit.

APPENDIX A – QUANTITATIVE REVIEW RESULTS

Delano Modified Community Correctional Facility Range of Summary Scores: 79.2% - 100%	
Audit Component	**Quantitative Score**
1. Administrative Operations	85.0%
2. Internal Monitoring & Quality Management	79.6%
3. Licensing/Certifications, Training & Staffing	100.0%
4. Access to Care	98.8%
5. Diagnostic Services	93.2%
6. Emergency Services & Community Hospital Discharge	91.7%
7. Initial Health Assessment/Health Care Transfer	98.2%
8. Medical/Medication Management	94.0%
9. Observation Cells (COCF)	Not applicable
10. Specialty Services	80.0%
11. Preventive Services	91.7%
12. Emergency Medical Response/Drills & Equipment	88.9%
13. Clinical Environment	100.0%
14. Quality of Nursing Performance	Not Applicable
15. Quality of Provider Performance	Not Applicable

1. Administrative Operations		Yes	No	Compliance
1.1	Does health care staff have access to the facility's health care policies and procedures and know how to access them?	5	0	100.0%
1.2	Does the facility have current and updated written health care policies and local operating procedures that are in compliance with *Inmate Medical Services Policies and Procedures* guidelines?	12	3	80.0%
1.3	Does the facility have current contracts/service agreements for routine oxygen tank maintenance service, hazardous waste removal, and repair, maintenance, inspection, and testing of biomedical equipment?	3	0	100.0%
1.4	Does the patient orientation handbook/manual or similar document explain the sick call and health care grievance processes?	2	0	100.0%
1.5	Does the facility's provider(s) access the California Correctional Health Care Services patient electronic medical record system regularly?	1	0	100.0%
1.6	Does the facility maintain a Release of Information log that contains ALL the required data fields and all columns are completed?	0	1	0.0%
1.7	Did the facility provide the requested copies of medical records to the patient within 15 business days from the date of the initial request?	18	0	100.0%
1.8	Are all patient and/or third party written requests for health care information documented on a CDCR Form 7385, *Authorization for Release of Information*, and copies of the forms filed in the patient's electronic medical record?	18	0	100.0%
	Overall Percentage Score:			**85.0%**

Comments:

Question 1.2 Three of the facility's health care LOPs reviewed, namely, the *Release of Information*, *Health Care Staff Licensure, Training and Staffing*, and *Narcan Use and Storage* were found to be non-compliant with the IMSP&P.

Question 1.6 The facility received a total of 19 ROI requests during the audit review period; however, only 18 requests were documented in the ROI log.

2. Internal Monitoring & Quality Management		Yes	No	Compliance
2.1	Did the facility hold a Quality Management Committee meeting a minimum of once per month?	4	0	100.0%
2.2	Did the Quality Management Committee's review process include documented corrective action plan for the identified opportunities for improvement?	4	0	100.0%
2.3	Did the Quality Management Committee's review process include monitoring of defined aspects of care?	0	4	0.0%
2.4	Did the facility submit the required monitoring logs by the scheduled date per Private Prison Compliance and Monitoring Unit program standards?	59	0	100.0%
2.5	Is data documented on the sick call monitoring log accurate?	13	5	72.2%
2.6	Is data documented on the specialty care monitoring log accurate?	16	1	94.1%
2.7	Is data documented on the hospital stay/emergency department monitoring log accurate?	15	2	88.2%
2.8	Is data documented on the chronic care monitoring log accurate?	18	2	90.0%
2.9	Is data documented on the initial intake screening monitoring log accurate?	18	2	90.0%
2.10	Are the CDCR Forms 602-HC, *Health Care Grievance (Rev. 06/17) and 602 HC A, Health Care Grievance Attachment (Rev. 6/17),* readily available to patients in all housing units?	2	0	100.0%
2.11	Are patients able to submit the CDCR Forms 602-HC, *Health Care Grievances,* on a daily basis in all housing units?	2	0	100.0%
2.12	Does the facility maintain a Health Care Grievance log that contains all the required information?	0	1	0.0%

2.13	Are institutional level health care grievances being processed within specified time frames?	2	0	100.0%
	Overall Percentage Score:			**79.6%**

Comments:

Question 2.3 The NCPR auditor's review of the QMC meeting minutes for the audit review period of November 2017 through February 2018 showed the facility did not conduct any validation audits to monitor defined aspects of care.

Question 2.5 The HPS I auditor reviewed 18 entries within the Sick call monitoring log for the audit review period and found five entries with missing/erroneous data; namely, (a) missing date of receipt of patient's sick call form, (b) misspelled first name of patient, (c) wrong date of receipt of sick call form, (d) sick call form missing in EHRS (two entries), and (e) the PCP's progress note missing in the EHRS.

Question 2.6 The HPS I auditor reviewed 17 entries within the Specialty Care monitoring log for the audit review period and found one entry with erroneous data. The date was documented showing a specialty service was provided; however, the test was postponed per the PCP's documentation on the CDCR Form 7393 *Notification of Diagnostic Test Results*.

Question 2.7 The HPS I auditor reviewed 17 entries within the Hospital/ED monitoring log for the audit review period and found two entries with erroneous data; namely, wrong PCP assessment date (one entry), and incorrect date of patient's return to the facility from the hub (the other entry).

Question 2.8 The HPS I auditor reviewed 20 entries within the Chronic Care monitoring log and found two entries with erroneous data; namely, wrong actual PCP assessment date (one entry), and missing PCP's progress note in the EHRS (the other entry).

Question 2.9 The HPS I auditor reviewed 20 entries within the Intake Screening monitoring log. Dates of initial intake screening for two of these entries could not be validated due to the CDCR Form 7277 missing in the patient's EHRS.

Question 2.12 The screening disposition drop down field in the facility's grievance log was not updated to the current requirements CCHCS Health Care Grievances Operational Standards and California Code of Regulations, Title 15, Article 8.6, Health Care Grievances. The current disposition criteria is to be stated as "intervention", "no intervention", or "no further intervention"; however, the drop down boxes in the log listed the options "granted", "partially granted", and "denied". Additionally, not all grievance response due dates documented on the log reflected the 45–business day time frame accurately.

3. Licensing/Certifications, Training, & Staffing		**Yes**	**No**	**Compliance**
3.1	Are all health care staff licenses current?	11	0	100.0%
3.2	Are health care and custody staff current with required emergency medical response certifications?	70	0	100.0%
3.3	Does the facility provide the required training to its health care staff?	10	0	100.0%
3.4	Is there a centralized system for tracking all health care staff licenses and certifications?	1	0	100.0%
3.5	Does the facility have the required health care and administrative staffing coverage per contractual requirement?	1	0	100.0%
3.6	Are the peer reviews of the facility's providers completed within the required time frames?	Not Applicable		
	Overall Percentage Score:			**100.0%**

Comments:

Question 3.6 The facility's new PCP started providing services to the patients on February 20, 2018. The initial peer review for the PCP is not due until April 24, 2018. Therefore, this question could not be evaluated for compliance due to the peer review time frame falling outside the audit review period. The peer review for the prior PCP was reviewed during the October 2017 audit.

4. Access to Care		**Yes**	**No**	**Compliance**
4.1	Did the registered nurse review the CDCR Form 7362, *Health Care Services Request*, or similar form, on the day it was received?	16	0	100.0%
4.2	Following the review of the CDCR Form 7362, or similar form, did the registered nurse complete a face-to-face evaluation of the patient within the specified time frame and document the evaluation in the appropriate format?	16	0	100.0%
4.3	Was the focused subjective/objective assessment conducted based upon the patient's chief complaint?	16	0	100.0%
4.4	Did the registered nurse implement appropriate nursing action based upon the documented subjective/objective assessment data within the nurse's scope of practice or supported by the standard Nursing Protocols?	16	0	100.0%
4.5	Did the registered nurse document that effective communication was established and that education was provided to the patient related to the treatment plan?	16	0	100.0%
4.6	If the registered nurse determined a referral to the primary care provider was necessary, was the patient seen within the specified time frame?	12	0	100.0%
4.7	Was the patient's chronic care follow-up visit completed as ordered?	14	2	87.5%
4.8	Did the Care Team regularly conduct and properly document a Care Team Huddle during business days?	19	0	100.0%
4.9	Does nursing staff conduct daily rounds in segregated housing units and collect CDCR Form 7362, *Health Care Services Request*, or similar forms? (COCF only)	Not Applicable		
4.10	Are the CDCR Forms 7362, *Health Care Services Request*, or similar form, readily accessible to patients in all housing units?	2	0	100.0%
4.11	Are patients in all housing units able to submit the CDCR Forms 7362, *Health Care Services Request*, or similar form, on a daily basis?	2	0	100.0%
	Overall Percentage Score:			**98.8%**

Comments:

Question 4.7 The nurse auditor reviewed 16 electronic health records and found chronic care visits for two patients were not completed within the specified time frames.

Question 4.9 This question does not apply to the California in-state MCCFs.

5. Diagnostic Services		**Yes**	**No**	**Compliance**
5.1	Did the primary care provider complete a Physician's Order for each diagnostic service ordered?	12	0	100.0%
5.2	Was the diagnostic test completed within the time frame specified by the primary care provider?	11	0	100.0%
5.3	Did the primary care provider review, sign, and date the patient's diagnostic test report(s) within two business days of receipt of results?	11	0	100.0%
5.4	Was the patient given written notification of the diagnostic test results within two business days of receipt of results?	8	3	72.7%
	Overall Percentage Score:			**93.2%**

Comments:

Question 5.4 The nurse auditor reviewed 11 patients' electronic health records, of which three records showed the patients were not provided a written notification of their diagnostic test results within two business days of receipt of the results.

6. Emergency Services & Community Hospital Discharge		**Yes**	**No**	**Compliance**
6.1	*For patients discharged from a community hospital:* Did the registered nurse review the discharge plan/instructions upon patient's return?	11	0	100.0%
6.2	*For patients discharged from a community hospital:* Did the RN complete a face-to-face assessment prior to the patient being re-housed?	11	0	100.0%
6.3	*For patients discharged from a community hospital:* Was the patient seen by the primary care provider for a follow-up appointment within five calendar days of return?	11	0	100.0%
6.4	*For patients discharged from a community hospital:* Were all prescribed medications administered/delivered to the patient per policy or as ordered by the primary care provider?	2	1	66.7%
	Overall Percentage Score:			**91.7%**

Comments:

Question 6.4 The nurse auditor reviewed three patients' electronic health records, of which one record was missing documentation of the delivery, no-show, or patient refusal of the newly prescribed medication.

7. Initial Health Assessment/Health Care Transfer		**Yes**	**No**	**Compliance**
7.1	Did the patient receive an initial health screening upon arrival at the receiving facility by licensed health care staff?	12	0	100.0%
7.2	If YES was answered to any of the questions on the Initial Health Screening form (CDCR Form 7277/7277A or similar form), did the registered nurse document an assessment of the patient?	9	0	100.0%
7.3	If the patient required referral to an appropriate provider based on the registered nurse's disposition, was the patient seen within the required time frame?	1	0	100.0%
7.4	If upon arrival, the patient had a scheduled or pending medical, dental, or a mental health appointment, was the patient seen within the time frame specified by the sending facility's provider?	2	0	100.0%
7.5	Did the patient receive a complete screening for the signs and symptoms of tuberculosis upon arrival?	12	0	100.0%
7.6	Did the patient receive a complete initial health assessment or health care evaluation by the facility's Primary Care Provider within the required time frame upon patient's arrival at the facility?	10	0	100.0%
7.7	When a patient transfers out of the facility, are all pending appointments that were not completed, documented on a CDCR Form 7371, Health Care Transfer Information Form, or a similar form?	6	1	85.7%
7.8	Does the Inter-Facility Transfer Envelope contain all the required transfer documents and medications?	2	0	100.0%
	Overall Percentage Score:			**98.2%**

Comments:

Question 7.7 The nurse auditor reviewed seven electronic health records, of which one record did not have documentation of the patient's chronic care appointment on the CDCR Form 7371.

8. Medical/Medication Management		Yes	No	Compliance
8.1	Were the patient's chronic care medications received by the patient within the required time frame?	11	5	68.8%
8.2	If the patient refused his/her keep-on-person medications, was the refusal documented on the CDCR Form 7225, Refusal of Examination and/or Treatment, or similar form?	Not Applicable		
8.3	If the patient did not show or refused the nurse administered/direct observation therapy medication(s) for three consecutive days or 50 percent or more doses in a week, was the patient referred to a primary care provider?	Not Applicable		
8.4	For patients prescribed anti-Tuberculosis medication(s): Did the facility administer the medication(s) to the patient as prescribed?	Not Applicable		
8.5	For patients prescribed anti-Tuberculosis medication(s): Did the facility monitor the patient monthly while he/she is on the medication(s)?	Not Applicable		
8.6	Did the prescribing primary care provider document that the patient was provided education on the newly prescribed medication(s)?	9	3	75.0%
8.7	Was the initial dose of the newly prescribed medication administered to the patient as ordered by the provider?	12	0	100.0%
8.8	Did the nursing staff confirm the identity of a patient prior to the delivery or administration of medication(s)?	2	0	100.0%
8.9	Did the same medication nurse who administers the nurse administered/direct observation therapy medication prepare the medication just prior to administration?	2	0	100.0%
8.10	Did the medication nurse directly observe the patient taking nurse administered/direct observation therapy medication?	2	0	100.0%
8.11	Did the medication nurse document the administration of nurse administered/direct observation therapy medications on the Medication Administration Record once the medication was given to the patient?	2	0	100.0%
8.12	Is nursing staff knowledgeable on the Medication Error Reporting procedure?	2	0	100.0%
8.13	Are refrigerated drugs and vaccines stored in a separate refrigerator that does not contain food or laboratory specimens?	1	0	100.0%
8.14	Does the health care staff monitor and maintain the appropriate temperature of the refrigerators used to store drugs and vaccines twice daily?	54	2	96.4%
8.15	Does the facility employ medication security controls over narcotic medications assigned to its clinic areas? (COCF only)	Not Applicable		
8.16	Are the narcotics inventoried at every shift change by two licensed health care staff? (COCF only)	Not Applicable		
8.17	Do patients, housed in Administrative Segregation Unit, have immediate access to the Short Acting Beta agonist inhalers or nitroglycerine tablets? (COCF Only)	Not Applicable		
	Overall Percentage Score:			**94.0%**

Comments:

Question 8.1 The nurse auditor reviewed 16 electronic health records of patients who were prescribed chronic care medications, of which 5 patient records indicated the facility failed to refill the patients' chronic care medications within the specified time frame. All five patients had run out of their first 30 day supply before they received their refills.

Question 8.2 and 8.3 There were no patients identified that refused their KOP, or nurse administered/direct observation therapy medications during the audit review period.

Questions 8.4 and 8.5 There were no patients on anti-TB medications housed in DMCCF during the audit review period.

Question 8.6. The nurse auditor reviewed 12 electronic health records of patients and three records were missing provider's documentation of providing education to the patients on the newly prescribed medications.

Question 8.14 The facility's refrigerator log for the month of February 2018 showed the facility staff failed to record temperature checks for two out of 56 shifts.

Questions 8.15 through 8.17 These questions do not apply to the California in-state MCCFs.

9. Observation Cells (COCF only)		Yes	No	Compliance
9.1	Does the health care provider order patient's placement into the observation cell using the appropriate format for order entry?	Not Applicable		
9.2	Does the health care provider document the need for the patient's placement in the observation cell within 24 hours of placement?	Not Applicable		
9.3	Does the registered nurse complete and document an assessment on the day of a patient's assignment to the observation cell?	Not Applicable		
9.4	Does the health care provider review, modify, or renew the order for suicide precaution and/or watch at least every 24 hours?	Not Applicable		
9.5	Does the treating clinician document daily the patient's progress toward the treatment plan goals and objectives?	Not Applicable		
9.6	Does nursing staff conduct rounds in observation unit once per watch and document the rounds in the unit log book?	Not Applicable		
	Overall Percentage Score:	**Not applicable**		

Comments:

Questions 9.1 through 9.6 These questions do not apply to the California in-state MCCFs.

10. Specialty Services		Yes	No	Compliance
10.1	Was the patient seen by the specialist for a specialty services referral within the specified time frame?	9	1	90.0%
10.2	Upon the patient's return from the specialty service appointment, did the registered nurse complete a face-to-face assessment prior to the patient's return to the assigned housing unit?	10	0	100.0%
10.3	Upon the patient's return from the specialty services appointment, did the registered nurse notify the primary care provider of any immediate medication or follow-up requirements provided by the specialty consultant?	2	2	50.0%
10.4	Did the primary care provider review the specialty consultant's report/discharge summary and complete a follow-up appointment with the patient within the required time frame?	8	2	80.0%
	Overall Percentage Score:			**80.0%**

Comments:

Question 10.1 The nurse auditor reviewed ten electronic health records and one record showed the patient was not seen for an urgent/high priority specialty services appointment within the 14-day time frame.

Question 10.3 The nurse auditor reviewed 11 electronic health records of patients who returned from specialty care appointments of which seven records did not meet the criteria for evaluation. Of the remaining four records reviewed, two records were missing documentation of the nursing staff notifying the facility provider of any immediate medication or follow-up appointments recommended by the specialty consultant.

Question 10.4 The nurse auditor reviewed ten electronic health records and two records were missing documentation of the nursing staff notifying the provider regarding recommended medications and/or other follow-up instructions from the specialist.

11. Preventive Services		Yes	No	Compliance
11.1	*For all patients:* Were patients screened annually for signs and symptoms of tuberculosis by the appropriate nursing staff and receive a Tuberculin Skin Test, if indicated?	20	0	100.0%
11.2	*For all patients:* Were patients offered an influenza vaccination for the most recent influenza season?	20	0	100.0%
11.3	*For all patients 50 to 75 years of age:* Were the patients offered colorectal cancer screening?	15	5	75.0%
11.4	*For female patients 50 to 74 years of age:* Were the patients offered a mammography at least every two years?	Not Applicable		
11.5	*For female patients 21 to 65 years of age:* Were the patients offered a Papanicolaou test at least every three years?	Not Applicable		
	Overall Percentage Score:			**91.7%**

Comments:

Question 11.3 The nurse auditor reviewed 20 electronic health records and five records were missing documentation of Fecal Occult Blood Test (FOBT) results, clinical results of colonoscopy, or a signed refusal of annual FOBT or screening colonoscopy.

Questions 11.4 and 11.5 These questions do not apply to facilities housing male patients.

12. Emergency Medical Response/Drills & Equipment		Yes	No	Compliance
12.1	Did the facility conduct emergency medical response drills quarterly on each shift when medical staff was present during the most recent full quarter?	3	0	100.0%
12.2	Did a registered nurse, a mid-level provider, or a primary care provider respond within eight minutes after emergency medical alarm was sounded?	12	0	100.0%
12.3	Did the facility hold an Emergency Medical Response Review Committee meeting a minimum of once per month?	4	0	100.0%
12.4	Did the Emergency Medical Response Review Committee perform timely incident package reviews that included the use of required review documents?	0	12	0.0%
12.5	Is the facility's clinic Emergency Medical Response Bag secured with a seal?	56	0	100.0%
12.6	If the emergency medical response and/or drill warranted an opening of the Emergency Medical Response Bag, was it re-supplied and re-sealed before the end of the shift?	1	0	100.0%
12.7	Was the Emergency Medical Response Bag inventoried at least once a month?	4	0	100.0%
12.8	Did the Emergency Medical Response Bag contain all the supplies identified on the facility's Emergency Medical Response Bag Checklist?	1	0	100.0%
12.9	Was the facility's Medical Emergency Crash Cart secured with a seal? (COCF Only)	Not Applicable		
12.10	If the emergency medical response and/or drill warranted an opening and use of the Medical Emergency Crash Cart, was it re-supplied and re-sealed before the end of the shift? (COCF Only)	Not Applicable		
12.11	Was the Medical Emergency Crash Cart inventoried at least once a month? (COCF Only)	Not Applicable		
12.12	Does the facility's Medical Emergency Crash Cart contain all the medications as required/approved per *Inmate Medical Services Policies and Procedures*? (COCF Only)	Not Applicable		

12.13	Does the facility's Medical Emergency Crash Cart contain the supplies identified on the facility's crash cart checklist? (COCF Only)	Not Applicable		
12.14	Does the facility have the emergency medical equipment that is functional and operationally ready?	6	0	100.0%
12.15	Does the facility store Naloxone (Narcan) in a secured area within each area of responsibility (medical clinics) and does the facility's health care staff account for the Narcan at the beginning and end of each shift?	0	1	0.0%
	Overall Percentage Score:			**88.9%**

Comments:

Question 12.4 A review of the EMRRC meeting minutes for the audit review period showed the facility failed to complete and submit the required emergency forms for the three emergency medical response drills and nine actual emergency medical responses that occurred during this period. The forms that were not completed were the CDCR Forms 7462, 7219, 7463, and 7229-B.

Questions 12.9 through 12.13 These questions do not apply to the California in-state MCCFs.

Question 12.15 The NCPR auditor conducted a check of the facility's Narcan storage location and found the facility stored the Narcan within the EMR bag secured in a locked room. However, DMCCF did not have a designated Narcan log to document a count for Narcan between two nursing shifts.

13. Clinical Environment		**Yes**	**No**	**Compliance**
13.1	Are packaged sterilized reusable medical instruments within the expiration dates shown on the sterile packaging?	Not Applicable		
13.2	If autoclave sterilization is used, is there documentation showing weekly spore testing?	Not Applicable		
13.3	Are disposable medical instruments discarded after one use into the biohazard material containers?	2	0	100.0%
13.4	Does clinical health care staff adhere to universal/standard hand hygiene precautions?	3	0	100.0%
13.5	Is personal protective equipment readily accessible for clinical staff use?	1	0	100.0%
13.6	Is the reusable non-invasive medical equipment disinfected between each patient use when exposed to blood-borne pathogens or bodily fluids?	2	0	100.0%
13.7	Does the facility utilize a hospital grade disinfectant to clean common clinic areas with high foot traffic?	1	0	100.0%
13.8	Is environmental cleaning of common clinic areas with high foot traffic completed at least once a day?	28	0	100.0%
13.9	Is the biohazard waste bagged in a red, moisture-proof biohazard bag and stored in a labeled biohazard container in each exam room?	2	0	100.0%
13.10	Is the clinic's generated biohazard waste properly secured in the facility's central storage location that is labeled as a "biohazard" area?	1	0	100.0%
13.11	Are sharps disposed of in a puncture resistant, leak-proof container that is closeable, locked and labeled with a biohazard symbol?	2	0	100.0%
13.12	Does the facility store all sharps in a secure location?	1	0	100.0%
13.13	Does health care staff account for and reconcile all sharps at the beginning and end of each shift?	56	0	100.0%
13.14	Is the facility's biomedical equipment serviced and calibrated annually?	11	0	100.0%
13.15	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	19	0	100.0%
13.16	*For Information Purposes Only (Not Scored):* Does the clinic visit location ensure the patient's visual and auditory privacy?	Not Scored		
	Overall Percentage Score:			**100.0%**

Comments:

Questions 13.1 and 13.2 The facility does not use and/or store re-usable medical instruments. Therefore, these questions do not apply.

14. Quality of Nursing Performance	Yes	No	Compliance
The quality of nursing performance is assessed during case reviews, conducted by CCHCS clinicians and is not applicable for the quantitative review portion of the health care monitoring audit. The methodology CCHCS clinicians use to evaluate the quality of nursing performance is presented in a separate document entitled *Private Prison Compliance and Health Care Monitoring Audit – Clinical Case Review Methodology/Guide.*	Not Applicable		

15. Quality of Provider Performance	Yes	No	Compliance
The quality of provider performance is assessed during case reviews, conducted by CCHCS clinicians and is not applicable for the quantitative review portion of the health care monitoring audit. The methodology CCHCS clinicians use to evaluate the quality of provider performance is presented in a separate document entitled *Private Prison Compliance and Health Care Monitoring Audit – Clinical Case Review Methodology/Guide.*	Not Applicable		

APPENDIX B – 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 Americans with Disability Act (ADA) patients housed at the facility, the Inmate Advisory Council (IAC) executive body, and a random sample of patients housed in general population (GP). The results of the interviews conducted at DMCCF are summarized in the table below.

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

Patient Interviews (not rated)
1. Are you aware of the sick call process?
2. Do you know how to obtain a CDCR Form 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 grievance process?
6. Do you know how to obtain a CDCR Form 602-HC, *Health Care Grievance*?
7. Do you know how and where to submit a completed health care grievance form?
8. Is assistance available if you have difficulty completing the health care grievance form?
Questions 9 through 21 are only applicable to ADA patients.
9. Are you aware of your current disability/DPP status?
10. Are you receiving any type of accommodation based on your disability? (Like housing accommodation, medical appliance, etc.)
11. Are you aware of the process to request reasonable accommodation?
12. Do you know where to obtain a reasonable accommodation request form?
13. Did you receive reasonable accommodation in a timely manner?
14. Have you used the medical appliance repair program? If yes, how long did the repair take?
15. Were you provided interim accommodation until repair was completed?
16. Are you aware of the grievance/appeal process for a disability related issue?
17. Can you explain where to find help if you need assistance for obtaining or completing a form, (i.e., CDCR Form 602-HC, *Health Care Grievance*, CDCR Form 1824, Reasonable Modification or Accommodation Request, 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:

The clinicians and HPS I auditor interviewed three IAC members and ten patients, of which three were ADA patients, during the onsite audit. The physician auditor interviewed the IAC members regarding their overall opinion with the quality of health care services provided at DMCCF. The IAC members described the medical access to care, delivery and provider, and nursing interaction as excellent. There was no expression of any problem with medication delivery, access to outside services, and overall health care delivery.

The HPS I auditor interviewed the three ADA patients housed at DMCCF. Two patients were mobility impaired with a permanent accommodation for the lower bunk, and were provided double mattresses for their injured back. The third patient was hearing impaired and used hearing aids. The auditor established effective communication by speaking slowly and at times loudly, confirming the patient understood the questions being asked. During this interview, the hearing impaired patient stated, he has never had problems in receiving new batteries for his hearing aids upon his request. All three patients interviewed did not express any concern and were satisfied with the accommodations provided to them by health care staff at DMCCF. The ADA patients also stated they were aware of the health care grievance, sick call, and request for reasonable accommodation processes at DMCCF.

Seven additional patients from GP were interviewed for their knowledge on the facility's sick call and health care grievance processes. All seven patients interviewed were aware of the facility's process for requesting these services and did not express any concerns with the quality of services provided to them by DMCCF health care staff.

APPENDIX C – BACKGROUND AND AUDIT METHODOLOGY

1. BACKGROUND AND PROCESS CHANGES

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

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

In accordance with the Receiver's directive, the CCHCS Field Operations and Private Prison Compliance and Monitoring Unit's (PPCMU) management plan on conducting two rounds of audits in a calendar year for the private facilities Modified Community Correctional Facilities (MCCF) and the California out-of-state correctional facilities (COCF) currently in contract with CDCR. During the first six months of the calendar year, the PPCMU audit team will conduct a full audit on all the facilities using the revised *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* (Revised November 2017) and Audit Tools. Based upon the overall audit rating received by the MCCF facility in their initial audit (*inadequate* or *adequate*), the facility will undergo a second round audit, which would be either a full or a Limited Review. The COCF facilities will undergo two rounds of audits (full review or Limited Review) per calendar year regardless of the score received during the initial audit.

2. OBJECTIVES, SCOPE, AND METHODOLOGY

The *Private Prison Compliance and Health Care Monitoring Audit Instruction Guide* was developed by 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: *IMSP&P*, *California Code of Regulations*, 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.

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 chapters in the *Administrative* and *Medical Component* sections as well as individual ratings for each component of the audit instrument.

To maintain a metric-oriented monitoring program that evaluates medical care delivery consistently at each correctional facility, CCHCS identified 12 medical and three administrative components 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 12 medical program components are: *Access to Care, Diagnostic Services, Emergency Services and Community Hospital Discharge, Initial Health Assessment/Health Care Transfer, Medical/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 three 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 component scores are calculated by taking the average of all the compliance scores for all applicable questions within that component. The outcome is expressed as a percentage rounded to the nearest tenth. The qualitative rating for each component is described as *proficient*, *adequate*, or *inadequate* according to whether standards were met more than 90%, more than 80% or less than 80%. See Table below for the breakdown of percentages and its respective quality ratings.

Percentile Score	Associated Rating
90.0% and above	Proficient
80.0% to 89.9%	Adequate
Less than 80.0%	Inadequate

Ratings for clinical case reviews in each applicable component and overall will be described similarly.

Qualitative Review

The *qualitative* portion of the audit consists of case reviews conducted by the clinicians. The clinicians include physicians and registered nurses. The clinicians complete clinical case reviews in order to evaluate

the quality and timeliness of care provided by the clinicians at the facilities. Individual patient cases are selected and followed utilizing an individual case review similar to well established methods utilized by the Joint Commission on Accreditation of Healthcare. 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 access to care, specialty care services, diagnostic services, medication management and urgent or emergent encounters. Once the required documentation is located in the record, the clinician reviews the documentation to ensure that the abovementioned services were provided to the patients in accordance with the standards and scope of practice and the IMSP&P guidelines and to ensure complete and current documentation.

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

1. *Nurse Case Review*

   The nurse consultants perform two types of case reviews:

   a. Detailed reviews – A retrospective review of ten selected patient health records is completed in order to evaluate the quality and timeliness of care provided by the facility's nursing staff during the audit review period.

   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 and two cases consist of patients transferred out of the facility with pending medical, mental health, or dental appointments. The cases are reviewed for appropriateness of initial nurse health screening, referral, timeliness of provider evaluations, continuity of care, and completeness of the transfer forms.

2. *Physician Case Review*

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

Overall Component Rating

The overall component rating is determined by reviewing the scores obtained from clinical case reviews and quantitative reviews. Scores for all components in the quantitative review are expressed as percentages. The clinical case review ratings are likewise reported in terms of the percentage of encounters that were rated as appropriate within the cases reviewed for each medical component. The final outcome for each component is expressed as a percentage and is calculated by averaging the quantitative and clinical case review scores received for that component.

For those components, where compliance is evaluated utilizing only one type of review (either clinical case or quantitative review), the overall component score will equate to the score attained in that specific review. For all those chapters under the *Medical Component* section, where compliance is evaluated utilizing both quantitative and clinical case reviews, **double weight** will be assigned to the results from the clinical case reviews, as it directly relates to the health care provided to patients. For example, in

Component 4, *Access to Care*, Facility A received 85.5% for clinical case review and 89.5% for quantitative review. The overall component score will be calculated as follows (85.5+85.5+89.5)/3 = 86.8%, equating to quality rating of *adequate*. *Note the double weight assigned to the case review score.*

Based on the derived percentage score, each quality component will be rated as either *proficient*, *adequate*, *inadequate*, or *not applicable*.

Overall Audit Rating

The overall rating for the audit is calculated by taking the percentage scores for all components (under both *Administrative* and *Medical* components) and dividing by the total number of applicable components.

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

The resultant percentage value is rounded to the nearest tenth and compared to the threshold value range (listed in Table below). The final overall rating for the audit is reported as *proficient, adequate, or inadequate* based on where the average percentage value falls among the threshold value ranges.

Average Threshold Value Range	Rating
90.0% - 100%	Proficient
80.0% - 89.9%	Adequate
0.0% to 79.9%	Inadequate

The compliance scores and ratings for each component are reported in the *Executive Summary table* of the final audit report.

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 component 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 the Private Prison Compliance and Monitoring Unit for review, the facility will be required to address and resolve all standards rated by the audit that have fallen below the 80.0% 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.