CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT

Desert View Modified Community Correctional Facility

Annual Audit

March 6 – 8, 2018

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DATE OF REPORT

June 6, 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 annual audit conducted at Desert View Modified Community Correctional Facility (DVMCCF), located in Adelanto, California, for the review period October 2017 through January 2018. At the time of the audit, CDCR's *Weekly Population Count* report, dated March 2, 2018 indicated a budgeted bed capacity of 700 beds, of which 692 were occupied with CDCR inmates.

EXECUTIVE SUMMARY

From March 6 through 8, 2018, the CCHCS audit team conducted an onsite health care monitoring audit at DVMCCF. The audit team consisted of the following personnel:

R. Delgado, Medical Doctor, Retired Annuitant (RA)
G. Hughes, Nurse Consultant, Program Review (NCPR), RA
S. Fields, NCPR, RA
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 DVMCCF. 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 CCHCS rates each of the components based on case reviews conducted by the clinician, medical record reviews conducted by Registered Nurse (RN), and onsite reviews conducted by the physician,

NCPR and HPS I auditors. The compliance scores for every applicable component may be derived from the clinical case review results alone, the medical record and/or onsite audit results alone, or a combination of both of these information sources (as reflected in the *Executive Summary Table* below).

Based on the quantitative and/or clinical case reviews conducted for the 14 components, DVMCCF achieved an overall compliance score of **86.6%,** which corresponds to a rating of *Adequate*. Refer to Appendix A for results of the quantitative review, Appendix B for results of the patient interviews conducted at DVMCCF, 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 DVMCCF audit conducted on October 31 through November 1, 2016, the overall compliance rating was 80.2%, indicating a current increase of 6.4 percentage points.

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

Executive Summary Table

Audit Component	MD Case Review Score	NCPR Case Review Score	Overall Case Review Score	Quantitative Review Score	Overall Component Score	Overall Component Rating
1. Administrative Operations	Not Applicable	Not Applicable	Not Applicable	97.5%	97.5%	Proficient
2. Internal Monitoring & Quality Management	Not Applicable	Not Applicable	Not Applicable	83.3%	83.3%	Adequate
3. Licensing/Certifications, Training & Staffing	Not Applicable	Not Applicable	Not Applicable	100.0%	100.0%	Proficient
4. Access to Care	80.0%	70.5%	75.3%	98.5%	83.0%	Adequate
5. Diagnostic Services	100.0%	100.0%	100.0%	89.6%	96.5%	Proficient
6. Emergency Services & Community Hospital Discharge	87.5%	63.6%	75.6%	85.0%	78.7%	Inadequate
7. Initial Health Assessment/Health Care Transfer	100.0%	91.7%	95.8%	92.4%	94.7%	Proficient
8. Medical/Medication Management	50.0%	84.6%	67.3%	91.9%	75.5%	Inadequate
9. Observation Cells	Not	Not	Not	Not	Not	Not
10. Specialty Services	100.0%	46.2%	73.1%	71.9%	72.7%	Inadequate
11. Preventive Services	Not Applicable	Not Applicable	Not Applicable	89.7%	89.7%	Adequate
12. Emergency Medical Response/Drills & Equipment	Not Applicable	Not Applicable	Not Applicable	100.0%	100.0%	Proficient
13. Clinical Environment	Not	Not	Not	100.0%	100.0%	Proficient
14. Quality of Nursing Performance	Not Applicable	75.4%	75.4%	Not Applicable	75.4%	Inadequate
15. Quality of Provider Performance	65.3%	Not Applicable	65.3%	Not Applicable	65.3%	Inadequate
				Overall Audit Score and Rating	86.6%	Adequate

NOTE: For specific information regarding any non-compliance findings indicated in the tables above, please refer to the *Identification of Critical Issues* (located on page five of this report), or to the detailed audit findings by component sections (located on pages seven through 33) of this report.

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 – Desert View Modified Community Correctional Facility	
Question 2.1	The Quality Management Committee meeting minutes are not consistently signed and approved by the facility's warden/designee. ***This is a new critical issue.***
Question 2.4	The facility did not submit all weekly and monthly monitoring logs within the specified time frames during the audit review period. ***This is a new critical issue.***
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 2.6	The facility does not accurately document all the data in the Specialty Services monitoring log. ***This critical issue remains unresolved since the October 2016 audit****.*
Question 2.7	The facility does not accurately document all the data on the Hospital/ Emergency Department (ED) monitoring log. ***This is a new critical issue.***
Question 2.13	The facility does not process patients' first level health care grievances within the specified time frame. ***This critical issue remains unresolved since the February 2016 audit****.*
Question 6.1	The facility nursing staff do not consistently review the patients' discharge plans/instructions upon their return from a community hospital visit. ***This is a new critical issue.***
Question 7.2	The facility RN does not consistently document an assessment of each question that is answered "yes" by the patients on the *Initial Intake Screening* Form (CDCR Form 7277/7277 A). ***This is a new critical issue.***
Question 7.3	The facility does not consistently refer patients to the appropriate provider based on the RN's disposition. ***This is a new critical issue.***
Question 8.1	The facility does not consistently provide the patients their chronic care medications within the specified time frame. ***This critical issue remains unresolved since the September 2017 Limited Review audit****.*
Question 8.7	The facility does not consistently administer newly prescribed medications to the patients within the specified time frame. ***This is a new critical issue.***
Question 10.3	The facility RN does not notify the facility provider of any immediate medication or follow-up appointments recommended by the specialty consultant, upon the patients' return from specialty care appointments. ***This is a new critical issue.***
Question 11.2	The facility did not consistently document the administration or the refusal of the influenza vaccine for all patients for the most recent influenza season. ***This is a new critical issue.***
Qualitative Critical Issue #1	The facility medical staff do not log into the electronic Unit Health Record System (e-UHR) besides accessing Cerner electronic Health Record System

	(EHRS). This resulted in the staff losing access to both e-UHR and EHRS which required password resets and/or account reactivation. ***This is a new critical issue.***
Qualitative Critical Issue #2	The facility does not consistently document the accurate health care grievance response due dates on the health care grievance log to reflect the 45-day time frame for processing grievances. ***This is a new critical issue.***
Qualitative Critical Issue #3	The facility does not utilize the Daily Huddle form appropriately. Information to report on must be entered prior to the Daily Care Team Huddles. Instead, the facility staff complete the form retrospectively throughout the day. ***This is a new critical issue.***
Qualitative Critical Issue #4	The facility's Request for Services (RFS) procedure to obtain approvals for outside consultations and procedures does not follow the IMSP&P guidelines for RFS review and approval. ***This is a new critical issue.***
Qualitative Critical Issue #5	The facility does not consistently obtain dictated consultations from offsite specialists in a timely manner. ***This is a new critical issue.***
Qualitative Critical Issue #6	The facility health care staff do not consistently document effective communication (EC) was established during patient encounters. ***This is a new critical issue.***

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 & 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: *97.5%*

Overall Score: 97.5%

The compliance for this component is evaluated by the auditors through the review of patient medical 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

Desert View Modified Community Correctional Facility received a compliance score of 97.5% *(Proficient)* for the *Administrative Operations* component. Out of 15 LOPs that were reviewed, 12 were determined to be compliant with the IMSP&P guidelines. The issues identified with the three non-compliant LOPs are listed below.

- The *Access to Care* policy does not include the *Complete Care Model* (CCM) component, the *Nurse Care Management/Care Coordinator process* as outlined in the IMSP&P Volume 4, Chapter 1.5. This procedure describes the nurse's role in assessing and developing a treatment plan for each patient and outlines the duties of the Registered Nurse (RN) and Licensed Vocational Nurse (LVN) as Care Manager and Care Coordinator respectively. The facility needs to include this component in their policy.
- The *Licensing/Certifications, Training and Staffing* policy does not state details of all peer reviews that are required to be conducted for the facility's Primary Care Provider (PCP) and the time frames for each review. It has to be stated in the policy that DVMCCF management will conduct an initial (two month and four month) review and a final probationary review (after six months) from the time the PCP began providing health care services to the patients. The policy should also state that follow-up reviews will be completed for the PCP if the PCP's performance is determined to be inadequate.
- The *Emergency Medical Response and Drills* policy does not include details of specific IMSP&P forms that are to be utilized during emergency medical responses and drills. These forms are namely, the CDCR Form 7463, *First Medical Responder*, CDCR Form 7462, *Cardiopulmonary Resuscitation Record* and CDCR Form 7464, *Triage and Treatment Services* per the IMSP&P, Vol 4, Chapter 12.2 - *Emergency Medical Response System Procedure*.

During this audit, it was discovered that DVMCCF has shown significant improvement by updating the majority of their LOPs in order to be compliant with IMSP&P. The administrative policies are largely compliant with the current IMPS&P guidelines, only 3 out of a total of 15 LOPs (noted above) need to be updated in order to meet the standards. The facility has implemented a new internal quality control process to ensure all medical documents sent to the hub are scanned into the EHRS. In this process, the medical staff attach a face sheet to the confidential medical document folder, staff will sign and add the date to this sheet. Once the documents are received by the medical record staff at the hub, Lancaster (LAC), they are requested to sign off on this sheet to confirm receipt of the medical records. The medical record staff at DVMCCF checks EHRS to confirm the documents sent were scanned into the EHRS after three to four days of sending the original documents to LAC. Staff will check 20% of all documents that are sent to LAC for scanning. This process was implemented in February 2018.

The facility maintains a Release of Information (ROI) log and documents all requests received in the ROI log. The HPS I auditor found that DVMCCF processed all ROI requests within 15 business days of receipt of the requests during the audit review period per the information documented on the ROI log. However, there was no date stamp on the patient's ROI request, CDCR Form 7385 *Authorization for Release of Protected Health Information,* to indicate the date the request was received by the medical record staff (MRS). The ROI request only indicated the date the RN triaged the request and all 16 requests were completed within 15 business days of the RN triaging the patient's request. The auditor advised the MRS to date stamp the request to indicate the date it was received by medical. This date should be documented in the ROI log. Following the completion of the ROI request and upon providing the requested copies of medical records to the patient, the ROI request should again be stamped with a "completed" seal with the date of completion documented. This date should be documented in the ROI log. The auditor informed the MRS that the dates on the ROI log should match with those on the ROI requests.

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. The facility's quality improvement processes are evaluated by reviewing 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.

Case Review Score:
Not Applicable
Quantitative Review Score: *83.3%*

Overall Score:
83.3%

Additionally, the auditors review the monitoring logs that the facility utilizes 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 by the auditors to validate accuracy of the data reported and timely submission of the logs. Lastly, the auditors evaluate whether the facility promptly processes and appropriately addresses health care grievances. 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

Desert View Modified Community Correctional Facility received an overall compliance score of 83.3% (*Adequate*) for the *Internal Monitoring and Quality Management* component. The facility did not achieve the compliance threshold of 80.0% for 6 out of 13 questions evaluated. Of the remaining seven questions, five were scored proficient and one received an adequate score. Upon review of the facility's Continuous Quality Improvement (CQI)[1] Meeting Minutes for the audit review period, the NCPR auditor noted that the CQI minutes for November 29, 2017 were not approved and signed by the facility's warden/designee.

During the audit review period of October 2017 through January 2018, 40 submissions of monitoring logs were required. Of the 40 monitoring logs, 22 were submitted on time. The weekly monitoring logs were not submitted on October 31 and November 21, 2017, and were submitted late for the weeks of October 10 and 17, November 7, and December 26, 2017. The facility failed to submit the monthly logs for the week of November 6, 2017, and submitted the monthly logs late for the week of October 5, 2017. This equates to 64.5% compliance. See table below for additional information and details.

Type of Monitoring Log	Required Frequency of Submission	Number of Required Submissions for the Audit Review Period	Number of Timely Submissions	Number of Logs not submitted	Number of Late Submissions
Sick Call	weekly	18	12	2	4
Specialty Care	weekly	18	12	2	4
Hospital Stay/Emergency Department	weekly	18	12	2	4
Chronic Care	monthly	4	2	1	1
Initial Intake Screening	monthly	4	2	1	1
	Totals:	**62**	**40**	**64.5%**	

A total of five questions are utilized to measure the accuracy of data documented on the weekly and monthly monitoring logs and DVMCCF failed to achieve 80.0% compliance threshold for three questions. The facility's failure to document accurate data on the Specialty Care log was initially identified during October 2016 audit when the facility was found to be 59.0% compliant. During the September 2017 Limited Review Audit, DVMCCF failed to achieve compliance for this requirement resulting in 79.3% compliance. During this audit, HPS I auditor found DVMCCF has repeatedly failed to correct this deficiency and were only 77.8% compliant with this requirement. Four of the fourteen entries reviewed on the Specialty Care monitoring log showed the facility staff had documented incorrect information, namely, wrong referral dates (two entries), wrong health problem (one entry), and one patient's refusal of specialty service was not documented on the log. Additionally, the facility staff also documented incorrect patient names and CDCR numbers on the Sick Call, Hospital/ED monitoring log, Intake Screening and Chronic Care logs. A detailed summary of deficiencies are listed in Appendix A - *Quantitative Review Results*.

[1] CQI – is equivalent to Quality Management Committee (QMC).

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 the 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

The facility achieved 100% compliance *(Proficient)* for the *Licensing/Certifications, Training and Staffing* component. The facility showed significant improvement by getting all their staff trained at the hub institution, LAC. The Health Services Administrator (HSA) at DVMCCF worked diligently with LAC staff to facilitate training of all DVMCCF health care staff by shadowing the health care staff at LAC in order to learn the processes involved in the delivery of correctional health care services. All staff successfully completed this training and the HPS I auditor also learned the HSA proactively schedules the newly hired staff for shadowing staff at LAC before their start date so they can be trained within their first few weeks of employment at DVMCCF. This was an unresolved critical issue DVMCCF had failed to mitigate previously as evidenced during the September 2017 Limited Review.

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:
75.3%
Quantitative Review Score: *98.5%*
Overall Score: 83.0%

Desert View Modified Community Correctional Facility received an overall compliance score of 83.0% (*Adequate*) in the *Access to Care* component. Specific findings related to the physician and nurse case reviews and the electronic health record reviews are documented below.

Case Review Results

The facility received an overall Case Review compliance score of 75.3% (*Inadequate*) for the *Access to Care* component. The clinicians reviewed a combined 210 encounters related to this component and identified 61 deficiencies. The NCPR auditor reviewed a total of 200 nursing encounters and identified 59 deficiencies; the physician auditor reviewed a total of ten provider encounters and identified two deficiencies. The details of the deficiencies identified by the NCPR and physician auditors are identified in the sections below.

Nurse Case Reviews

The NCPR auditor reviewed a total of 200 encounters for the *Access to Care* component and found 59 deficiencies. Most of the nursing deficiencies were related to the DVMCCF nursing staff's failure to follow Nursing Protocols and/or incorrect use of the Nursing Protocols while conducting assessments and issuing medications. The nursing staff also failed to document effective communication (EC) in 30 encounters; this issue was previously identified during the September 2017 Limited Review. The details of the deficiencies identified in each case has been further explained under *Quality of Nursing Performance* section. Below is a brief description of each of the deficiencies and the associated cases where they were identified:

The RNs at DVMCCF did not follow the Nursing Protocols during several encounters with patients. The examples of deficiencies identified are listed below:

- The nursing staff did not record vital signs of the patient (Case 16).
- There was no documentation to show if the nursing staff cleaned the patient's wounds per Nursing Protocol (Case 18).
- The RNs issued medications per Protocol without conducting an assessment of the patient (Cases 19, 23, 24, and 25).
- The RN did not arrange for a patient with chest pains to be transported to the ED immediately as ordered by the on-call provider at LAC. The patient was transported 40 minutes later to the ED (Case 17).
- Nursing staff did not re-check the blood pressure (BP) of patients when their diastolic blood pressure was 90 millimeters of mercury (mm Hg[2]) or greater (Cases 19, 20, 21, 22, and 25).
- Nursing staff failed to document Effective Communication (EC) was established with the patients during several encounters (Cases 19, 22, 23, and 24) and in two other cases, it was not documented how EC was obtained (Cases 21 and 25).
- Nursing staff failed to document that a daily dressing change was completed. (Case 16)
- Incomplete or no nursing assessment completed and/or documented (Cases 16, 17, 18, 19, 20, 21, 23, 24, and 25).

[2] Hg – the chemical symbol of Mercury.

- The facility RN did not sign the patient's CDCR Form 7362 (Case 24).
- The RNs incorrectly used Nursing Protocols while assessing and treating patients (Cases 18, 21, 22, 23, and 24).

Recommendations:

The facility's supervising RN/HSA is advised to review the following requirements with the RNs to ensure patients are accurately assessed and treated for their medical conditions:

- Conduct a focused subjective and objective assessment of each patient in order to develop and implement a treatment plan per the Nursing Protocols.
- Conduct a thorough assessment of all of the patient's medical complaints or symptoms documented on the CDCR Form 7362.
- Re-assess vital signs of the patients when they are outside normal parameters (for e.g., when a low systolic or high diastolic blood pressure is identified during initial check).

Physician Case Reviews

The physician auditor reviewed a total of ten encounters for this component and identified two deficiencies.

- In **Case 4**, a patient with a history of hypertension and Type 2 Diabetes Mellitus (DM) was seen on November 9, 2017, for his initial appointment in the Chronic Care (CC) clinic for DM. There was no documentation in the patient's electronic health record to indicate if micro albumin levels had been checked previously or if a monofilament3 test and an eye exam were completed. The physician auditor noted the CC documentation was minimal and although if the above mentioned tests had not been performed during each visit, it was important the PCP tracked the patient's performance. The auditor also noted the patient was on Acetyl Salicylic Acid (ASA) medication for extended time without documentation of medical necessity. Additionally the facility PCP did not document if EC was established with the patient during this appointment. The patient was seen again on November 17, 2017, for complaint of bilateral knee and foot pain and following a minimal evaluation, the PCP referred the patient to the pain management clinic at LAC. The auditor determined this decision was premature since the PCP did not conduct a complete evaluation of the patient.
- In **Case 5**, the patient was seen by the PCP on December 19, 2017, for complaint of five days of lower back pain. The auditor determined the PCP's evaluation of the back pain to be inadequate because there was no mention of genitourinary or gastrointestinal symptoms, fever, sweats, a neurological exam, or a straight leg raising test was not conducted although the L3-L44 was noted to be tender when palpated which suggested muscular trauma not excluding infectious/traumatic cause. The patient was prescribed ibuprofen without obvious consideration of more serious causes of the pain and did not complete a follow up on the symptoms.

[3] Monofilament test – An inexpensive, easy-to-use, and portable test for assessing the loss of protective sensation to detect peripheral neuropathy in otherwise normal feet.
[4] L3-L4 – Lumbar Discs of the spine

This patient was also seen on January 16, 2018, for hypertension and GERD[5]. There was no documentation to indicate the PCP evaluated the patient's GERD during this visit.

Recommendations:

- The facility PCP needs to document in his progress notes if EC was established during patient encounters.
- The PCP should ensure more complete documentation especially regarding the history of the patient's present illnesses.
- The PCP is encouraged to review the chronic care encounter template and strive toward more complete documentation on CC clinic visits.

Quantitative Review Results

The facility received a quantitative compliance score of 98.5% (*Proficient*) for the *Access to Care* component with no deficiencies identified. Eight of the ten questions reviewed in this chapter scored 100.0% (*Proficient*). However, one qualitative issue was identified during the onsite audit. During the observation of the Daily Care Team huddle during the onsite audit on March 7, 2018, the NCPR auditors noted the Daily Huddle form did not contain the required information to report on, during the huddle. The facility medical staff added information to the Daily Huddle form throughout the day. This is against the established procedure because the purpose of the Daily Huddle form is to provide the Care Team with the information for that day's workload - "a plan for the day". Therefore, the facility needs to work towards resolving this qualitative issue in order to be compliant with the procedure stated in the DVMCCF's LOP as well with IMPS&P guidelines.

5. DIAGNOSTIC SERVICES

For this component, the clinicians assess several types of diagnostic services such as radiology, laboratory, and pathology. The auditors review the patient medical records to determine whether radiology and laboratory services were provided timely, whether the primary care provider completed a timely review of the results, and whether the results were communicated to the patient within the required time frame. 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: *100.0%*
Quantitative Review Score: *89.6%*
Overall Score: 96.5%

Desert View Modified Community Correctional Facility received an overall compliance score of 96.5% (*Proficient*) in the *Diagnostic Services* component. Specific findings identified by the physician and NCPR auditors during case reviews and electronic health record reviews are documented below.

[5] GERD – Gastro-Esophageal Reflux Disease is a digestive disorder that affects the lower esophageal sphincter (LES), the ring of muscle between the esophagus and stomach. Symptoms include heartburn, a sour, burning sensation in the back of the throat, chronic cough, laryngitis, and nausea.

Case Review Results

The facility received a 100.0% Case Review compliance score for the *Diagnostic Services* component. The clinicians reviewed a combined total of 12 encounters for this component. The NCPR auditor reviewed a total of two nursing encounters and the physician auditor reviewed a total of ten provider encounters. The physician and NCPR auditors did not identify any deficiencies with the care provided by the facility provider and nursing staff.

Nurse Case Reviews

The facility received a 100% compliance score for the nursing Case Reviews. The NCPR auditor did not identify any specific areas of concern within the two nursing encounters reviewed.

Physician Case Reviews

The facility received a 100% compliance score for the physician Case Reviews. The physician auditor did not identify any specific areas of concern within the ten provider encounters reviewed.

Quantitative Review Results

The facility received a quantitative compliance score of 89.6% (*Adequate*) for the *Diagnostic Services* component with no deficiencies identified. Two out of four questions reviewed for this component had *proficient* scores of 100.0% and 91.7% respectively. The remaining two questions both received an *adequate* score of 83.3%. During the electronic health record review, the nurse auditor found one patient's blood test was not completed within the specified time frame and two out of 12 diagnostic test results were not reviewed, signed and dated by the facility's PCP; the copies of these results were also not provided to the patients within two business days of receipt of the results.

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: *75.6%*
Quantitative Review Score: *85.0%*
Overall Score: 78.7%

The auditors evaluate the emergency medical response system and the facility's ability to provide effective and timely emergency medical responses. The clinicians assess the timeliness and adequacy of the medical care provided based on the patient's emergency situation, clinical condition, and need for a higher level of care.

Desert View Modified Community Correctional Facility received an overall compliance score of 78.7% (*Inadequate*) in the *Emergency Services and Community Hospital Discharge* component.

Specific findings related to the physician and NCPR case reviews and the electronic health record reviews are documented below.

Case Review Results

The facility received a 75.6% Case Review compliance score for the *Emergency Services and Community Hospital Discharge* component. The clinicians reviewed a combined total of 19 patient encounters and identified five deficiencies. The NCPR auditor reviewed 11 encounters and identified four deficiencies. The physician auditor reviewed eight encounters and found one deficiency during the case reviews.

Nurse Case Reviews

The NCPR auditor reviewed 11 nursing encounters for this component and identified three deficiencies within one case which were related to missing and/or incomplete assessment of the patient by DVMCCF nursing staff for the patient's complaints and failure to assess the patient upon his return from community hospital ED visits.

- In **Case 17**, the patient returned from the LAC Treatment and Triage (TTA) on November 10, 2017, following a community hospital ED visit for chest pains. The NCPR auditor could not locate documentation in the patient's electronic health record to show the RN's receipt and review of the discharge documentation and instructions from the hospital or if the RN contacted LAC to request the patient's discharge paperwork.
- In **Case 17**, the patient returned from an ED visit on November 13, 2017 and, this time, the patient had his right arm in a sling. However, there was no documentation to indicate the RN completed an assessment of the patient's right arm to assess the condition upon his return.
- In **Case 17**, the patient was brought to the clinic on December 12, 2017, due to the patient stating he was having a stroke. The NCPR auditor noted the RN did not conduct an assessment of the patient for symptoms of stroke.
- In **Case 18**, when the patient returned from the hub following the treatment of a laceration on the left fourth finger, the RN did not document an injury, sensation, and mobility assessment and if dressing was applied or intact.

Recommendations:

- The RN shall complete an objective assessment of the patients upon their return from specialty services, community hospital discharge or emergency services based upon the services provided by the outside providers.
- The RNs shall document the receipt and review of recommendations and/or instructions received from the specialty services provider, hub provider, community hospital and/or the ED upon patient's return from these visits.

Physician Case Reviews

Out of a total of eight clinical encounters reviewed, the physician auditor identified one deficiency.

- **In Case 7,** the patient suffering from acute monoarticular inflammation of the knee was sent to the ED for a joint aspiration for suspected gout. The patient returned on November 10, 2017, without expected joint aspiration; the ED report did not show deficiencies and the lab documentation showed normal CBC[6] and uric acid levels that indicated diagnosis of gout or infection unlikely. The patient was prescribed steroids and the medication Colchicine[7]. The patient's condition improved over time; however, the PCP did not follow up with the patient although the pain intensity was recorded as 4/10 during the follow-up appointment on November 10, 2017. The physician auditor determined this lack of follow-up was severely inadequate due to the potential for serious effects of septic joint[8]. Additionally, the PCP did not document EC during the initial follow-up appointment and there were no hospital records found in the patient's record at the time of this case review.

Quantitative Review Results

The facility received a quantitative compliance score of 85.0% (*Adequate*) for the *Emergency Services and Community Hospital Discharge* component with only one deficiency identified for question 6.1. This was due to the facility RN not reviewing the discharge plans/instructions when patients return from community hospital ED visits or from a hospital discharge and this resulted in a compliance score of 40.0% for this question.

7. INITIAL HEALTH ASSESSMENT/HEALTH CARE TRANSFER

Case Review Score: *95.8%*
Quantitative Review Score: *92.4%*
Overall Score: 94.7%

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.

Desert View Modified Community Correctional Facility received an overall compliance score of 94.7% (*Proficient*) in the *Initial Health Assessment/Heath Care Transfer* component. Specific findings related to the physician and nurse case reviews and the electronic health record reviews are documented below.

[6] CBC - complete blood count
[7] Colchicine - is used to prevent or treat attacks of gout (also called gouty arthritis)
[8] Septic joint - Joint inflammation caused by infection from blood poisoning (sepsis) or from infection within the affected joint itself, or as a side effect of infection in other body tissues.

Case Review Results

The facility received a 95.8% Case Review compliance score for the *Initial Health Assessment/Health Care Transfer* component. The clinicians reviewed a combined total of 13 encounters. The NCPR auditor reviewed 12 encounters related to this component and identified only one deficiency. The physician auditor did not find any provider deficiencies for this component for the one provider encounter reviewed.

Nurse Case Reviews

- **In Case 29**, the patient was transferring out of DVMCCF on November 2, 2017. The patient was assessed by the RN who documented the patient's Keep-on-Person (KOP) medications were in the patient's property. Per IMSP&P policy, the medications are to be removed from the patient's property and placed in the medical transfer envelope during transfers.

Physician Case Reviews

There were no provider deficiencies identified, by the physician auditor for this component, during the case reviews.

Quantitative Review Results

The facility received a quantitative compliance score of 92.4% for this component. The facility scored a 100% for six out of a total of eight questions evaluated. The deficiencies identified were related to the RN's failure to assess the patient when the patient answered "yes" to any of the questions in the Initial Intake Screening form (question 7.2) and the patient not being seen by the PCP within the specified time frame when referred by the facility RN during intake screening (question 7.3).

8. MEDICAL/MEDICATION MANAGEMENT

Case Review Score: *67.3%*
Quantitative Review Score: *91.9%*
Overall Score: 75.5%

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 that is in line with 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 clinicians 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.

Desert View Modified Community Correctional Facility received an overall compliance score of 75.5% (*Inadequate*) in the *Medical/Medication Management* component. Specific findings related to the physician and nurse reviews and the electronic health record reviews are documented below.

Case Review Results

The facility received a 67.3% Case Review compliance score for the *Medical/Medication Management* component. The clinicians reviewed a combined total of 152 encounters related to this component and identified 29 deficiencies. The NCPR auditor reviewed 136 nursing encounters and identified 21 deficiencies; the physician auditor reviewed 16 provider encounters of which 8 encounters were determined to be deficient. A summary of the NCPR and physician auditors' findings are documented below.

Nurse Case Reviews

The NCPR auditor reviewed a total of 136 nursing encounters related to this component and identified 21 deficiencies. Most of the deficiencies were related to the facility providing additional KOP medication refills without the patient requesting additional refills, the RNs not signing the *Medication Administration Record* (MAR) after issuing medications and for not reviewing patients' MAR to check if the medication refills requested by patients had already been issued to them recently or if the medications are due to be refilled. The RNs also did not assess the patients to find out the reason for the refill requests when the patients had already received these refills days before.

- **In Case 16,** the PCP ordered the Hepatitis vaccine to be administered to the patient on November 4, 2017. However, the documentation in the MAR showed the PCP's order was not implemented timely. The injection was administered late on November 30, 2017. The same patient submitted a CDCR Form 7362 for a refill of ibuprofen on December 23, 2017. The date of receipt and review by the RN was not documented on the request. This patient also received an additional 90-day supply of acetaminophen tablets on January 22, 2018, 12 days after having received a 90-day supply of the same medication on January 10, 2018. There was no documentation to show the patient had requested an additional refill.
- **In Case 18,** the patient received an additional 30-day supply of ibuprofen tablets on November 7, 2017, seven days after having received a 30-day supply of the same medication on October 31, 2017. There was no documentation to show the patient had requested an additional refill and the KOP MAR was not signed by the RN issuing the medication.
- **In Case 19,** the patient received an additional 30-day supply of hydrocortisone on November 7, 2017, seven days after having received a 30-day supply of the same medication on October 30, 2017. The KOP MAR was not signed by the RN issuing the medication.
- **In Case 20,** the patient received an additional 30-day supply of selenium lotion on October 19, 2017, 13 days after having received a 30-day supply of the same medication on October 6, 2017. There was no documentation to show the patient had requested an additional refill. The same patient received a refill of all his chronic care medications on November 7, 2017, just 13 days after receiving a 30-day supply on October 31, 2017. There was no documentation to show the patient had requested these replacement refills.

- **In Case 21,** the patient submitted a refill request for ibuprofen on December 21, 2017. The request was triaged and reviewed by the RN on the same day. Although the PCP had discontinued the medication on November 28, 2017, the RN documented the patient had an active prescription for ibuprofen and faxed the refill request to the pharmacy.
- **In Case 22,** the PCP ordered a 30-day supply of Fiber-lax for the patient on November 11, 2017. However, the documentation in the MAR showed the medication was administered late on December 19, 2017. The same patient received his 30-day refill for amlodipine 2 days late on January 8, 2018. His previous 30-day supply was provided on December 6, 2017.
- **In Case 23,** the patient received a 5-day supply of Tylenol on October 9, 2017. There was no documentation to show the patient had requested additional medication. This was a duplicate order. The same patient received a 30-day supply of Lisinopril and DSS[9] on November 3, 2017, six days after having received a 30-day supply of the same medication on October 27, 2017. There was no documentation to show the patient had requested an additional refill. The PCP ordered the first dose of Hepatitis-B vaccine to be administered to the patient on November 4, 2017 and the second dose to be given on December 4, 2017. There was no documentation in the MAR to show if the patient received these doses timely or if the patient had refused the vaccines both times. The RN did not sign the KOP MAR after issuing a 30-supply of cetirizine to the patient on November 7, 2017. The same patient was ordered Omeprazole on December 12, 2017. There is no documentation in the MAR to show this medication was administered to the patient as prescribed. This patient also received 60 tablets of Tums on January 19, 2018; however, the PCP's order for the medication could not be located in the patient's electronic health record. The nursing staff are not allowed to issue medications without a prior written order from the PCP.
- **In Case 24,** the patient submitted a refill request for acyclovir and cetirizine on December 11, 2017. The RN triaged and reviewed the request the same day and faxed a refill request to Central Fill Pharmacy. The RN failed to note the patient had already received a 30-day refill for acyclovir on November 27, 2017. The RN did not inquire with the patient to find out the reason for being out of this medication. This patient again submitted a second request for refills for the same medications on December 15, 2017. Another RN received and reviewed the request and faxed a refill request to Central Fill Pharmacy. This RN also failed to note the patient had been already provided with a 30-day refill for acyclovir on November 27, 2017. Once again, the RN failed to inquire the reason why the patient was out of this medication. The PCP ordered a 30-day supply of Ranitidine on December 27, 2017. There was no documentation in the patient's MAR to show the patient received this medication as ordered. Lastly, the patient submitted a CDCR Form 7362 requesting refills for acyclovir, heartburn and allergy pills on January 19, 2018. The request was triaged and reviewed by the RN on the same day. However, the RN failed to note the patient had already received calcium carbonate (for heartburn) on January 17, 2018, and cetirizine on January 18, 2018. There was no documentation of the patient requesting additional medications.

[9] DSS – Docusate. It is a stool softener used to treat or prevent constipation, and to reduce pain or rectal damage caused by hard stools or by straining during bowel movements.

Physician Case Reviews

The physician auditor reviewed a total of 16 provider encounters related to this component and identified 8 deficiencies.

- In **Case 1,** the patient was seen by the PCP on January 30, 2018, for a follow up on the patient's abnormal lab results showing an increase in hepatocellular enzyme levels. The PCP did not assess and document the patient's history of any high risk behavior for Hepatitis C. Additionally, the patient had submitted a CDCR Form 7362 complaining of severe headache (pain intensity 4/10) that was not addressed during the appointment.
- In **Case 2**, the patient was seen on January 9, 2018, for lower back pain. The PCP did not examine the patient's back and renewed a year old prescription for 500 milligrams (mg) B.I.D[10] Naprosyn. The documentation in the PCP's progress notes was inadequate and there was no explanation in the notes to indicate if long term high dose of Naprosyn is beneficial or risky for the patient.
- In **Case 4,** the patient was seen on November 17, 2017, for complaints of bilateral knee and foot pain. The patient had a history of motor vehicle accident two years ago. The PCP conducted a focused exam and diagnosed it as probable post traumatic arthritis and referred the patient to LAC's pain management clinic. The PCP did not document any evidence to support this diagnosis. The physician auditor determined the referral to pain management was premature and inappropriate; the evaluation was determined to be incomplete; the PCP should have excluded acute vascular, infectious and inflammatory causes before referring the patient to LAC.
- In **Case 8,** the patient was seen in the clinic on November 30, 2017, for complaints of nausea, weakness and dizziness. There were no orthostatic changes noted and no tachycardia noted; the patient felt to have "dehydration". The patient was referred to the ED for intravenous (IV) fluids where he was diagnosed with anxiety disorder. While being seen at the clinic, the patient complained of pain (intensity noted as 8/10); however, the physician auditor noted the PCP did not address this in his progress note.
- In **Case 12,** the patient was seen for a follow-up on December 26, 2017, for recurrent rectal bleeding. The PCP's notes indicated a request for colonoscopy was submitted to LAC on November 17, 2017. However, there was no *Request for Services* (RFS) found in the chart and no note was found requesting the status of the RFS. This patient was seen for some unknown reason by the TTA provider at LAC on November 14, 2017, where it appeared the TTA provider stated the patient refused further work up. This patient demonstrated the medical need for further medical evaluation; however, due to the breakdown in communication between the facility PCP and LAC's TTA provider, the TTA provider's failure to document an informed refusal and communicate this to the facility PCP lead to a potentially serious oversight. The facility PCP appeared to believe that colonoscopy is still pending, however, it appears LAC is not in agreement. As of this date, the requested colonoscopy is not done and the PCP has no apparent follow up planned which the physician auditor deemed to be inadequate care.

[10] B.I.D – "bis in die" in Latin which means twice a day.

- In **Case 13,** the patient was seen on October 23, 2017, for complaints of severe abdominal pain. The pain intensity was recorded as 3/10 and it was noted patient had elevated resting heart rate (tachycardia). A focused exam was conducted that showed the abdomen to be soft and non-tender. However the PCP's notes did not mention the possibility of gastrointestinal bleeding. Although the progress notes hinted gastritis, a follow up was not ordered. The cause of the patient's symptoms was not identified.
- In **Case 14**, the patient was seen on October 20, 2017, for pain due to an old compression fracture caused by a motor vehicle accident two years prior. The exam was benign with no apparent red flags; however, the PCP's documentation regarding the history was sparse and incomplete. The PCP ordered an X-ray of the lumbosacral spine during the visit but failed to include notes that justified the necessity for the X-ray. The patient was seen for a follow up visit to discuss the diagnostic imaging results on November 13, 2017, during which time the patient complained of ongoing pain (pain intensity noted as 5/10); however, the PCP did not conduct an exam nor addressed the ongoing pain during the visit. The PCP also did not order a future follow up visit for the patient. The patient was seen again on January 31, 2018, by the mid-level provider to renew the soft shoe chrono[11] owing to the patient's lower back pain. The patient again complained of ongoing pain (pain scale noted as 7/10) during the visit. Although the provider's exam was recorded as normal, the patient's chrono was renewed. The physician auditor did not find any justification documented in the notes that explained the medical necessity for a soft shoe chrono. Additionally, the patient's complaints of severe pain was not addressed by the mid-level provider during that visit.

Quantitative Review Results

The facility received a quantitative compliance score of 91.9% for this component with two deficiencies identified. Eight of the ten questions reviewed scored a 100.0% while two questions scored below the required 80.0% threshold; 43.8% and 75.0% respectively.

The nurse auditor reviewed electronic health records of patients who were prescribed chronic care medications during the audit review period and found DVMCCF failed to consistently provide patients their chronic care medications within the required time frame. The health record reviews also showed the facility did not consistently administer the newly prescribed medications to the patients in a timely manner.

[11] Chrono – Fully known as *"Comprehensive Accommodation Chrono"* (CDCR Form 7410), the form utilized by the CCHCS/contract physicians to document recommendation for reasonable accommodation of the patient based on medical necessity or to ensure the patient has equal access to prison services, programs and activities.

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

Case Review Score: *73.1%*
Quantitative Review Score: *71.9%*
Overall Score: 72.7%

Desert View Modified Community Correctional Facility received an overall compliance score of 72.7% (*Inadequate*) in the *Specialty Services* component. Specific findings related to the physician and nurse case reviews and the electronic health record reviews are documented below.

Case Review Results

The facility received a 73.1% Case Review compliance score for the *Specialty Services* component. The clinicians reviewed a combined total of 16 encounters related to this component and identified seven deficiencies. The NCPR auditor reviewed 13 encounters related to this component and identified 7 deficiencies. The physician auditor reviewed three encounters and did not identify any deficiencies during his review. A summary of the NCPR and physician case reviews is documented below.

Nurse Case Reviews

The NCPR auditor reviewed 13 nursing encounters and identified seven deficiencies. Six out of the seven deficiencies were related to the RN's failure to review and document the receipt and review of specialty service provider's instructions and/or recommendations. In the cases where these were not received by the facility, there lacked documentation to indicate the RNs took action to obtain

them. The remaining one deficiency was related to missing documentation in the electronic health record of the RN's assessment of the patient upon return from specialty service appointment. A brief summary of each case is provided below.

- In **Case 21**, the patient returned from an eye clinic appointment at LAC on October 23, 2017. The RN assessed the patient but did not document review of the instructions or orders from the specialty service provider. It was not documented if the RN received the documentation or if the RN contacted LAC to request the documentation if it was not available previously.
- In **Case 22**, the patient had two specialty care appointments at LAC on December 12, 2017, and January 9, 2018. Upon the patient's return from these appointments, the RN assessed the patient but failed to document a review of the LAC provider's recommendations or the notification of the facility PCP regarding the recommendations/orders on both occasions.
- In **Case 23**, the patient returned to DVMCCF following specialty care appointments in LAC on October 24, November 21, and December 12, 2017. On all three occasions, the RN did not document the review of the off-site provider's orders or instructions, nor was there documentation regarding contact made with LAC requesting discharge instructions.
- In **Case 25**, the patient had an off-site ophthalmology appointment on November 6, 2017. The NCPR auditor could not locate documentation in the electronic health record showing the RN's assessment of the patient upon his return from the off-site visit.

Physician Case Reviews

There were no provider deficiencies identified, by the physician auditor for this component, during the case reviews. However, while reviewing the case of a 24 year old patient, the physician auditor noted this patient was seen December 18, 2017, for acute onset of urinary symptoms and possible stricture of urethra. The PCP's notes indicated an urgent urology consult was ordered but no RFS was found in the health record. The patient was referred to ED where minimal workup was performed. The patient returned from ED to LAC on January 9, 2018, where he was seen by a mid-level provider at LAC and the provider wrote an RFS for urology consult; however, the RFS was denied on January 12, 2018, by the Chief Medical Executive at LAC stating the patient's work up as "incomplete". The patient was seen again on January 18, 2018, by another LAC mid-level provider and a second RFS was written but the CHCCS physician auditor could not find any evidence in the electronic health record to show it had been reviewed. Without further evidence of approval, the patient was seen tele medically by urology on February 1, 2018, with appropriate consultation documented timely in the electronic health record. The patient encounters at DVMMCF were brief but found to be overall adequate; however, the initial evaluation which occurred on December 18, 2017, was incomplete and an RFS should have been generated by DVMCCF. The facility's process of requesting specialty services and LAC's approval process does not appear to follow IMSP&P guidelines. Therefore, this has been identified as a Qualitative Critical Issue in this report.

Quantitative Review Results

The facility received a quantitative compliance score of 71.9% for the *Specialty Services* component which is similar to the inadequate score received for the case reviews. Out of a total of four questions evaluated for this component, DVMCCF received 0.0% compliance score for one question and one was 100% compliant. The remaining two questions both received a proficient score of

93.8%. The deficiency identified during quantitative reviews was exactly the same as those identified in nursing case reviews. The nurse auditor reviewed seven patient electronic health records and found that for all seven records reviewed, the facility RN had failed to notify the PCP of the off-site provider's recommendations/orders following the patient's return from his specialty care appointment.

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 evaluation, 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: *89.7%*

Overall Score: 89.7%

Quantitative Review Results

Desert View Modified Community Correctional Facility received a compliance score of 89.7% (*Adequate*) for quantitative reviews conducted for the *Preventative Services* component. Of the three questions reviewed, the facility scored a 100% for two questions. The facility did not achieve a compliance threshold of 80.0% for question 11.2 because a review of 13 patient electronic health records revealed DVMCCF did not offer an influenza vaccination to 4 of these patients during the most recent influenza season, which resulted in the facility receiving only 69.2% for this question.

12. EMERGENCY MEDICAL RESPONSE/DRILLS AND EQUIPMENT

For this component, the NCPR auditor reviews the facility's emergency medical response documentation to assess the response time frames of facility's health care staff during medical emergencies and/or drills. The NCPR auditor also inspects 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.

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

Overall Score: 100.0%

Quantitative Review Results

Desert View Modified Community Correctional Facility received an overall compliance score of 100.0% (*Proficient*) for the *Emergency Medical Response/Drills and Equipment* component. All ten

questions evaluated were proficient. The NCPR auditor found DVMCCF continues to regularly conduct monthly Emergency Medical Response Review Committee (EMRRC) meetings and documents the EMRRC minutes accurately. The facility also re-checks and re-seals all their Emergency Medical Response (EMR) bags following an emergency medical response/drill and the EMR bags contained all the supplies identified on the facility's checklist. Desert View MCCF had failed to achieve compliance for these three requirements during the October 2016 audit. The facility corrected these issues and was found to be 100% compliant during the November 2017 Limited Review. The facility continues to remain compliant in these areas as evidenced during this audit.

13. CLINICAL ENVIRONMENT

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

This component measures the general operational aspects of the facility's clinic(s). The clinical 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.

Quantitative Review Results

The facility received an overall compliance score of 100.0% (*Proficient*) for the *Clinical Environment* component. All 15 questions received a 100% compliance score. 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.

14. QUALITY OF NURSING PERFORMANCE

Case Review Score: *75.4%*
Quantitative Review Score: *Not Applicable*
Overall Score: 75.4%

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 Results

Desert View Modified Community Correctional Facility received a compliance score of 75.4% (*Inadequate*) for the *Quality of Nursing Performance* component. This determination was based upon the auditor's review of nursing services provided to ten patients housed at DVMCCF during the audit review period of October 2017 through January 2018. Of the ten detailed case reviews conducted by the NCPR auditor, eight were found i*nadequate* (scored less than 80.0%), and two cases were rated as *adequate* (scored between 80.0 and 89.9%). Of the 362 total nursing encounters assessed within the 10 detailed case reviews, 91 deficiencies were identified related to nursing care and performance, details of which are documented under the *Access to Care, Emergency Services and Community Hospital Discharge, Medical/Medication Management and Specialty Services* component sections above.

The following critical case review findings resulted in DVMCCF receiving an *inadequate* rating for nursing performance:

- The RN's failure to follow Nursing Protocols during assessment and treatment of patients
- Failure to conduct subjective and/or objective assessment of patient's symptoms and issue of medications to patients without documenting a nursing diagnosis
- Incorrect use of Nursing Protocols during assessment and treatment of patients (such as prescribing medications without following the Nursing Protocol)
- Poor and/or lack of proper documentation of patient's history, assessment and treatment provided
- Failure to document EC and/or failure to document how EC was obtained during patient encounters
- Failure to implement on-call provider's orders in a timely manner
- Failure to document the receipt and review of the instructions/recommendations received from the off-site providers when patients return from specialty care appointments at the hub or with offsite provider.
- Failure to inform the facility PCP regarding new medication orders and/or instructions received from the LAC provider/community hospital physician
- Failure to document receipt and review of the discharge paperwork when patients return to DVMCCF following an ED visit or community hospital stay, and/or lack of documentation showing the RN contacted the offsite provider or hub to obtain the reports and/or discharge instructions if not received when patient returned to DVMCCF.
- Failure to document an assessment of the patients upon their return from specialty care appointments
- Failure to document administration of vaccines per the PCP's order
- Failure to provide refills for chronic care medications and/or newly prescribed medications to patients within specified timeframes and/or lack of documentation to show the medications were administered as prescribed.
- Failure to sign the KOP MARs after issuing medications to patients
- Failure to review patient MARs to ensure the validity of patient's request for medication refills which resulted in the RNs issuing 30-day and 90-day medication refills to patients for medications that had been filled recently without the patients requesting additional refills. None of these incidents were reported as medication errors.
- Failure to re-check patient's BP when the diastolic reading is 90 mmHg or greater

Below is a brief synopsis of each case the NCPR auditor determined to be inadequate due to poor nursing performance.

Case Number	Deficiencies
Case 16	***Inadequate (77.1%).*** The patient is a 42 year old male who was seen by the PCP and nursing staff during the audit review period for an infected right great toe, pain in the left elbow, sore throat, chest pain and skin lesions on the left arm. The NCPR auditor reviewed 35 nursing encounters and identified eight deficiencies. The majority of the deficiencies were related to lack of documentation of nursing subjective and objective information upon return from outpatient care and during recovery time at DVMCCF. Examples of missing, incomplete or deferred nursing subjective and objective information included: vital signs deferred, wound care/dressing changes, status of wound healing and irritation of wound by the shoe. Medication management deficiencies included lack of nursing documentation on the CDCR Form 7362 for a refill of ibuprofen; delay in patient receiving the first dose of Hepatitis B vaccine and an additional 90-day refill for acetaminophen tablets was refilled even though the patient had just received a refill 12 days earlier.
Case 17	***Inadequate (66.7%).*** The patient is a 41 year old male who was seen by the PCP and nursing staff during the audit review period for chest pain, neck, right shoulder, and arm pain. The NCPR auditor reviewed 15 encounters and identified five deficiencies. The patient had two ED visits during the review period. The majority of deficiencies were related to emergency response, timeliness of treatment for chest pain, and documentation upon patient's return to DVMCCF. During the chest pain event, the patient "walked" to the medical clinic, there was a 40 minute delay in transporting the patient to an outside ED after the order was received to transport, and the patient's vital signs were only assessed twice in a one hour period. Upon return from the ED, there was missing documentation of RN's review of discharge instructions or attempts to contact the hub or ED for discharge instructions/paperwork. The second ED visit was related to pain in the right arm and clavicle due to an injury the patient thought he sustained about a month ago. Upon return to DVMCCF, the RN issued a "lay-in" but failed to document an assessment of the right arm or if the patient's arm was still in the sling. About a month after the right arm injury, the patient presented to the clinic complaining he was having a "stroke". Vital signs were assessed but there was no stroke assessment completed by the RN.
Case 18	***Inadequate (76.9%).*** The patient is a 46 year old male who was seen by the PCP and nursing staff during the audit review period for lacerations and wound care of the first and fourth fingers on his left hand. The NCPR auditor reviewed 13 encounters and identified 3 deficiencies related to medication management, access to care and emergency services. The patient was issued an additional 30-day supply of ibuprofen, within seven days of issuing a 30-day supply of the same medication. The KOP MAR was not signed by the RN and there was no documentation to show the patient requested an additional refill. Upon return from LAC for treatment of the left finger lacerations, the RN did not document an assessment of the injury, sensation, mobility or if dressing was applied or intact. Later in the review period the patient sustained a second finger laceration (he works in the kitchen) and was treated by the RN. The RN did not follow Nursing Protocol guidelines and failed to document the wound location.
Case 19	***Inadequate (78.1%).*** The patient is a 41 year old male who was seen by the PCP and nursing staff during the audit review period for a history of hypertension and cold/allergy symptoms. The NCPR auditor reviewed 32 encounters and identified seven deficiencies. The majority of the deficiencies were related to missing objective nursing assessments. On several occasions the RN issued medication without an objective assessment, for example; rash on buttocks was not assessed but topical medication ordered. It was determined at the time of the audit the RNs had

	been instructed not to conduct assessments below the waist. The RNs also failed to recheck blood pressures when diastolic pressure was 90mmHG (millimeter of mercury) or greater. Effective communication was not documented for three encounters.
Case 21	***Inadequate (74.1%).*** The patient is a 41 year old male who was seen by the PCP and nursing staff
Case 22	***Inadequate (62.5%).*** The patient is a 46 year old male who was seen by the PCP and nursing staff
Case 23	***Inadequate (72.0%).*** The patient is a 44 year old male who was seen by the PCP and nursing staff
Case 24	***Inadequate (78.0%).*** The patient is a 44 year old male who was seen by the PCP and nursing staff during the audit review period for allergies, GERD, herpes, and hemorrhoids. The NCPR auditor reviewed 50 encounters and identified 11 deficiencies. Effective communication was not documented for three encounters. The nursing staff did not sign the CDCR Form 7362 after the assessment. Medications duplicates were ordered for Tums, acyclovir, and cetirizine. The PCP ordered Ranitidine, but there is no documentation showing the patient received the medication as ordered. The correct Nursing Protocols were not used for dental complaint, allergic rhinitis, inflammatory skin, and hemorrhoids resulting in the RN not documenting a complete subjective and objective assessment and not ordering correct medications per protocol.

Recommendations

- The supervising RN should review the following requirements with the facility RNs so they can provide adequate care to patients per established Nursing Protocols:
    - A focused subjective and objective assessment of patient's needs to be completed/documented in order to develop and implement a Nursing Protocol plan.
    - Conduct and document an assessment of all of the patient's medical complaints or symptoms documented on the CDCR Form 7362.
    - Conduct and document an objective assessment of the patients upon their return from specialty services, community hospital discharge or emergency services based on the services provided.
    - Documentation of the receipt and review of recommendations or instructions received from specialty service provider, hub provider, community hospital or ED upon patient's return to DVMCCF.
    - Re-assess vital signs when the vitals are not within normal parameters.
- The RN needs to document the status of wound healing to include wound care or wound healed.
- Transferring patient's KOP medications need to be handed over to the nurse at the time of transfer and placed in the white medical transfer envelope.
- The RNs shall document EC by either using an EC stamp or affixing a label on the CDCR Form 7362 after each encounter.
- The RNs are required to check the patient's KOP MAR prior to submitting refill request to Central Fill Pharmacy, in order to identify when the patients received their last refill for medications. This will help prevent the issue of duplicate refills to patients.
- The RN must sign the KOP MAR immediately after issuing medications to patients.
- If patient is requesting an early medication refill, the RN shall interview and document the patient's responses to determine and document the reason for an early refill request.
- It is recommended the supervising RN conduct periodic audits of the nursing documentation in order to ensure completion and compliance with the established Nursing Protocols.

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: 65.3%
Quantitative Review Score: *Not Applicable*
Overall Score: 65.3%

Case Review Results

Desert View Modified Community Correctional Facility received a compliance score of 65.3% (*Inadequate*) for the *Quality of Physician Performance* component. This determination was based on the detailed review of 15 cases conducted by the physician auditor to review the quality of services rendered by the facility PCP to ten patients housed at DVMCCF during the audit review period of October 2017 through January 2018. Of the 15 detailed case reviews conducted, 6 were found *proficient*, 1 *adequate*, and 8 cases were rated as *inadequate*. Out of a total of 48 physician encounters/visits assessed, 11 deficiencies were identified.

The physician auditor found overall medical services provided by the PCP generally met the standards of care applied in the CDCR institutions and determined the PCP's performance to be adequate. Patients were seen timely and in a professional and compassionate manner. The PCP was articulate, well-groomed and hygienic, and took time to educate the patients during encounters. Referrals to offsite care and laboratory tests were deemed to be appropriate. The PCP's prescribing methods seemed, overall, to be consistent with best practices. However, the physician auditor found the PCP had a complacent attitude and appeared to be poorly motivated to improve the health care delivery due to his plans to retire in about eight months.

The facility staff had access to CCHCS policies and appeared to generally operate in accord with written guidelines and policy, aside from RFS process. Additionally, the facility has recently started utilizing the EC stamp since February 2018, and due to this reason, a number of cases reviewed for the audit period did not have EC documented. The PCP was not knowledgeable about the CDCR criteria for issuing medical chronos. The physician auditor provided a copy of the criteria to the PCP for reference while making his determinations regarding the patient's need for a medical chrono. 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 which typically lasts 20-30 minutes where the entire medical team discusses patient related issues such as patient send outs, patients seen or presented to the on-call provider, patients transferred to chronic care clinics, prescriptions that are due to expire within three days, laboratory reconciliation, etc. The audit team observed the Daily Care Huddle on March 7, 2018, during the onsite audit. The huddle discussion and review did not follow the typical CCHCS "script" and appeared extremely casual. The PCP's most recent peer review was current, completed on June 2017; it was reviewed by the physician auditor and found to be satisfactory.

The physician auditor found DVMCCF's need for sending out patients for specialty services was infrequent; however, when the need is appropriate, DVMCCF and LAC appear to be processing the RFS incorrectly. LAC reportedly refuses to accept an official "RFS" form and instead, directs the PCP to write an order for the referral, and the patient is then transported to LAC to determine if the request is appropriate. It was apparent the offsite specialists infrequently produce and transmit dictated consultations to DVMCCF after patient encounters. This issue was very much evident during case reviews and was discussed during a conference call between CCHCS Contract Beds Unit, DVMCCF and LAC where the physician auditor requested LAC to work collaboratively with DVMCCF by allowing the DVMCCF PCP to submit RFS to LAC and process these requests per established guidelines. This was also mentioned during the audit exit conference.

Another issue was identified with the DVMCCF health care staff was when a patient returns from a specialty care appointment, the dictated consultation report is not being sent to the DVMCCF PCP in a timely manner. The physician auditor will be working on establishing contact between DVMCCF and CCHCS Medical Contracts Unit and request the Medical Contracts Unit work collaboratively with DVMCCF staff to identify vendors that are not meeting their contractual obligations with submission of patients' dictated consultation reports.

Below is a brief synopsis of each case for which the physician determined the facility provider's performance to be *inadequate*.

Case Number	Deficiencies
Case 1	***Inadequate (75.0%).*** This is a 32 year old patient who was seen during the audit review period for abnormal lab work results and severe headache. The physician auditor reviewed a total of four encounters and identified one deficiency. The PCP failed to address the patient's headache during the CC clinic visit and did not address the patient's history of potential high risk behavior for Hepatitis C. No follow-ups were ordered to address the abnormal lab results. The physician auditor determined that elevated hepatocellular enzymes suggested low grade Hepatitis and the PCP should have ordered a follow up for the abnormal test results.
Case 2	***Inadequate (0.0%).*** This is a 56 year old patient who was seen during the audit review period for lower back pain. The physician auditor reviewed only one encounter and determined it to be deficient. The PCP did not examine the patient's back and renewed a yearlong prescription for 500 milligrams B.I.D Naprosyn. The documentation in the PCP's progress notes was inadequate and there was no explanation in the notes to indicate if long term high dose of Naprosyn is beneficial or risky for the patient.
Case 4	***Inadequate (0.0%).*** This is a 44 year old patient with history of Type 2 DM who was seen for his CC condition during the audit review period. The physician auditor reviewed two encounters and found both to be deficient. The PCP did not document in the patient's health record if micro albumin levels had been checked previously or if a monofilament test and an eye exam were completed. The chronic care documentation was minimal and there was no evidence to show if the PCP tracks performance of micro albumin, eye and monofilament examinations. The patient was on ASA medication for extended time without documentation of medical necessity. EC was not documented for one encounter. The PCP conducted a focused exam for complaints of bilateral knee and foot pain and diagnosed it as probable post traumatic arthritis without documenting any evidence to support this diagnosis. The patient was referred to LAC's pain management clinic before excluding the possibilities such as acute vascular, infectious, and inflammatory causes. The physician auditor determined the referral to pain management was premature and inappropriate; the evaluation was determined to be incomplete.

Case 5	***Inadequate (66.7%).*** This is a 39 year old patient with hypertension who was seen during the audit review period for complaint of five days of lower back pain. The physician auditor reviewed three encounters and identified one deficiency. The PCP's evaluation of the back pain was inadequate because there was no mention of genitourinary or gastrointestinal symptoms, fever, and sweats; a neurological exam or a straight leg raising test was not conducted although the L3-L4 was noted to be tender when palpated which suggested muscular trauma not excluding infectious/traumatic cause. The patient was prescribed ibuprofen without obvious consideration of more serious causes of the pain and the PCP did not complete a follow up on the symptoms. There was no documentation to indicate the PCP evaluated the patient's GERD during the CC visit. There was also no mention of potential esophageal symptoms.
Case 7	***Inadequate (50.0%).*** This is a 41 year old patient was seen during the audit review period for acute monoarticular inflammation of the knee and was sent to the ED for a joint aspiration for suspected gout. The physician auditor reviewed two encounters and identified one deficiency. The ED report revealed normal CBC and uric acid levels, suggesting gout unlikely. The patient was prescribed steroids and Colchicine. However, the PCP did not follow up with the patient although the patient had been in considerable pain during the initial visit. The physician auditor determined this lack of follow-up was severely inadequate due to the potential for serious effects of septic joint. Additionally, the PCP did not document EC during the initial appointment and there were no hospital records found in the patient's record at the time of this case review.
Case 12*	***Inadequate (75.0%).*** This is a 42 year old patient who was seen several times during the audit review period for rectal bleeding. The physician auditor reviewed four encounters and identified one deficiency. The patient was seen for a follow-up for recurrent rectal bleeding. The PCP's notes indicated a request for colonoscopy was submitted to LAC during November 2017. However, the RFS could not be located in the patient's health record and there was no note to indicate the status of the RFS was requested. This patient demonstrated the medical need for further medical evaluation; however, due to the breakdown in communication between the facility PCP and LAC provider, and TTA provider's failure to document an informed refusal and communicate this to the facility PCP, lead to a potentially serious oversight. The PCP appeared to believe that a colonoscopy was still pending, however, it appears LAC is not in agreement. As of this date, the requested colonoscopy is not done and the PCP has no apparent follow up planned which the physician auditor deemed as inadequate care.
Case 13	***Inadequate (0.0%).*** This is a 32 year old patient who was seen during the audit review period for complaints of severe abdominal pain. The physician auditor reviewed one encounter and which was determined to be inadequate. The PCP's notes did not mention the possibility of gastrointestinal bleeding. Although the progress notes hinted gastritis, a follow up was not ordered. The cause of the patient's symptoms was not identified which resulted in the physician auditor deeming the care provided to be inadequate.
Case 14	***Inadequate (33.3%).*** This is a 32 year old patient apparently healthy aside from a compression fracture caused by a motor vehicle accident two years prior. The patient was seen during the audit review period for pain due to the fracture. The physician auditor reviewed three encounters and identified two deficiencies. The PCP's documentation regarding the history was sparse and incomplete. The progress notes did not include a justification for an X-ray of the lumbosacral spine. During a follow up visit to discuss the diagnostic imaging results, the PCP did not conduct an exam nor address the patient's ongoing pain during the visit and did not order a follow up visit. The mid-level provider renewed a chrono for soft shoes for lower back pain although the provider's exam was recorded as normal. There was no justification documented in the notes that explained the medical necessity for a soft shoe chrono. Additionally, the patient's complaints of severe pain was not addressed by the mid-level provider during that visit.

*Update – Following the audit, the physician auditor communicated with the facility PCP and recommended the PCP to follow up with this patient to discuss the consequences of refusing a colonoscopy with the patient since it appeared to the auditor the patient does not fully comprehend the fact he may be refusing a procedure which could potentially be lifesaving. Although the patient has the right to refuse medical procedures, he needs to clearly understand the gravity of such. The physician auditor also recommended the PCP to fully document the possible implications of rectal bleeding and the importance of evaluating this symptom in a timely manner. The facility PCP saw the patient as recommended and the patient agreed for a colonoscopy; however, the patient requested the PCP to schedule the test towards the end of August 2018 so that he could complete his classes and avoid a parole extension. The PCP agreed to do so and documented the discussion that occurred in his progress note.

During the case reviews, the physician auditor observed the PCP's notes to be too focused and frequently incomplete in most of the cases reviewed. The history of symptoms noted was often incomplete and not all patients received the follow-ups required for proficient care. During conversations with the PCP, the physician auditor realized the PCP was frustrated by the inability to obtain consultations and offsite specialist services without prior review by the providers at LAC who were not familiar with the patient's clinical symptoms and/or history. The case reviews further affirm the breakdown in appropriate communication between the DVMCCF and its hub, LAC. The physician auditor determined there is a high potential for adverse consequences to occur as a result of this breakdown in communication and lack of cohesiveness between DVMCCF and LAC on the RFS process.

Recommendations:

- Desert View Modified Community Correctional Facility should follow the CCHCS IMSP&P's and CCHCS Utilization Management's procedures to process, review and adjudicate RFS's. This is a qualitative critical issue and should be addressed by the facility immediately to avoid adverse patient outcomes.
- The facility should contact the offsite consultants to obtain the dictated consultation notes and/or hospital reports if these are not received at the time of patient's return to the facility following offsite appointments. The current status is unacceptable.
- The facility should work on devising a more formal structure for the Daily Care Team Huddles by following CDCR's script for conducting huddles.
- The PCP should utilize CDCR's criteria for issuing medical accommodation chronos which was provided to the PCP during the onsite audit.
- All health care staff should document EC for all patient encounters timely and appropriately.
- The PCP should provide more complete documentation, particularly the history of present illness.
- The PCP should review the chronic care encounter template and strive toward more complete chronic care visits.

PRIOR CRITICAL ISSUE RESOLUTION

The previous Limited Review audit conducted on September 12 through 14, 2017, resulted in the identification of nine quantitative critical issues and two qualitative critical issues. During the current audit, auditors found eight of the 11 issues resolved, and the remaining 3 not resolved within the established compliance threshold. 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 August 2015 audit. At that time, none of DVMCCF's LOPs were compliant with IMSP&P which resulted in a 0.0% compliance score. During the February 2016 audit, the facility failed to update all of their LOPs which resulted in 6.3% compliance. During the October 2016 audit, the facility's score slightly improved where three of eleven LOPs were found to be compliant resulting in 21.4% compliance. A review of DVMCCF's LOPs during September 2017 Limited Review once again showed DVMCCF's failure to update all their LOPs that resulted in 35.7% compliance rating. During the current audit, the HPS I auditor found DVMCCF has made significant improvement by updating 12 of the facility's 15 LOPs to meet IMSP&P standards. As a result, DVMCCF 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 has been resolved by the facility.***
Question 2.6 – THE FACILITY DOES NOT ACCURATELY DOCUMENT DATES FOR PROVIDER REFERRALS, SPECIALIST APPOINTMENT, APPOINTMENT DISPOSITIONS, PROVIDER AND REGISTERED NURSE (RN) ASSESSMENTS IN THE SPECIALTY SERVICES MONITORING LOG.	**Unresolved***	During the October 2016 audit, the facility failed to accurately document dates on the Specialty Care monitoring log. During the September 2017 Limited Review, although DVMCCF improved their compliance score from 59.0% to 79.3%, it was still below the 80% compliance threshold. During the current audit, four out of 18 line entries reviewed had incorrect data resulting in the decrease of DVMCCF's compliance score from 79.3% to 77.8%. ***This Critical Issue has been unresolved since the October 2016 audit.***
Question 2.13 – THE FACILITY DOES NOT PROCESS PATIENT FIRST LEVEL HEALTH CARE GRIEVANCES WITHIN 30 WORKING DAYS OF RECEIVING THE APPEALS.	**Unresolved***	This issue was initially identified during August 2014 audit. The facility received a compliance score of 38.7% for this requirement. Desert View MCCF managed to resolve this issue following this audit. The facility was 100% compliant during both February 2015 and August 2015 audits. However, during the February 2016 audit, the facility failed to meet this requirement receiving 66.7% compliance score. During

		the October 2016 audit, DVMCCF's compliance score decreased to 37.5%. During the September 2017 Limited Review, the HPS I auditor once again found the facility has continuously failed to correct this deficiency receiving only 50.0% compliance rating. During the current audit, the auditor's review of 13 health care grievances showed the facility has repeatedly failed to correct this deficiency receiving 61.5% compliance score. ***This Critical Issue has been unresolved since the February 2016 audit.***
Question 4.8 – THE FACILITY HEALTH CARE STAFF DOES NOT CONSISTENTLY CONDUCT AND PROPERLY DOCUMENT DAILY CARE TEAM HUDDLES.	**Resolved**	This issue was initially identified during the October 2016 audit. The facility had failed to conduct Daily Care Team Huddles for 13 out of a total of 21 business days reviewed scoring 38.1% compliance. During the September 2017 Limited Review, the NCPR auditor reviewed documentation for 20 business days and noted although DVMCCF held Daily Huddles on all 20 days, the facility did not use the standard CDCR Daily Care Team Huddle form; instead, staff utilized a Correct Care solution form which did not capture all the required information. This resulted in a score of 0.0%. During the current audit, the auditor reviewed 21 days of documentation and found them to be 100% compliant. ***This Critical Issue has been resolved by the facility.***
Question 5.3 – THE PRIMARY CARE PROVIDER (PCP) DOES NOT REVIEW, SIGN, AND DATE THE PATIENT'S DIAGNOSTIC TEST REPORT(S) WITHIN TWO BUSINESS DAYS OF RECEIPT OF RESULTS.	**Resolved**	This issue was initially identified during September 2017 Limited Review. Three of the 12 patient test results reviewed were not signed and dated by the PCP within two business days of DVMCCF's receipt of the test results which resulted in a compliance score of 75.0%. During the current audit, the nurse auditor reviewed 12 patient records and found only two patients' test results were not signed and dated by the PCP within the specified time frame resulting in a compliance score of 83.3%. ***This Critical Issue has been resolved by the facility.***
Question 5.4 – THE PATIENTS ARE NOT CONSISTENTLY GIVEN WRITTEN NOTIFICATION OF THE DIAGNOSTIC TEST RESULTS WITHIN TWO BUSINESS DAYS OF RECEIPT OF RESULTS.	**Resolved**	This issue was initially identified during September 2017 Limited Review. Of the 12 patient records reviewed, four records indicated the patients were not given a written notification of their test results within two business days of DVMCCF's receipt of test results which resulted in 66.7% compliance. During the current audit, the nurse auditor reviewed 12 patient records and found only two patients did not receive a written notification of their test results within the specified time frame resulting in

		83.3% compliance. ***This Critical Issue has been resolved by the facility.***
Question 7.8 – THE INTER-FACILITY TRANSFER ENVELOPE DOES NOT CONTAIN ALL THE REQUIRED TRANSFER DOCUMENTS AND MEDICATIONS.	**Resolved**	This issue was initially identified during September 2017 Limited Review. The facility RN was interviewed regarding DVMCCF's transfer process. The RN had stated the facility did not use the Transfer checklist and Transfer Summary. During the current audit, there were no inmates scheduled to be transferred out. Therefore, the NCPR auditor interviewed the facility RN regarding their transfer process and the RN stated the facility includes the required transfer documents and medications in the transfer envelope prior to patients' transfer. As a result, DVMCCF scored 100% compliance. ***This Critical Issue has been resolved by the facility.***
Question 8.1 – THE PATIENTS DO NOT CONSISTENTLY RECEIVE CHRONIC CARE MEDICATIONS WITHIN THE REQUIRED TIME FRAME.	**Unresolved***	This issue was initially identified during September 2017 Limited Review. Of the 16 patient health records reviewed, the nurse auditor found only two patients were provided with their chronic care medications within the required time frame resulting in 12.5% compliance. During the current audit, a review of 16 patient records showed only seven patients received their chronic care medications timely. Although this is a slight improvement from the previous audit score, the facility failed to achieve the 80% compliance threshold and received only a score of 43.8%. ***This Critical Issue has been unresolved since the September 2017 Limited Review audit.***
Question 8.11 – THE MEDICATION NURSE DOES NOT DIRECTLY OBSERVE THE PATIENT TAKING NURSE ADMINISTERED/DIRECT OBSERVATION THERAPY (NA/DOT) MEDICATION.	**Resolved**	This issue was initially identified during the September 2017 Limited Review. The NCPR auditor observed two pill passes during the onsite visit and noted the RN did not check the patient's mouth after administering DOT medication. The facility was determined to be 50% compliant. During the current audit, the NCPR auditor observed one pill pass and saw the RN following the NA/DOT medication administration process accurately. The facility was found to be 100% compliant. ***This Critical Issue has been resolved by the facility.***
Qualitative Issue # 1 – THE FACILITY'S PCP AND THE NURSING STAFF HAVE NOT RECEIVED TRAINING FROM THE HUB ON CDCR HEALTH CARE DELIVERY PROCESSES.	**Resolved**	This issue was initially identified during the October 2016 audit. During the onsite audit, the auditors found the PCP and the nursing staff were not knowledgeable about health care delivery processes in correctional facilities. The auditors recommended DVMCCF work with their hub institution (LAC) to ensure all facility staff are scheduled to shadow health care staff at the hub to learn the processes to be followed in

		correctional medicine. During the September 2017 Limited Review, the auditors again found the facility had not worked diligently towards coordinating with the hub to get its staff trained on these processes. However, during the current audit, the HPS I auditor found all 16 health care staff at DVMCCF have completed their training at the hub and were knowledgeable about the health care delivery processes. ***This Critical Issue has been resolved by the facility.***
Qualitative Issue # 2 – THE FACILITY DOES NOT ACCURATELY PROCESS THE PATIENT'S FIRST LEVEL HEALTH CARE APPEALS AND DOES NOT DOCUMENT THE DATE OF RECEIPT AND DATE WHEN THE DECISION WAS DELIVERED TO THE PATIENT IN SECTION C OF THE CDCR FORM 602 HC, PATIENT INMATE HEALTH CARE APPEAL.	**Resolved**	This qualitative issue was initially identified during October 2016 audit. The HPS I auditor reviewed eight health care grievances and a variety of issues were identified in five of them such as missing dates of receipt, response dates, missing copy of response, multiple grievances for the same issue and no evidence to show the facility had responded to these grievances, etc. The facility was scheduled by PPCMU staff to receive training from Inmate Correspondence and Appeals Branch; the facility later informed the staff completed their training. During the September 2017 Limited Review, the auditors reviewed 14 health care grievances and found DVMCCF had failed to correct this issue. Seven of the 14 grievances were non-compliant due to missing dates of receipt and date when decision was delivered to the patients. During the current audit, the auditor found the facility completed all sections of the 18 health care grievances submitted during the audit review period appropriately. ***This Critical Issue has been resolved by the facility.***

* The facility failed to address this deficiency effectively; therefore, it is considered unresolved and will continue to be monitored during subsequent audits until resolved.

CONCLUSION

The audit findings discussed in this report are a result of a thorough evaluation of the health care services that were provided by DVMCCF to the patient population during the audit review period of October 2017 through January 2018. The facility's overall performance during this time frame was rated as *Adequate.* Of the 14 components evaluated, the auditors found six components to be *Proficient*, three *Adequate* and five *Inadequate* (refer to the *Executive Summary Table* on page four). The facility resolved eight of the 11 prior critical issues, three issues remain unresolved of which the first issue was identified during the August 2014 audit, the second during the October 2016 audit and the third unresolved critical issue was identified during the September 2017 Limited Review. In addition, nine new Quantitative Critical issues and six new Qualitative Critical Issues were identified during the current audit.

Since the August 2014 audit, DVMCCF has struggled to consistently maintain compliance for ten critical issues listed below. The facility has constantly struggled to submit the monitoring logs timely and failed to input accurate data on the logs. During the current Full Audit, the HSA at DVMCCF agreed to review the logs periodically to ensure accuracy of data. The HSA stated the facility has ongoing issues with email services which impacts the ability of staff to submit the logs in a timely manner. The HPS I auditor advised the HSA the facility could submit the logs a day earlier so the facility staff is afforded more time to re-send the logs in case the email is not delivered the first time. The HPS I auditor informed the HSA the facility will not be penalized for submitting the logs a day early as long as the data in the logs are complete and accurate. The timely processing of patients' first level health care grievances is another issue DVMCCF has struggled with since the August 2014 audits. Following the October 2015 audit, the facility HSA received training from Health Care Correspondence and Appeals Branch, CCHCS, on how to track, process and provide responses to patients' health care grievances. However, quantitative and qualitative issues were identified with the DVMCCF health care grievances tracking log during the current audit which were due to the log containing incorrect response due dates and responses provided to the patients past the due date. The HPS I auditor provided information to the HSA on how to calculate the due dates accurately so the facility could meet the 45-day time frame requirement for processing first level health care grievances.

Critical Issues	Full Audit August 2014	Full Audit February 2015	Full Audit August 2015	Full Audit February 2016	Full audit October 2016	Limited Review September 2017	Full Audit March 2018
Question 2.1 - The Quality Management Committee meeting minutes are not consistently signed and approved by the facility's warden/designee.	Not Applicable	Pass	Fail	Fail	Pass	Not Applicable	Fail
Question 2.5 - The facility does not accurately document information on the sick call monitoring log.	Pass	Fail	Pass	Pass	Fail	Pass	Fail
Question 2.6 - The facility does not accurately document information on the specialty care monitoring log.	Fail	Fail	Pass	Pass	Fail	Fail	Fail

Question 2.7 - The facility does not accurately document information on the hospital/ED monitoring log.	Fail	Fail	Fail	Fail	Pass	Not Applicable	Fail
Question 2.13 - The facility does not process patients' first level health care grievances within the specified time frame.	Fail	Pass	Pass	Fail	Fail	Fail	Fail
Question 6.1 - The facility RN does not consistently review the patients' discharge plan/instructions upon their return from a community hospital visit.	Not Applicable	Fail	Not Applicable	Fail	Pass	Not Applicable	Fail
Question 7.2 - The facility RN does not consistently document an assessment of each question that is answered "yes" by the patient in the Initial Intake Screening form.	Not Applicable	Not Applicable	Fail	Fail	Pass	Pass	Fail
Question 8.1 - The facility does not consistently provide the patients their chronic care medications within the specified time frame.	Pass	Fail	Fail	Fail	Pass	Fail	Fail
Question 8.7 - The facility does not consistently administer newly prescribed medications to the patients within the specified time frame.	Pass	Fail	Fail	Fail	Pass	Pass	Fail
Question 10.3 – The facility RN does not notify the provider of any immediate medication orders or follow-up instructions received from the specialty consultant, upon the patients' return from specialty care appointments.	Fail	Not Applicable	Fail	Pass	Not Applicable	Not Applicable	Fail

Not Applicable- Questions with a documented Not Applicable 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.

Desert View Modified Community Correctional Facility achieved an overall compliance score of 86.6% during the current audit. Although the facility received a proficient score for six components in quantitative reviews, it failed in three components receiving inadequate scores due to a multitude of deficiencies identified during case reviews. The facility made noticeable improvements by resolving the majority of its past critical issues by implementing an internal audit process to ensure timely scanning of patient health care records by LAC into the EHRS, implementing a process for documenting EC during patient encounters, and updating 12 of the 15 LOPs to meet IMPS&P guidelines. However, the current audit identified a number of systemic deficiencies which have been listed in the table above and explained in the individual component sections.

The auditors identified three major issues with DVMCCF's health care processes. The first issue which had been identified was the facility health care staff's failure to document EC during patient

guidelines. However, the current audit identified a number of systemic deficiencies which have been listed in the table above and explained in the individual component sections.

The auditors identified three major issues with DVMCCF's health care processes. The first issue which had been identified was the facility health care staff's failure to document EC during patient encounters. Although this deficiency was not identified within the sample population selected for electronic health record reviews, it was a predominant deficiency identified in most of the cases reviewed by the NCPR and physician auditors. When the auditors discussed this with the HSA, the auditors were told the facility has recently implemented the process of placing EC stamps on the encounter forms to indicate EC was established with the patients during encounters. However, this process was implemented beginning in February 2018 and had not been in effect during the audit review period. Therefore, the effectiveness of this new process will be evaluated during subsequent audits.

The second issue identified involved the facility's Daily Huddle form which did not have the required "huddle script" prior to the Daily Care Team Huddle meetings. This is not in accordance with the guidelines set forth in the IMSP&P. The facility was informed regarding this and advised to correct the documentation in the Daily Huddle form to be compliant with the established guidelines.

The third issue identified was the facility and the hub's current process of requesting and processing of RFS's. The deficiencies identified with the RFS process are explained in detail under the *Quality of Provider Performance* section. The facility health care staff and management are advised to work with their hub, LAC, on this issue immediately to avoid any adverse impact to the quality of specialty care services provided to the patient population in DVMCCF. The facility is also urged to maintain regular and timely communications with the LAC TTA providers, community hospitals, and offsite specialists to ensure timely receipt of specialist consultation notes and hospital discharge documents when patients return from offsite appointments/hospital visits. The facility management's expedited approach to resolve these critical issues is extremely critical to meet CCHCS's health care delivery standards.

At the conclusion of the audit, the auditors held an Exit Conference and discussed the preliminary audit findings and recommendations with DVMCCF facility and health care management. The health care staff at DVMCCF 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

Desert View Modified Community Correctional Facility Range of Summary Scores: 71.9% - 100.0%	
Audit Component	**Quantitative Score**
1. Administrative Operations	97.5%
2. Internal Monitoring & Quality Management	83.3%
3. Licensing/Certifications, Training & Staffing	100.0%
4. Access to Care	98.5%
5. Diagnostic Services	89.6%
6. Emergency Services & Community Hospital Discharge	85.0%
7. Initial Health Assessment/Health Care Transfer	92.4%
8. Medical/Medication Management	91.9%
9. Observation Cells (COCF)	Not Applicable
10. Specialty Services	71.9%
11. Preventive Services	89.7%
12. Emergency Medical Response/Drills & Equipment	100.0%
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?	1	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?	1	0	100.0%
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?	16	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?	16	0	100.0%
	Overall Percentage Score:			**97.5%**

Comments:

Question 1.2. Three of Desert View MCCF's policies and procedures reviewed, namely, the facility's LOPs for *Access to Care*, *Licensing/Certifications, Training and Staffing* and *Emergency Medical Response and Drills* were found to be non-compliant with the IMSP&P.

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?	3	1	75.0%
2.2	Did the Quality Management Committee's review process include documented corrective action plan for the identified opportunities for improvement?	3	0	100.0%
2.3	Did the Quality Management Committee's review process include monitoring of defined aspects of care?	3	0	100.0%
2.4	Did the facility submit the required monitoring logs by the scheduled date per Private Prison Compliance and Monitoring Unit program standards?	40	22	64.5%
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?	14	4	77.8%
2.7	Is data documented on the hospital stay/emergency department monitoring log accurate?	11	5	68.8%
2.8	Is data documented on the chronic care monitoring log accurate?	17	3	85.0%
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?	7	1	87.5%
2.11	Are patients able to submit the CDCR Forms 602-HC, *Health Care Grievances,* on a daily basis in all housing units?	8	0	100.0%

2.12	Does the facility maintain a Health Care Grievance log that contains all the required information?	1	0	100.0%
2.13	Are institutional level health care grievances being processed within specified time frames?	8	5	61.5%
			Overall Percentage Score:	**83.3%**

Comments:

Question 2.1. The NCPR auditor reviewed four Quality Management Committee (QMC) meeting minutes for the audit review period and found the minutes of one QMC meeting were not signed and approved by facility warden.

Question 2.4. The facility failed to submit six weekly logs and two monthly logs to PPCMU during the audit review period. The facility did not submit the Sick Call, Specialty Care and Hospital Stay/ED logs for the weeks of October 31 and November 21, 2017, and the Chronic Care and Intake Screening logs for November 2017. The facility submitted the weekly logs late during the weeks of October 10, October 17, November 7 and December 26, 2017. The Chronic Care and Intake Screening monthly logs were submitted late in October 2017.

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 erroneous data, namely, wrong patient CDCR numbers (two entries), misspelled last name of patient (one entry), misspelled first name of patient (one entry) and wrong chief complaint (one entry).

Question 2.6. The HPS I auditor reviewed 18 entries within the Specialty Care monitoring log for the audit review period and found four entries with erroneous data, namely, inaccurate provider referral dates (two entries), incorrect problem listed (one entry) and failure to document patient refusal (one entry).

Question 2.7. The HPS I auditor reviewed 16 entries within the Hospital/ED monitoring log for the audit review period and found five entries with erroneous data, namely, patient's first name misspelled (one entry), wrong CDCR number (one entry), wrong provider assessment dates (two entries) and a patient refusal was documented for one entry although this patient did not refuse treatment at the ED per the documentation in the patient's health record.

Question 2.8. The HPS I auditor reviewed 20 entries within the Chronic Care monitoring log and found three entries with erroneous data, namely, wrong CDCR number (one entry), misspelled first name (one entry) and misspelled last name of the patient (one entry).

Question 2.9. The HPS I auditor reviewed 20 entries within the Intake Screening monitoring log and found two entries with erroneous data. One entry had the wrong first name for the patient and the other entry had the wrong intake screening, and history and physical exam dates.

Question 2.10. Auditors surveyed a total of eight housing units for the availability of CDCR Forms 602-HC*, Health Care Grievance (Rev. 06/17)* and 602 HC A*, Health Care Grievance Attachment (6/17)* and found that housing unit B-3 did not have the CDCR Form 602 HC A readily available for patients at the time of the onsite audit.

Question 2.13. The HPS I auditor reviewed a total of 18 health care grievances received and/or processed by DVMCCF during the audit review period. Four of these had been withdrawn by the patients within the 45 day time frame and the decision for one grievance was not due to the patient until March 22, 2018. Therefore, these five were excluded from review. Upon reviewing the remaining 13 grievances, the auditor found that responses to five grievances were delivered to the patients after the 45 day response time frame had elapsed.

3. *Licensing/Certifications, Training, & Staffing*		Yes	No	Compliance
3.1	Are all health care staff licenses current?	16	0	100.0%
3.2	Are health care and custody staff current with required emergency medical response certifications?	169	0	100.0%
3.3	Does the facility provide the required training to its health care staff?	16	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?	1	0	100.0%
	Overall Percentage Score:			**100.0%**

Comments:

None.

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?	15	1	93.8%
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?	10	1	90.9%
4.7	Was the patient's chronic care follow-up visit completed as ordered?	16	0	100.0%
4.8	Did the Care Team regularly conduct and properly document a Care Team Huddle during business days?	21	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?	8	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?	8	0	100.0%
	Overall Percentage Score:			**98.5%**

Comments:

Question 4.3. The nurse auditor reviewed 16 electronic health records and found that the documentation of the focused subjective/objective assessment in one patient's record did not include all required elements. The facility's RN completed an abdominal assessment, but did not address the characteristic of bowel sounds. Additionally, the patient's ongoing medication (calcium carbonate) was not addressed during the assessment.

Question 4.6. The nurse auditor reviewed 11 electronic health records and did not find documentation in one record to show the patient, who was in need of an urgent referral, was referred to the provider within the specified 24-hour time frame.

Question 4.9. This question does not apply to California in-state modified community correctional facilities.

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	1	91.7%
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?	10	2	83.3%
5.4	Was the patient given written notification of the diagnostic test results within two business days of receipt of results?	10	2	83.3%
	Overall Percentage Score:			**89.6%**

Comments:

Question 5.2. The nurse auditor reviewed 12 patients' electronic health records of which one record showed the patient's blood test was not completed within the specified time frame.

Question 5.3. The nurse auditor reviewed 12 patients' electronic health records of which two records showed the patients' diagnostic test reports were not reviewed, signed and dated by the PCP within two business days of receipt of the results.

Question 5.4. The nurse auditor reviewed 12 patients' electronic health records of which two 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?	4	6	40.0%
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?	10	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?	10	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?	8	0	100.0%
	Overall Percentage Score:			**85.0%**

Comments:

Question 6.1. The nurse auditor reviewed 10 patient electronic health records of which six records were missing documentation of the RN's review of the patients' discharge plans/ instructions.

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?	8	3	72.7%
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?	8	4	66.7%
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?	1	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?	12	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?	3	0	100.0%
7.8	Does the Inter-Facility Transfer Envelope contain all the required transfer documents and medications?	1	0	100.0%
	Overall Percentage Score:			**92.4%**

Comments:

Question 7.2. The nurse auditor reviewed 11 patient electronic health records of which three records showed that the LVN had documented an assessment of each question that was answered "yes" by the patients instead of the RN.

Question 7.3. The nurse auditor reviewed 12 patient electronic health records of which three records showed the patients' referrals were based on LVN's disposition instead of the RN's disposition. The remaining one record was non-compliant because the initial health assessment documentation on December 28, 2017, indicated the patient required a referral within 24 hours. Although the patient was referred to the appropriate provider based on the RN's disposition, the provider failed to see the patient within the specified time frame.

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?	7	9	43.8%
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):*			Not Applicable

	Did the facility monitor the patient monthly while he/she is on the medication(s)?			
8.6	Did the prescribing primary care provider document that the patient was provided education on the newly prescribed medication(s)?	12	0	100.0%
8.7	Was the initial dose of the newly prescribed medication administered to the patient as ordered by the provider?	9	3	75.0%
8.8	Did the nursing staff confirm the identity of a patient prior to the delivery or administration of medication(s)?	1	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?	1	0	100.0%
8.10	Did the medication nurse directly observe the patient taking nurse administered/direct observation therapy medication?	1	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?	1	0	100.0%
8.12	Is nursing staff knowledgeable on the Medication Error Reporting procedure?	1	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?	62	0	100.0%
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:			**91.9%**

Comments:

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

Questions 8.2 and 8.3. There were no patients identified that refused their keep on person (KOP), or nurse administered/direct observation therapy (NA/DOT) medications during the audit review period.

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

Question 8.7. The nurse auditor reviewed 12 electronic health records of patients who were prescribed new medications and found three records to be non-compliant. Two patients were not administered their newly prescribed medications within the specified time frame and one record did not have documentation of the patient's receipt, refusal, or no-show for the newly prescribed medication.

Questions 8.15 through 8.17. These questions do not apply to California in-state modified community correctional facilities.

9. Observation Cells (COCF only)		Yes	No	Compliance
9.1	Does the health care provider order patient's placement into the		Not Applicable	
9.2	Does the health care provider document the need for the patient's		Not Applicable	
9.3	Does the registered nurse complete and document an assessment on the		Not Applicable	
9.4	Does the health care provider review, modify, or renew the order for		Not Applicable	
9.5	Does the treating clinician document daily the patient's progress toward		Not Applicable	
9.6	Does nursing staff conduct rounds in observation unit once per watch and		Not Applicable	
	Overall Percentage Score:			**Not Applicable**

Comments:

Questions 9.1 through 9.6. Not Applicable. These questions do not apply to California in-state modified community correctional facilities.

10. Specialty Services		Yes	No	Compliance
10.1	Was the patient seen by the specialist for a specialty services referral within	16	0	100.0%
10.2	Upon the patient's return from the specialty service appointment, did the	15	1	93.8%
10.3	Upon the patient's return from the specialty services appointment, did the	0	7	0.0%
10.4	Did the primary care provider review the specialty consultant's	15	1	93.8%
	Overall Percentage Score:			**71.9%**

Comments:

Question 10.2. The nurse auditor reviewed 16 electronic health records of patients who returned from specialty care appointments and found that one record did not have documentation of the RN's face-to-face assessment of the patient following the patient's return from the specialty care appointment.

Question 10.3. The nurse auditor reviewed seven electronic health records of patients who returned from specialty care appointments and found that none of the seven records had documentation to show the RN notified the facility PCP of any immediate medication or follow-up appointments recommended by the specialty consultant.

Question 10.4. The nurse auditor reviewed seven electronic health records and did not find documentation in any of the records to indicate the RN had notified the PCP 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?	9	4	69.2%
11.3	*For all patients 50 to 75 years of age:* Were the patients offered colorectal cancer screening?	10	0	100.0%
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:			**89.7%**

Comments:

Question 11.2. The nurse auditor reviewed 13 electronic health records and found the records of four patients had missing or incomplete documentation of the administration or refusal of the influenza vaccine for the most recent influenza season.

Question 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?	6	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?	12	0	100.0%
12.5	Is the facility's clinic Emergency Medical Response Bag secured with a seal?	93	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?	8	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?	5	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?	93	0	100.0%
	Overall Percentage Score:			**100.0%**

Comments:

Questions 12.9 through 12.13. These questions do not apply to California in-state modified community correctional facilities.

13. Clinical Environment		**Yes**	**No**	**Compliance**
13.1	Are packaged sterilized reusable medical instruments within the expiration dates shown on the sterile packaging?	1	0	100.0%
13.2	If autoclave sterilization is used, is there documentation showing weekly spore testing?	4	0	100.0%
13.3	Are disposable medical instruments discarded after one use into the biohazard material containers?	1	0	100.0%
13.4	Does clinical health care staff adhere to universal/standard hand hygiene precautions?	5	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?	3	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?	62	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?	3	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?	3	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?	93	0	100.0%
13.14	Is the facility's biomedical equipment serviced and calibrated annually?	13	0	100.0%
13.15	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	25	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:

None.

14. Quality of Nursing Performance	Yes	No	Compliance
The quality of nursing performance is assessed during case reviews, conducted by the clinicians and is not applicable for the quantitative review portion of the health care monitoring audit. The methodology the 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 the clinicians and is not applicable for the quantitative review portion of the health care monitoring audit. The methodology the 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 DVMCCF are summarized in the table below.

Please note 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 auditors interviewed two IAC members and ten patients during the onsite audit of which four were ADA patients. The physician auditor interviewed the IAC members regarding their overall opinion of the health care services provided at DVMCCF. 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 four ADA patients housed at DVMCCF. Two patients were hearing impaired and used hearing aids; the HPS I auditor established EC by speaking slowly and at times loudly, confirming their understanding of the questions being asked. Both patients were satisfied with the accommodations provided to them by health care staff at the facility. During this interview, the hearing impaired patients stated that upon request, they had no difficulty in receiving new batteries and one of the patients stated that the facility ordered a new hearing device promptly when the old device could not be repaired. The remaining two patients had mobility issues and one of them had a knee brace. Both patients did not express any concern regarding their accommodations and one patient was extremely happy about the facility's decision to provide him with orthotic shoes. This patient also had a learning disability and the auditor established and documented EC while interviewing him. All ADA patients stated they were aware of the health care grievance, sick call, and request for reasonable accommodation processes at DVMCCF.

Six additional patients were interviewed for sick call and health care grievance process. All six 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 DVMCCF 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 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 'Not Applicable', 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. For the purpose of component compliance calculations, Not Applicable 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 Not Applicable.

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.