September 10, 2018

Gerard Brochu, Warden
Patsy Brinson, Health Services Administrator
Golden State Modified Community Correctional Facility
611 Frontage Road
McFarland, CA 93250

Dear Warden Brochu and Ms. Brinson,

The staff from California Correctional Health Care Services (CCHCS) completed an onsite health care monitoring audit at Golden state Modified Community Correctional Facility (GSMCCF) on May 22 through 24, 2018. The purpose of this audit was to ensure GSMCCF is meeting the performance targets established based on the *Receiver's Turnaround Plan of Action* dated June 8, 2006.

On August 23, 2018, a draft report was sent to your management providing the opportunity to review and dispute any findings presented in the draft. On September 4, 2018, your facility submitted a response accepting the findings in the report.

Attached you will find the final audit report in which GSMCCF received and overall audit rating of ***Adequate***. The report contains an Executive Summary Table, an explanation of the methodology behind the audit, findings detailed by component of the *Private Prison Compliance and Health Care Monitoring Audit Instructions Guide* and findings of the physician and nurse case reviews conducted by CCHCS clinician auditors.

The audit findings reveal that during the audit review period of December 2017 through March 2018, GSMCCF was providing adequate health care to CDCR patients housed at the facility. The current score of 80.0% is a 5.3 percentage point decrease from the 85.3% compliance scored achieved during the March 2017 audit. Additionally, during the present audit, the identification of 19 new critical issues were identified and the following program components failed to obtain the 80.0% compliance threshold score:

- Administrative Operations
- Internal Monitoring & Quality Management
- Access to Care
- Emergency Services & Community Hospital Discharge
- Initial Health Assessment/Health Care Transfer
- Preventive Services
- Emergency Medical Response/Drills & Equipment
- Quality of Nursing Performance

While the auditors found the overall delivery of health care at GSMCCF to be adequate, continued training of health care staff is needed. It is imperative executive and health care management work together to update the facility's health care policies and provide training to health care staff to bring the eight inadequate components to an adequate level of health care services.

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

Sincerely,

Joseph (Jason) Williams, Deputy Director
Field Operations, Corrections Services
California Correctional Health Care Services

Enclosure

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

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

PRIVATE PRISON COMPLIANCE AND HEALTH CARE MONITORING AUDIT

Golden State Modified

Community Correctional Facility

Annual Audit

May 22 – 24, 2018

TABLE OF CONTENTS

DATE OF REPORT

September 10, 2018

INTRODUCTION

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

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

This report provides the findings associated with the audit conducted at Golden State Modified Community Correctional Facility (GSMCCF), located in McFarland, California for the review period of December 2017 through March 2018. At the time of the onsite audit, CDCR's *Weekly Population Count Report*, dated May 18, 2018, the patient population was 690, with a budgeted capacity of 700.

EXECUTIVE SUMMARY

From May 22 through 24, 2018, the audit team conducted an onsite health care monitoring audit at GSMCCF. The audit team consisted of the following personnel:

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

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

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

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

Based on the quantitative and/or clinical case reviews conducted for 14 components, GSMCCF achieved an overall compliance score of **80.0%,** 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 GSMCCF, and Appendix C for additional information regarding the methodology utilized to determine the facility's compliance for each individual component and overall audit scores and ratings. Comparatively speaking, during the previous annual GSMCCF audit conducted March 21 through 23, 2017, the overall compliance score was 85.3%, indicating a current decrease of 5.3 percentage points.

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

Executive Summary Table

Audit Component	NCPR Case Review Score	MD Case Review Score	Overall Case Review Score	Quantitative Review Score	Overall Component Score	Overall Component Rating
1. Administrative Operations	N/A	N/A	N/A	74.1%	74.1%	Inadequate
2. Internal Monitoring & Quality Management	N/A	N/A	N/A	75.3%	75.3%	Inadequate
3. Licensing/Certifications, Training & Staffing	N/A	N/A	N/A	100.0%	100.0%	Proficient
4. Access to Care	73.8%	80.0%	76.9%	84.4%	79.4%	Inadequate
5. Diagnostic Services	83.8%	85.7%	84.5%	78.6%	82.5%	Adequate
6. Emergency Services & Community Hospital Discharge	50.0%	100.0%	75.0%	N/A	75.0%	Inadequate
7. Initial Health Assessment/Health Care Transfer	50.0%	100.0%	75.0%	85.7%	78.6%	Inadequate
8. Medical/Medication Management	79.3%	87.0%	83.1%	85.4%	83.9%	Adequate
9. Observation Cells	N/A	N/A	N/A	N/A	N/A	N/A
10. Specialty Services	100.0%	100.0%	100.0%	60.7%	86.9%	Adequate
11. Preventive Services	N/A	N/A	N/A	46.7%	46.7%	Inadequate
12. Emergency Medical Response/Drills & Equipment	N/A	N/A	N/A	79.4%	79.4%	Inadequate
13. Clinical Environment	N/A	N/A	N/A	100.0%	100.0%	Proficient
14. Quality of Nursing Performance	71.7%	N/A	N/A	N/A	71.7%	Inadequate
15. Quality of Provider Performance	N/A	86.7%	N/A	N/A	86.7%	Adequate
Overall Audit Score and Rating					**80.0%**	**Adequate**

NOTE: For specific non-compliance findings indicated in the table, please refer to the *Identification of Critical Issues* located on page 5, or to the specific component section located on pages 7 through 28.

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.

Critical Issues – Golden State Modified Community Correctional Facility	
Question 1.2	The facility's local operating procedures/policies are not all compliant with the CCHCS Inmate Medical Services Policies and Procedures. ***This is an unresolved critical issue since the March 2017 audit.***
Question 1.4	The facility's patient orientation handbook/manual does not adequately explain the health care grievance process. ***This is a new critical issue.***
Question 1.8	The facility does not consistently document the release of health care information on the CDCR Form 7385, *Authorization for Release of Information* when a patient or third party requests the release of health care information. ***This is a new critical issue.***
Question 2.4	The facility does not consistently submit all weekly monitoring logs within the specified time frame during the audit review period. ***This is a new critical issue.***
Question 2.7	The facility does not document all required data on the Hospital/ Emergency Department monitoring log. ***This is a new critical issue.***
Question 2.12	The Health Care Grievance log does not contain all the required information. ***This is a new critical issue.***
Question 2.13	The facility does not consistently process first level health care grievances (formerly appeals) in the specified time frames. ***This is a new critical issue.***
Question 4.7	The patients' chronic care follow-up visits are not consistently completed as ordered. ***This is a new critical issue.***
Question 4.8	The facility does not regularly conduct and adequately document a Daily Care Team Huddle during all business days. ***This is an unresolved critical issue since the March 2017 audit.***
Question 5.2	The facility does not consistently complete diagnostic tests within the time frame specified by the primary care provider. ***This is a new critical issue.***
Question 5.3	The primary care provider does not consistently review, sign, and date patient diagnostic test reports within two business days of receipt. ***This is a new critical issue.***
Question 5.4	The facility does not consistently provide patients with written notification of their diagnostic test results within two business days of receipt of results. ***This is a new critical issue.***
Question 7.8	The facility nursing staff does not appropriately identify all required transfer documents and medications to be included in the Transfer Envelope. ***This is a new critical issue.***
Question 8.1	The chronic care medications are not consistently received by the patient within the required time frame. ***This is an unresolved critical issue since the March 2017 audit.***

Question 8.4 (Formerly 8.5)	The facility does not administer the prescribed anti-Tuberculosis medications to the patients. This deficiency was not reviewed during the November 2017 Limited Review and the current audit due to unavailability of samples that met the criteria for this question. ***This is an unresolved critical issue since the March 2017 audit.***
Question 10.2	Upon the patients' return from specialty service appointments, the facility RN does not complete a face-to-face assessment prior to the patients' return to their assigned housing units. ***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 11.1	The facility's nursing staff does not consistently screen for signs and symptoms of tuberculosis, and administer a Tuberculin Skin Test, if indicated, annually. ***This is a new critical issue.***
Question 11.3	The facility does not consistently offer colorectal cancer screening to the patient population 50 to 75 years of age. ***This is a new critical issue.***
Question 12.1	The facility does not consistently conduct emergency medical response drills quarterly on each shift. ***This is a new critical issue.***
Question 12.2	The facility does not consistently document whether an RN, or provider, responds to an emergency medical alarm within the specified time frames. ***This is a new critical issue.***
Question 12.4	The Emergency Medical Response Review Committee does not consistently perform timely incident package reviews utilizing the required documents. ***This is a new critical issue.***
Question 12.15	The facility does not utilize a naloxone[1] (Narcan) log to account for the use and storage of intranasal naloxone in the facility. ***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 on page 29 of this report.

[1] Naloxone - medication administered via injection or nasally that blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing, or loss of consciousness. Naloxone is used to treat a narcotic overdose in an emergency situation.

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: *74.1%*

Overall Score: 74.1%

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

Quantitative Review Results

Golden State Modified Community Correctional Facility achieved an overall compliance score of 74.1% (*Inadequate*) with two new and one unresolved critical issues identified. This score represents a decrease of 13 percentage points from the previous March 2017 score of 87.1%. Eight questions were reviewed; three were rated proficient, one was rated adequate, three were rated inadequate, and one was unable to be rated.

The facility's LOPs have consistently been non-compliant with the IMSP&P since the March 2017 audit. During the current audit, 6 of the 15 health care LOPs reviewed were found non-compliant with the IMSP&P (Question 1.2). The deficiencies identified are as follows:

- Four LOPs did not indicate they were reviewed annually. The *Diagnostic Services, Health Screening,* and *Emergency Response and Review Committee* LOPs had an effective date of February 15, 2017. The *Continuous Quality Improvement/Performance Improvement and Risk Management Program Committee* LOP had an effective date of November 15, 2016.
- The facility's *Emergency Medical Response Training Drills* policy was found to have several deficiencies as listed below:
    a. The LOP did not include all the forms required to be completed when evaluating emergency medical responses or drills, e.g., CDCR Form 7463, *First Medical Responder Data Collection Tool*, and CDCR Form 7462, *CPR Record*. The list of required documents is located in IMSP&P, Volume 4, Chapter 12.8, *Emergency Medical Response: Post Event Review Procedure*.
    b. The facility LOP stated, emergency medical response reports are to be reviewed by the Emergency Response Review Committee within "thirty (30) days from the date of the incident." The 30-day time frame is not in accordance with the IMSP&P requirement which states the reports are to be presented to the committee at the next scheduled

meeting. This is noted in IMSP&P, Volume 4, Chapter 12.8, *Emergency Medical Response: Post Event Review Procedure.*

- The facility's Medication Management policy was found to have several deficiencies as documented below:
    a. The LOP did not document all the required steps to be completed when a patient refuses to sign a CDCR Form 7225, *Refusal of Examination or Treatment*. Specifically missing is the requirement to have two witnesses sign the form instead of the patient per IMSP&P, Volume 4, Chapter 11.5, *Medication Adherence Procedure*.
    b. The LOP did not indicate the time frames required for making medication available to the patient. Per IMSP&P Volume 4, Chapter 11.4, *Medication Administration Procedure*, and Volume 4, Chapter 11.2, *Medication Orders-Prescribing Procedure*.
    c. The LOP did not clarify which nursing staff is responsible for monitoring weekly missed medication doses and checking the Medication Administration Record (MAR) daily for pending order expirations. Per IMSP&P, Volume 4, Chapter 11.5, *Medication Adherence Procedure*.
- The facility did not have a policy on the use and storage of naloxone (Narcan) per the CCHCS memorandum, *Deployment and Use of Intranasal Naloxone within California Department of Corrections and Rehabilitation Adult Institutions*, dated March 21, 2017.

The facility did not update their Inmate Orientation Handbook to include the revised name of the CDCR Form 602 HC (Rev. 6/17), *Health Care Grievance,* and introduction of the CDCR Form 602 HC A (6/17), *Health Care Grievance Attachment* (Question 1.4). The HPS auditor discussed the revision with the Golden State MCCF Health Services Administrator (HSA) during the onsite audit.

Question 1.5, which measures the facility PCP's ability to access the CCHCS patient electronic health record system could not be rated as the facility's PCP was not available during the onsite audit. The PCP was on vacation and a Physician's Assistant was providing coverage.

While conducting the pre-audit review of the monthly Release of Information (ROI) Logs, the auditor found 4 of the 20 ROI entries could not be validated (Question 1.8). Upon review of the patient electronic health record, CDCR Form 7385, *Authorization for Release of Information* could not be found.

2. INTERNAL MONITORING & QUALITY MANAGEMENT

This component focuses on whether the facility completes internal reviews and holds committee meetings in compliance with CCHCS policies. Auditors review the minutes from the Quality Management Committee meetings to determine if the facility identifies opportunities for improvement; implements action plans to address the identified deficiencies; and continuously monitors the quality of health care provided to patients. Auditors review the monitoring logs utilized by the facility to document and track all patient medical encounters such as initial intake, health assessment, sick call,

Case Review Score: *Not Applicable*
Quantitative Review Score: *75.3%*

Overall Score: 75.3%

chronic care, emergency services, and specialty care services. These logs are reviewed for accuracy and timely submission to CCHCS. Lastly, auditors evaluate whether the facility promptly processes and appropriately addresses health care grievances.

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

Quantitative Review Results

Golden State Modified Community Correctional Facility received an overall compliance score of 75.3% (*Inadequate*) with four new critical issues identified. This is a significant decrease of 19.5 percentage points from the previous March 2017 score of 94.8%. Thirteen questions were reviewed; six were rated proficient, three were rated adequate, four were rated inadequate.

During the audit review period of December 2017 through March 2018, 59 submissions of monitoring logs were required, of which 47 were submitted on time (Question 2.4). The weekly monitoring logs were not submitted on January 9 and 16, 2018 and were submitted late for the weeks of December 19, 2017 and January 24, 2018. The facility submitted all of the monthly logs timely. This equates to 79.7% 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	17	13	2	2
Specialty Care	weekly	17	13	2	2
Hospital Stay/Emergency Department	weekly	17	13	2	2
Chronic Care	monthly	4	4	N/A	N/A
Initial Intake Screening	monthly	4	4	N/A	N/A
	Totals:	**59**	**47**	**6**	**6**

A total of five questions are utilized to measure the accuracy of data documented on the weekly and monthly monitoring logs, one of which did not achieve 80.0% (Question 2.7). The facility did not provide all the required data on the Hospital Stay/Emergency Department Log. The log was missing the date of the patient's return to the facility from the hub institution, the date of the RN assessment upon return to the facility, and the date of the PCP follow-up assessment.

The facility's Institutional Level Health Care Grievance Log was not updated to reflect the changes to the health care grievance regulations implemented by CCHCS on September 1, 2017 (Question 2.12). The log did not include the date the RN triaged the grievance form, or the current terminology associated with the grievance disposition. The current log was provided to the HSA by the HPS I shortly after the onsite audit.

During the review period, two health care grievances were submitted. Upon review of the grievances, the HPS auditor found the facility did not respond to one of the grievances within the required 45 business day time frame (Question 2.13). The grievance response letter was dated 13 days after the due date.

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 also determine whether clinical and custody staff are current with their emergency medical response certifications and if the facility is meeting staffing requirements specified in the contract.

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

Overall Score: 100.0%

This component is evaluated by auditors through the review of the 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. The overall component score is based entirely on the results of the quantitative review.

Quantitative Review Results

The facility was found 100% compliant *(Proficient)*. Six questions were rated, and all received a score of 100%. This is the second consecutive time the facility achieved full compliance for this component. The facility is commended for their performance.

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: *76.9%*
Quantitative Review Score: *84.4%*

Overall Score: 79.4%

The facility received an overall compliance score of 79.4% (*Inadequate*). This is a decrease of 5.5 percentage points from the March 2017 audit score. Specific findings related to the nurse and physician case reviews, and the electronic health record and onsite quantitative reviews are documented below.

Case Review Results

The facility received a case review compliance score of 76.9% (*Inadequate*) for this component with two critical issues identified. The clinician auditors reviewed a combined total of 57 encounters.

Nurse Case Reviews

The NCPR auditor reviewed 42 nursing encounters and identified 11 deficiencies. Six of the 11 deficiencies were found in one case, Case 19.

- In **Case 16**, two deficiencies were identified, both related to implementation of the provider's orders. The PCP saw the patient on December 20, 2017, and ordered weekly blood pressure checks for 30 days. The patient's blood pressure was checked on December 27, 2017; however, it was not checked again until two weeks later on January 11, 2018. The patient was seen for follow-up by the PCP on January 19, 2018 and ordered weekly blood pressure checks for 12 months. There is no documentation showing the patient's blood pressure was being monitored weekly within the ordered time frame.
- In **Case 18**, the patient was scheduled for daily dressing changes with the RN beginning on January 23 through January 29, 2018. The dressing change was documented for each day except January 29, 2018.
- In **Case 19**, six deficiencies were identified. In three instances, nursing staff did not retain the sick call request form in the health record. There were no corresponding forms found in the patient's medical record for sick call visits documented on December 18, 20, and 22, 2018. On January 30, 2018, nursing staff documented the patient was referred to the PCP; however, the RN did not document the name of the PCP and time of the referral, resulting in a nursing documentation deficiency. On February 21 and March 5, 2018, two nursing assessment deficiencies were identified. On February 21, 2018, nursing staff did not document an objective nursing assessment for the patient complaining of testicular pain. On March 5, 2018, nursing staff did not document an adequate nursing assessment for the patient with tonsil pain.
- In **Case 20**, the patient was seen by the PCP on January 5, 2018, who ordered weekly blood pressure checks for 90 days. There is no discoverable documentation in the medical record showing nursing staff implemented the provider's orders of weekly blood pressure checks as directed.
- In **Case 22**, the PCP ordered daily dressing changes for the patient with the RN beginning on January 10, 2018, until the patient's wound healed. There is no documentation that nursing staff implemented the PCP's orders as there were no dressing changes documented on January 15, 16, 21, and 24, 2018, as ordered.

Physician Case Reviews

The physician auditor reviewed 15 provider encounters and identified three deficiencies. In three out of the 15 cases reviewed, the patient was prescribed long term use of aspirin without documentation of an American College of Cardiology (ACC) 10-year Heart Risk Assessment[2] justifying the use (Cases 9, 13, and 15).

[2] ACC 10-Year Heart Risk Assessment – calculation used for patients who have not had a prior heart event to predict how likely they are to have a heart attack or stroke in the future.

- In **Case 9**, the patient with diagnoses of dyslipidemia and hypertension was seen in the Chronic Care Clinic on December 27, 2017. The patient is maintained on a statin[3] medication and low dose of aspirin. The chronic care visit does not document an ACC 10-year risk assessment to justify the use of aspirin. Hypertension and hyperlipidemia chronic care visits should include an ACC 10-year risk assessment.
- In **Case 12**, the patient was seen on December 20, 2017, for new onset of low back pain. The PCP's note does not document if the patient experienced any lack of bowel or bladder incontinence, or fever, and doesn't discuss risky behavior that might suggest a deep-seated infection.
- In **Case 13**, the patient was seen on February 5, 2018 in the Diabetes Chronic Care Clinic. The patient is prescribed a long term low dose aspirin, however there is no documentation of an ACC 10-year risk assessment to show whether the aspirin regimen is appropriate. Without the documented ACC 10-year risk assessment, the long term low dose aspirin is inappropriate and unnecessary. Additionally, there is no clear documentation of the medical necessity to treat the patient's toe nail fungus. Prescribing medically unnecessary medications pose a risk with little benefit.
- In **Case 15**, the patient is prescribed a low dose of aspirin which appears inappropriate. This deficiency is discussed in further detail in Component 8, *Medical/Medication Management*.

Quantitative Review Results

The facility received a quantitative compliance score of 84.4% (*Adequate*) with one new and one unresolved critical issues identified. Ten questions were rated; eight were proficient, and two were inadequate.

A review of patient health records indicated patients are not consistently seen for chronic care follow-up visits as ordered (Question 4.7). Ten of the 16 patient health records reviewed were in compliance with this requirement resulting in a rating of 62.5%. The facility has struggled with this requirement since the May 2012 audit, intermittently scoring below the required compliance threshold in six out of nine audits.

A review of the March 2018 Daily Huddle Activity Sheets indicated staff adequately addressed the planning and coordinating of patient care activities during the Daily Care Team Huddle on 2 out of 22 days, resulting in a score of 9.1% compliance (Question 4.8). During the onsite audit, the clinician auditors attended the Daily Care Team Huddle on Wednesday, May 23, 2018, which validated the findings of the activity sheet review. The huddle discussion was found to be disorganized and incomplete. This critical issue was first identified during the March 2017 annual audit (47.4%) and again during the November 2017 Limited Review audit (15.0%). During the onsite audit, the NCPR auditor discussed, in detail, the requirements for holding and documenting the Daily Care Team Huddles. A copy of CCHCS' Daily Care Huddle Script was provided to the HSA along with a sample of a completed Daily Huddle Activity Sheet.

[3] Statin - a class of drugs used to lower the level of cholesterol in the blood by reducing the production of cholesterol by the liver.

Recommendations:

- The PCP should actively engage in the Daily Care Huddle. Discussion of each patient currently being housed in a community hospital or the hub institution should be included with an update of the reason for the continued offsite stay documented.
- The PCP should expand the documentation of encounters. Often documentation is found to be focused and lack significant information including both family and personal health history, and essential elements of the current medical issue.
- Chronic Care Clinic encounters for hypertension, diabetes and dyslipidemia should include an ACC 10-year risk assessment to guide the use of low dose aspirin as well as lipid lowering agents.
- Avoid use of systemic antifungal agents for minor onychomycosis infections. If necessary to treat the infection, document the medical necessity of the treatment including co-morbidities and extent of the disease.

5. DIAGNOSTIC SERVICES

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

Case Review Score: *84.5%*
Quantitative Review Score: *78.6%*

Overall Score: 82.5%

The facility received an overall compliance score of 82.5% (*Adequate*). This is an increase of 5.5 percentage points from the March 2017 audit score of 77.0%. Specific findings related to the nurse and physician case reviews, and the electronic health record quantitative review are documented below.

Case Review Results

The facility received a case review compliance score of 84.5%. The clinician auditors reviewed a combined total of 20 encounters for this component.

Nurse Case Reviews

The NCPR auditor reviewed six nursing encounters and identified one deficiency.

- In **Case 20**, on January 5, 2018, the PCP ordered routine laboratory tests. All but one test was collected on January 15, 2018. The Hepatitis C viral load was not collected until January 31, 2018. Routine laboratory test samples need to be collected within 14 days of the order per IMSP&P Volume 4, Chapter 10, Section III-B, *Laboratory Services, Routine Order*.

Physician Case Reviews

The physician auditor reviewed 14 provider encounters and identified two deficiencies.

- In **Case 1**, the patient's laboratory test results were available for review on February 1, 2018; however, the PCP did not review the report until February 14, 2018, two weeks after they were available for review.
- In **Case 13**, the patient was seen on February 5, 2018 in the Diabetes Chronic Care Clinic. The patient's A1C[4] test showed the patient's blood sugar is well controlled. There is no documentation as to why the PCP ordered a repeat A1C test within a couple of weeks of the first test. Ordering a repeat A1C test that soon is deemed medically unnecessary.

Quantitative Review Results

The facility received a quantitative compliance score of 78.6% (*Inadequate*) with three new critical issues identified. The facility's current score is a significant decrease of 20 percentage points from the 98.6% compliance score received during the March 2017 audit. Four questions were rated; one was proficient, and three were inadequate.

During the electronic health record review, the nurse auditor found 3 out of 11 diagnostic tests were not completed within the time frame specified by the PCP (Question 5.2). In 3 out of 12 health records reviewed, the nurse auditor found the PCP did not review, sign, and date the diagnostic test results within two business days of receipt (Question 5.3). In addition, the copies of these three results were also not provided to the patients within two business days of receipt of the results (Question 5.4). The health care staff do not appear to access the diagnostic test results via the online Quest Quanum (formerly Care360) database to obtain the patient results in a timely manner. The facility does not have a designated health care staff member assigned to track and monitor laboratory results to ensure the results are provided to the PCP for review within the required time frames.

Recommendation:

- Develop a system to track and monitor laboratory tests and results, and assign designated staff to access the Quest Quanum database daily to ensure timely receipt of test 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: *75.0%*
Quantitative Review Score: *Not Applicable*

Overall Score: 75.0%

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

[4] A1C - a test to measure a patient's average blood glucose or blood sugar level over the past three months.

clinician auditors assess the timeliness and adequacy of the medical care provided based on the patient's emergency situation, clinical condition, and need for a higher level of care.

The facility received an overall compliance score of 75.0% (*Inadequate*). Specific findings related to the nurse and physician case reviews, and the electronic health record quantitative review are documented below.

Case Review Results

The facility received a Case Review compliance score of 75.0% for this component. The clinicians reviewed a combined total of nine encounters for this component.

Nurse Case Reviews

The NCPR auditor reviewed eight nursing encounters for this component and identified four deficiencies.

- In **Case 16**, on February 13, 2018, the patient was seen by an RN with a complaint of chest pain, diaphoresis[5], and pain 3/10 radiating to neck and jaw. The patient was referred to the PCP right away, however nursing staff did not follow the Chest Pain Nursing Protocol for a patient manifesting acute coronary symptoms. The RN should have administered oxygen, chewable aspirin 325mg, and sublingual Nitroglycerin as specified in the nursing protocol. Additionally, on February 27, 2018, upon the patient's return to GSMCCF from an offsite visit, the face-to-face assessment form completed by the RN did not have documentation of a nursing assessment or review of the patient's discharge instructions.
- In **Case 17**, on January 6, 2018, the patient was seen by the RN with a complaint of chest pain 6/10, radiating to the right shoulder down to his flank. Patient was referred to the PCP right away and subsequently transported to the Emergency Department (ED). However, nursing staff did not follow the Chest Pain Nursing Protocol. The chest pain protocol should have been utilized and followed such as administration of oxygen, chewable aspirin 325mg, and sublingual Nitroglycerin.
- In **Case 18**, the patient returned to GSMCCF on January 22, 2018 from the hub institution North Kern State Prison (NKSP), post hospitalization. Nursing staff completed a face-to-face assessment upon the patient's return; however, did not document their name, signature, and title.

Physician Case Reviews

The physician auditor reviewed one provider encounter and did not identify any deficiencies.

Quantitative Review Results

There were no samples identified during the electronic medical record review that met the criteria for this component during the audit review period. Therefore, the quantitative section was not scored during this audit.

[5] Diaphoresis – excessive perspiration or sweating.

7. INITIAL HEALTH ASSESSMENT/HEALTH CARE TRANSFER

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.

Case Review Score: *75.0%*
Quantitative Review Score: *85.7%*

Overall Score: 78.6%

The facility received an overall compliance score of 78.6% (*Inadequate*). This is a decrease of 12.7 percentage points from the March 2017 audit compliance score of 91.3%. Specific findings related to the nurse and physician case reviews, and the electronic health record and onsite quantitative reviews are documented below.

Case Review Results

The facility received a case review compliance score of 75.0% for this component. The clinicians reviewed a combined total of 17 encounters for this component.

Nurse Case Reviews

The nurse case review score of 50.0% during the current audit for this component is a significant decrease of 37.5 percentage points from the 87.5% compliance score received during the March 2017 audit. The NCPR auditor reviewed 14 nursing encounters and identified seven deficiencies.

- In **Case 17**, the patient returned to GSMCCF from NKSP on February 23, 2018. Nursing staff completed an initial health screening; however, the RN did not complete an assessment of the patient for condition(s) related to the questions answered "yes" by the patient on the Initial Health Screening form. Additionally, there is no documentation the patient received a screening for signs and symptoms of tuberculosis (TB) upon his return to GSMCCF.
- In **Case 19**, the patient arrived at GSMCCF on December 5, 2017 as a transfer from a CDCR institution. The TB screening form was filled out; however, the RN did not mark the "No Symptoms" box on the form.
- In **Case 20**, the patient arrived at GSMCCF on December 29, 2017 as a transfer from a CDCR institution. The TB symptom screening was completed; however, the nurse incorrectly marked the screening as "Annual" screening. Annual screening is only completed during the patient's birth month (June). Additionally, nursing staff completed an initial health screening during which the RN did not complete an assessment of the patient for condition(s) related to the questions answered "yes" by the patient on the Initial Health Screening form.
- In **Case 26**, the patient arrived at GSMCCF on February 20, 2018 as a transfer from a CDCR institution. The patient answered "yes" to a question on the Initial Health Assessment form,

however, the RN did not document an assessment of the patient for condition answered "yes." In addition, the TB symptom screening was completed, however the nurse incorrectly marked the screening as "Annual". Annual TB screenings are only completed during the patient's birth month (December).

- In **Case 28**, the patient arrived at GSMCCF on February 23, 2018 as a transfer from a CDCR institution. The TB symptom screening was completed; however, the nurse incorrectly marked the screening as "Annual". Annual screenings are only completed during the patient's birth month (November).

Physician Case Reviews

The physician auditor reviewed three provider encounters and did not identify any deficiencies.

Quantitative Review Results

The facility received a quantitative compliance score of 85.7% with one new critical issue identified. This score is a decrease of 13.1 percentage points from the 98.8% compliance score received during the March 2017 audit. Seven questions were rated; six were proficient (all scored 100%), and one was inadequate.

During the onsite visit, no patients transferred out of the facility. The NCPR auditor interviewed the designated RN and asked her to describe the process for gathering and securing the required transfer documents and medication in the transfer envelope. The RN was unable to provide the information. As a result, the facility received a compliance score of 0.0% for (Question 7.8).

8. MEDICAL/MEDICATION MANAGEMENT

Case Review Score: *83.1%*
Quantitative Review Score: *85.4%*

Overall Score: 83.9%

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

The facility received an overall compliance score of 83.9% (*Adequate*). Specific findings related to the nurse and physician case reviews, and the electronic health record quantitative review are documented below.

Case Review Results

The facility received a Case Review compliance score of 83.1% for this component. The clinicians reviewed a combined total of 81 encounters for this component.

Nurse Case Reviews

The NCPR auditor reviewed 58 nursing encounters and identified 12 deficiencies. Of those 12 deficiencies, 8 were related to medication administration, and 4 were related to nursing documentation on the MAR.

- In **Case 16**, on February 12, 2018, the patient received KOP medication. The previous MAR for this medication shows the patient received the medication on December 13, 2017. There is no MAR showing the patient received the medication in January 2018.
- In **Case 18**, nursing notes dated January 5, 2018, indicate the patient received two antacid tablets; however, there is no MAR documenting the tablets were given.
- In **Case 20**, on January 5, 2018, the PCP ordered KOP topical cream; however, there is no MAR documenting the patient received the medication. The patient also received a KOP medication for lisinopril late on February 6, 2018, more than 30 days after receiving his previous 30-day supply on December 29, 2017. The patient is required to receive his medications at least one day prior to the previous supply being depleted.
- In **Case 23**, four deficiencies were identified by the NCPR auditor, all related to the timeliness of KOP medication received by the patient. On December 8, 2017, the patient received a 30-day supply of the KOP medications atorvastatin, calcium, metformin HCL, lisinopril, and aspirin. The NCPR auditor could not determine if the patient received the KOP medications timely on December 8, 2017. There was no MAR showing patient's receipt of the medications on November 9, 2017. The only document available was a signed receipt of medications by nursing staff on a Medication Reconciliation form. On January 9, 2018, the patient received the next supply of KOP medications. These medications were received late as they are required to be received by the patient no less than one business day prior to exhaustion of medication supply unless otherwise ordered. On February 5, 2018, a refill request for the medication naproxen was faxed to the pharmacy; however, there was no MAR indicating the naproxen was received by the patient.
- In **Case 24**, the patient did not receive his medications timely on two occasions and nursing staff did not document appropriately on the MAR. On February 7, 2018, the patient received a 10-day supply of ibuprofen for pain. The patient initially requested a refill of ibuprofen on January 27, 2018, but did not receive it. He again requested it on February 4, 2018, and received it on February 7, 2018, 11 days after the original request refill. The patient requested a refill of the same 10-day supply of ibuprofen on February 15 and 18, 2018, and received it on February 21, 2018, six days after the original refill request. It was also noted that the pharmacy fill date was February 16, 2018. The patient should have received it on the fill date or the day after. When the patient received the ibuprofen medication on January 10, 2018, the nursing staff failed to sign the MAR. On January 19, 2018, the nursing staff again failed to sign the MAR, but did document the patient's receipt on the Medication Reconciliation form instead.

Physician Case Reviews

The physician auditor reviewed 23 provider encounters and identified three deficiencies. Two of the three deficiencies identified related to the facility's PCP prescribing the use of low dose aspirin for primary cardiac prevention. The third deficiency related to prescribing a long term non-steroidal anti-inflammatory drugs (NSAID) without adequate justification. The use of low dose aspirin for primary cardiac prevention should be utilized only when the benefit outweighs the risk; the use and completion of the ACC risk calculator is an important part of documenting the medical necessity. Long term prescription of NSAID should be minimized and if required, a detailed note documenting its medical necessity should be placed in the health record explaining how the benefits outweigh the risks of this treatment.

- In **Case 7**, on March 5, 2018, the PCP refilled a prescription for the medication naproxen 500mg to be taken twice daily for testicular pain despite negative ultrasound results and no documented evidence of pain at the follow up appointment the prior month, February 6, 2018. It is inappropriate to prescribe a high dose of NSAID with no documented medical indication.
- In **Case 12**, the patient is diagnosed with Hepatitis C Virus[6] (HCV). On February 7, 2018, the PCP refilled a prescription for a high dose of the NSAID medication naproxen for 120 days with no medically documented reasons. Per the patients follow up appointment for the back pain on January 3, 2018, the pain was nearly resolved. Treatment with NSAIDs for HCV patients should be short term use only as long term use could risk aggravating the patient's liver, potentially outweighing the benefits.
- In **Case 15**, the patient is diagnosed with Diabetes Mellitus and prescribed long term aspirin use. Per ACC recommendations, this patient's ACC risk assessment suggests there is insufficient evidence to justify long term aspirin use and is deemed inappropriate for this patient.

Quantitative Review Results

The facility received a quantitative compliance score of 85.4% (*Adequate*) with one unresolved critical issue identified. Seven questions were rated; six were proficient, and one was inadequate.

The nurse auditor reviewed the electronic health record for 16 patients who were prescribed chronic care medications during the audit review period, and found nursing staff failed to consistently provide patients their chronic care medications within the required time frame (Question 8.1). One out of 16 records reviewed indicated the patient received their chronic care medications timely. This is an unresolved critical issue from the March 2017 audit.

There were no patients prescribed anti-TB medications at GSMCCF during the audit review period; therefore, auditors were unable to evaluate whether the facility monitors patients monthly while on the medications (Question 8.4, formerly Question 8.5 in former audits). This question remains an unresolved critical issue from the March 2017 annual audit and will be evaluated during subsequent audits to determine compliance.

[6] Hepatitis C Virus – a viral infection that causes liver inflammation, sometimes leading to serious liver damage.

Recommendations:

- Nursing staff to provide KOP refills to the patient population in accordance with the requirement that the patient receive KOP medications no less than one business day prior to his previous supply being exhausted.
- Prescription of NSAIDs for long-term use should be minimized. But if deemed necessary ensure a detailed note in the health record documents its medical necessity and explains how the benefits outweigh the risks of the treatment.

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

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

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

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

10. SPECIALTY SERVICES

In this component, clinician auditors determine whether patients are receiving approved specialty services timely, whether the provider reviews related specialty service reports timely and documents their follow-up action plan for the patient, and whether the results of the specialist's 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: *100.0%*
Quantitative Review Score: *60.7%*
Overall Score: 86.9%

The facility received an overall compliance score of 86.9% (*Adequate*). Specific findings related to the nurse and physician case reviews, and the electronic health record quantitative review are documented below.

Case Review Results

The facility received a case review compliance score of 100% for this component. The clinicians reviewed a combined total of 12 encounters for this component. The NCPR auditor reviewed six nursing encounters, and the physician auditor reviewed six provider encounters. No deficiencies were identified.

Quantitative Review Results

The facility received a quantitative compliance score of 60.7% (*Inadequate*) with two new critical issues identified. This score is a significant decrease of 37.2 percentage points from the 97.9% compliance score received during the March 2017 annual audit. Four questions were rated; two were found adequate, and two were inadequate.

The nurse auditor reviewed seven patient's electronic health records and found two records did not indicate the RN completed a face-to-face assessment of the patient upon return from a specialty service appointment and prior to being rehoused (Question 10.2). The electronic health records of three patients identified as returning from specialty services appointments were reviewed by the nurse auditor. All three noted the need for immediate medication or follow-up requirements per the specialty services provider; although, none of the health records contain documentation demonstrating the nurse notified the PCP of the immediate medication or follow-up requirements (Question 10.3).

Recommendation:

- Facility staff should reach out and work with the Contract Beds Unit, the hub institution, and the CDCR Transportation Unit to discuss potential barriers for patients returning from specialty appointments at the hub in timely manner.

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: *46.7%*

Overall Score: 46.7%

Quantitative Review Results

The facility received a compliance score of 46.7% (*Inadequate*) for the quantitative reviews with two critical issues identified. This score is a significant decrease of 48.3 percentage points from the 95.0% compliance score received during the March 2017 annual audit. Three questions were rated; one was adequate, and two were inadequate.

Twenty patient health records were reviewed by the nurse auditor, all of which were found to have incomplete or missing documentation for their annual signs and symptoms TB screenings during their birth months resulting in a 0.0% compliance score (Question 11.1). The nurse auditor noted the majority of the patients (16 out 20) were screened for signs and symptoms of TB, but not during the correct time frame. Effective June 2017, patients are to be screened during their birth month, or as soon as possible after their birth month.[7] The facility did not change their process from an annual screening of all patients,

[7] IMSP&P, Volume 10, Chapter 3.2, Tuberculosis Surveillance Program Procedure.

to a monthly screening of patients by birth month. During the onsite audit, the nurse auditor discussed, at length with the HSA, the requirements for the annual screening for signs and symptoms of TB of the patient population at GSMCCF.

The facility was also found non-compliant in offering colorectal cancer screening to all patients 50 to 75 years of age. The electronic health records of 7 out of 15 patients did not have documentation of a Fecal Occult Blood Test (FOBT) result, clinical results of a colonoscopy, or a signed refusal of the two diagnostic tests (Question 11.3). Four of the seven patient health records showed the FOBT was ordered by the PCP, however, there was no documentation of the test being completed or refused by the patient. The remaining three records did not contain documentation indicating the patient was offered a colorectal cancer screening within the last year. The health records showed the patients last received a FOBT test on September 23, 2016, September 27, 2016, and December 1, 2016, respectively.

12. EMERGENCY MEDICAL RESPONSE/DRILLS and EQUIPMENT

Case Review Score: *Not Applicable*
Quantitative Review Score: *79.4%*

Overall Score: 79.4%

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

Quantitative Review Results

The facility received an overall compliance score of 79.4% (*Inadequate*) with four new critical issues identified. This is a decrease of 3.6 percentage points from the 83.0% compliance score received during the March 2017 annual audit. Ten questions were rated; six were proficient (all scored 100%), and four were inadequate.

During the audit review period, the facility did not conduct emergency medical response drills quarterly on each shift (Question 12.1). The facility conducted drills on the first and third shifts; however, did not conduct an emergency medical response drill on the second shift (Question 12.2). The facility failed to submit the emergency medical response documentation for the emergency medical responses or drills dated December 15, 2017, January 5 and 6, 2018, and February 13, 2018. Without this documentation the NCPR auditor was unable to determine if an RN or PCP responded within eight minutes of the emergency medical alarm sounding. Additionally, the facility's EMRRC did not perform a timely incident package review for the four medical emergency responses noted above as no documents were submitted (Question 12.4) for the EMRRC's review.

During the onsite audit, the NCPR auditor noted the facility stores the medication intranasal naloxone, also known as Narcan, in a secured area, although medical staff do not utilize a designated naloxone accountability log (Question 12.15). The facility received a compliance score of 0.0% for this question. The CCHCS policy memorandum, *Deployment and Use of Intranasal Naloxone within California Department of Corrections and Rehabilitation Adult Institutions*, dated March 21, 2017, states, "The institution shall ensure that there is a process in place to account for each dose of intranasal naloxone stored at each location by using the *Intranasal Naloxone Accountability Log."* The NCPR auditor discussed this requirement in detail with the HSA.

Recommendation:

- All issues related to emergency medical responses and drills should be brought to the attention of the facility's EMRRC for corrective action and further monitoring.

13. CLINICAL ENVIRONMENT

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

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

Overall Score: 100.0%

Quantitative Review Results

The facility received an overall compliance score of 100% (*Proficient*) with no critical issues identified. All 15 questions reviewed for this component were scored 100% compliant. The auditors found the clinical space was clean and organized with excellent access to hand washing, sanitizers, 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

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

Case Review Score: *71.7%*
Quantitative Review Score: *Not Applicable*

Overall Score: *71.7%*

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

Case Review Results

The facility received an overall compliance score of 71.7% (*Inadequate)*. This determination was based upon the detailed case review of the nursing services provided to a random sample of ten patients housed at GSMCCF during the audit review period of December 2017 through March 2018. Of the ten detailed case reviews conducted by the NCPR auditor, three were found proficient, one was found adequate, and six were found inadequate. Of 124 total nursing encounters assessed within the 10 detailed case reviews, 32 deficiencies relating to nursing care and performance were identified. The details of these deficiencies are documented in the previous components; *Access to Care, Diagnostic Services, Emergency Services and Community Hospital Discharge, Initial Health Assessment/Health Care Transfer, Medical/Medication Management, and Specialty Services*.

The current overall case review score of 71.7% is a significant decrease of 22.8 percentage points from the previous March 2017 annual audit score of 94.5%. Nursing performance decreased in three of the six components. The *Emergency Services and Community Hospital Discharge* component was not scored during the March 2017 audit as there were no samples meeting the criteria. However, the facility failed to meet the 80.0% compliance threshold during the current audit. Please see the table below for additional information.

Medical Component	Nurse Case Review Score March 2017 Annual Audit	Nurse Case Review Score May 2018 Annual Audit	Percentage Point Change
4. Access to Care	93.6%	73.8%	-19.8
5. Diagnostic Services	40.0%	83.3%	+43.3
6. Emergency Services and Community Hospital Discharge	N/A	50.0%	N/A
7. Initial Health Assessment/Health Care Transfer	87.5%	50.0%	-37.5
8. Medical/Medication Management	95.9%	79.3%	-16.6
10. Specialty Services	88.9%	100.0%	+11.1

The facility did not have a nurse supervisor/HSA to provide direction and supervision to the nursing staff during the audit review period. The facility's new HSA began work the week of the current onsite audit. The lack of a nursing supervisor and inconsistent nursing staff coverage at GSMCCF appears to have impacted the facility's ability to provide adequate health care. For instance, during the onsite audit, the NCPR auditor learned the RNs working at the facility during the onsite audit were per diem[8] and not regular full-time nurses. Without a nursing supervisor/HSA at the facility to monitor per diem staff and ensure per diem staff receive proper training with IMSP&P requirements for nursing care, the quality of patient care is compromised.

The clinician auditors attended a Daily Care Team Huddle while at GSMCCF for the onsite audit. The NCPR auditor provided feedback and discussed issues that required a plan of action or follow-up and provided a copy of the Daily Care Team Huddles Script and a sample of a completed Daily Care Team Huddle sheet to guide the facility's nursing staff on what to document.

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

Case Number	Deficiencies
Case 16	***Inadequate (72.2%).*** This is a 51-year old male patient with chronic diagnoses of hypertension, Gastroesophageal Reflux Disease[9], dyslipidemia and hypothyroidism. During the audit review period, the patient complained of chest pain and was transferred to the ED. A total of 14 nursing encounters were reviewed and 5 were deemed deficient: Two deficient encounters were related to Access to Care, i.e., blood pressure monitoring was not done as ordered on two occasions. Two additional deficient encounters were related to Hospital/Emergency Services, i.e., nursing staff's failure to implement the nursing protocol for chest pain and upon patient's return from the hospital, nursing failed to perform a nursing assessment, and review discharge instructions. The fifth deficient encounter was related to Medication Management, i.e., the MAR did not show levothyroxine was received in the month of January.
Case 17	***Inadequate (33.3%).*** This is a 29-year-old male patient with a history of hypertension, Diabetes Mellitus II, asthma, and seizures. During the audit review period, the patient complained of chest pain and was transferred to the ED. Three nursing encounters were reviewed, two were deficient. Nursing staff failed to implement the nursing protocol for chest pain. The nursing staff also failed to conduct TB screening and did not document the Initial Health Screening adequately
Case 18	***Inadequate (57.1%).*** This is a 28-year old male patient with no chronic diagnosis. During the audit review period, the patient complained of severe abdominal pain and was sent out to the ED where he was diagnosed with acute cholecystitis. He had an open cholecystectomy. A total of seven nursing encounters were reviewed. Three were deficient: failed to perform daily dressing change; failed to document on the MAR antacid was given; and failed to document name, signature, and title of the staff conducting the face-to-face assessment.

[8] Per Diem staff –staff hired on a daily basis to cover vacant positions.

[9] Gastroesophageal Reflux Disease – a condition where stomach acid frequently flows back into the tube connecting the mouth and stomach (esophagus). This backwash (acid reflux) can irritate the lining of the esophagus.

Case 19	***Inadequate (66.7%).*** This is a 38-year-old male patient with a history of a gunshot wound and abdominal hernia. During the audit review period, he complained of testicular pain and was diagnosed with testicular epididymitis. A total of 21 nursing encounters were reviewed, 7 were deemed deficient. Six deficient encounters were related to Access to Care. On three occasions, nursing failed to complete a sick call request form (CDCR Form 7362) on behalf of the patient. On two occasions, nursing failed to conduct an adequate assessment related to testicular pain and sore throat. On another occasion, nursing failed to document the name of the PCP to whom she made a referral. The seventh deficient encounter was related to the Health Care Transfer screening, nursing failed to mark the "No Symptoms" box on the TB screening form.
Case 20	***Inadequate (45.5%).*** This is a 37-year-old male patient with chronic hepatitis, dyslipidemia, and morbid obesity. During the audit review period, the patient was being monitored for hypertension and chronic hepatitis. A total of 11 nursing encounters were reviewed, 6 were found deficient. Two deficient encounters were related to medication management; on one occasion, the patient did not receive lisinopril timely; on another occasion, the MAR did not show the patient received Nizoral 2% cream as ordered. Two deficient encounters were related to the health care transfer process: The TB screening form was incorrectly marked as "annual" instead of “transfer”. In addition, nursing failed to describe or conduct an assessment of the questions or medical conditions answered "yes" by the patient during Initial Health Screening. Another deficient encounter was related to the untimely performance of an ordered laboratory exam (HCV vl), which was completed outside the 14-day required time frame for routine diagnostic service. The sixth deficient encounter was related to the absence of nursing documentation showing weekly blood pressure monitoring was done as ordered.
Case 23	***Inadequate (71.4%).*** This is a 54-year-old male patient with chronic diagnoses of hypertension, Diabetes Mellitus, dyslipidemia, and status post laminectomy. During the audit review period, he was sent out to the CDCR hub institution for a mental health evaluation. A total of 14 nursing encounters were reviewed and 4 were found deficient, all related to medication management. On two occasions, routine KOP medications (Fiber-Lax, lisinopril, atorvastatin, metformin, and aspirin) were not received timely by the patient. KOP medications need to be received by the patient at least one day before the previous 30-day supply is depleted. On another two occasions, there was no MAR documentation to show the patient received the ordered medications (naproxen, calcium, metformin, etc.).

Recommendation:

- Provide comprehensive orientation to the new HSA and staff nurses regarding the IMPS&P requirements.
- Provide training to nursing staff involved in the Daily Care Team Huddle on the requirements for documentation.

15. QUALITY OF PROVIDER PERFORMANCE

In this component, the physician auditor provides 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: *86.7%*
Quantitative Review Score: *Not Applicable*
Overall Score: 86.7%

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

Case Review Results

The facility's provider performance received a compliance score of 86.7% (A*dequate*). Based on the detailed review of 15 cases conducted by the physician auditor, nine were found proficient, two adequate, and four inadequate. There were a total of 62 provider encounters/visits assessed within the 15 detailed cases, eight of which the physician auditor found deficient.

The current PCP has worked three and a half years at the facility and has ten years of correctional medicine experience. The facility also employs a physician assistant (PA) to provide coverage when the PCP is on scheduled time off. During the onsite audit, May 22 through 24, 2018, the PA was providing coverage. The PA reported he does not have access to either of the CCHCS electronic health records systems (Electronic Health Record System and electronic Unit Health Record) and stated nursing staff provide him with access to health records as needed for ongoing patient care delivery. The physician auditor observed the PA providing care to patients in a professional and compassionate manner, taking time to educate patients. The PA is supervised by the Regional Medical Director (RMD) - Western Region for the Geo Group[10]. The RMD is located offsite but available by phone.

The physician auditor found overall medical services provided by the physician and PA generally met the standards of care applied in the CDCR institutions and determined their performance to be adequate. The prescribing methods seemed, overall, to be consistent with best practices. However, the physician auditor found the physician does not always utilize the ACC risk assessment when prescribing long term low dose aspirin for primary cardiac prevention. The ACC risk assessment is an important part of documenting the medical necessity for low dose aspirin use. Long term use of NSAIDs at a high dose and should be weighed against the reasons for prescribing the medication and clearly substantiate the reasons in the patient's health record. In addition, use of potentially hepatotoxic medication for mild onychomycosis should be avoided unless coexisting morbidities or other documented reasons necessitate its use.

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

[10] The Geo Group - is a multi-nation company that owns and manages private prisons and detention centers including several modified community correctional facilities housing California inmates.

Case Number	Deficiencies
Case 7	***Inadequate (50.0%).*** The patient is a 34-year old male seen prior to the audit review period for a complaint of testicular pain and diagnosis of possible epididymal[11] nodule. A testicular ultrasound and high dose of the medication Naprosyn was ordered. The ultrasound was performed on February 1, 2018 and the patient was seen by the physician for follow-up on February 6, 2018. The nodule was no longer palpated and there was no evidence of pain documented. The long term NSAID, Naprosyn, was continued for no documented medical reason. The risk of long term high dose NSAID use is substantial and requires a documented medical condition.
Case 9	***Inadequate (50.0%).*** The patient is a 56-year old male with diagnoses of dyslipidemia and hypertension who was seen in the chronic care clinic during the audit review period. The patient is maintained on a statin medication and low dose of aspirin. The chronic care visit does not document an ACC 10-year risk assessment to justify the use of aspirin. Hypertension and hyperlipidemia chronic care visits should include an ACC 10-year risk assessment.
Case 12	***Inadequate (75.0%).*** The patient is a 37-year old male who was seen by the physician multiple times as referred by an RN from sick call. The physician's lower back pain evaluation did not address possible "red flag" indictors which might suggest deep seated infection. Despite the resolution of patient's low back pain, he was prescribed a high dose of the NSAID, Naprosyn, long term which appears medically unnecessary and risky.
Case 13	***Inadequate (60.0%).*** The patient is a 35-year-old male seen in chronic care clinic for Type II Diabetes with long term blood sugar documented as well controlled on A1C test. The A1C test was repeated within a couple of weeks without a clear reason documented which makes the test medically unnecessary. The patient was also taking a long term low dose of aspirin without a documented ACC 10-year risk assessment which makes the aspirin inappropriate and unnecessary.

Recommendations:

- The physician should continue to encourage nursing staff to seek contemporaneous advice or physical examination of patients with new symptoms or worsening conditions.
- The physician to document phone calls to specialists, emergency department physicians, and other providers who have seen patients to assure the physician and outside providers are communicating as needed.
- The physician is encouraged to place a personalized note in the patient's health record for each refusal of services, clearly and extensively documenting the patient understands the implications of his refusal.
- Continue monthly quality improvement meetings, keeping written documentation (meeting minutes) of what is discussed and plans for improvement to be implemented.

[11] Epididymal Nodule –an abnormal mass that forms in the testicles.

PRIOR CRITICAL ISSUE RESOLUTION

The previous Limited Review audit conducted on November 1 through 3, 2017, resulted in the identification of four quantitative critical issues. During the current audit, auditors found none of the critical issues were resolved. Below is a discussion of each previous critical issue:

Critical Issue	Status	Comment
Question 1.2 – THE FACILITY'S LOCAL OPERATING PROCEDURES/ POLICES ARE NOT ALL IN COMPLIANCE WITH THE INMATE MEDICAL SERVICES POLICIES AND PROCEDURES.	**Unresolved**	This deficiency was initially identified during the March 2017 audit. At that time, 8 out of 14 policies were compliant with IMSP&P resulting in a 57.1% compliance score. During the November 2017 Limited Review, 6 out of 12 policies were compliant resulting in a 50.0% compliance score. During the current audit, 9 out of 15 policies were found compliant resulting in a 60.0% compliance score. ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***
Question 4.8 – THE FACILITY'S HEALTH CARE STAFF (CARE TEAM) DID NOT REGULARLY CONDUCT AND DOCUMENT A CARE TEAM HUDDLE DURING BUSINESS DAYS.	**Unresolved**	This deficiency was initially identified during the March 2017 audit. Documentation for 19 Daily Care Team Huddles was reviewed by the nurse auditor. Ten out of 19 days did not have adequate documentation which resulted in a 47.4% compliance score. During the November 2017 Limited Review, documentation for 20 days was reviewed and 17 days did not have adequate documentation which resulted in 15.0% compliance. During the current audit, the facility's score decreased as the documentation for 20 out of 22 Daily Care Team Huddles were found to be inadequate resulting in 9.1% compliance. ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***
Question 8.1 – THE CHRONIC CARE MEDICATIONS WERE NOT RECEIVED BY THE PATIENT WITHIN THE REQUIRED TIME FRAME.	**Unresolved**	This deficiency was initially identified during the March 2017 audit. The health records of 24 patients receiving chronic care medications were reviewed by the nurse auditor. Six out of 24 patients did not receive their chronic care medication within the required time frame (75.0%). During the November 2017 Limited Review, 12 out of 16 health records reviewed revealed the patients did not receive their chronic care medications timely (25.0%). During the current audit, 15 of the 16 health records reviewed revealed the patients did not receive their chronic care medications timely (6.3%). ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***
Question 8.4 (formerly Question 8.5) – THE FACILITY FAILED TO ADMINISTER THE PRESCRIBED ANTI-TUBERCULOSIS MEDICATIONS TO THE PATIENTS.	**Unresolved**	This deficiency was initially identified during the March 2017 audit. During the audit review period for that audit, there was one patient housed at GSMCCF who was prescribed anti-TB medication. A review of the patient's health record, indicated the facility did not consistently administer the anti-Tb medication to the patient. During the audit review periods for the November 2017 Limited Review and the current annual audit, there were no patients housed at GSMCCF who were prescribed anti-TB medication. This requirement could not be evaluated during the November 2017 Limited Review and current annual audit. ***This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.***

CONCLUSION

The audit findings discussed in this report are a result of a thorough evaluation of the health care services provided by GSMCCF to the patient population during the audit review period of December 2017 through March 2018. The facility's overall performance during this time frame is rated as *Adequate* (80.0%) which is a decrease of 5.3 percentage points from the March 2017 annual audit score of 85.3%. The facility failed to resolve four prior critical issues which were identified during the March 2017 annual audit. The auditors identified 19 new quantitative critical issues, resulting in a total of 23 critical issues.

Of the 14 components evaluated, auditors found 2 components to be proficient, 5 adequate, and 7 inadequate (refer to the Executive Summary Table on page four for additional details). The facility's overall compliance scores for 8 of the 14 components evaluated during the current audit decreased since the March 2017 annual audit. The *Administration Operations, Internal Monitoring and Quality Management, Access to Care, Emergency Services and Community Hospital Discharge, Initial Health Assessment/Health Care Transfer, Preventative Services, and Quality of Nursing Performance* components scored below the 80.0% compliance threshold.

Six of the facility's 15 policies and procedures are not in compliance with IMSP&P (Question 1.2). It is imperative the facility revise their policies as adherence to the IMSP&P requirements is essential to provide adequate health care to the CDCR patient population at GSMCCF. The facility must provide training on all policies and procedures to health care staff upon hire and annual training thereafter. Additional training should be provided as revisions to the IMSP&P are received and policies are updated.

The facility continues to struggle with conducting and adequately documenting the Daily Care Team Huddles (Question 4.8). The nurse auditor discussed the requirements for the documentation, and provided the *Daily Care Team Huddle Script* and sample huddle documentation to the facility's HSA during the current audit. The facility is encouraged to provide training to staff who are responsible for completing the documentation for the Daily Care Team Huddle.

Three recurrent critical issues are found in the *Diagnostic Services* component. While the facility obtained an overall rating of *Adequate* for the *Diagnostic Services Component*, the facility has struggled to maintain compliance to ensure (a) PCP orders for diagnostic tests are completed as ordered by the PCP (Question 5.2), (b) the PCP reviews, signs, and dates the test reports timely (Question 5.3), and (c) the patient is provided with written notification of the test results (Question 5.4) in a timely manner. These requirements are not consistently found compliant from one audit to the next.

The facility has not consistently provided patients their chronic care medications within the required time frame since the March 2017 audit (Question 8.1). The facility must work diligently toward resolving this critical issue immediately.

Please see the table below showing the facility's score (*pass/fail*) for each critical issues which failed to meet the required minimum compliance threshold for three or more audits. Since February 2010, the facility has struggled to maintain compliance with 15 requirements.

Critical Issues	**2/2010**	2/2011	9/2011	05/2012	11/2012	06/2013	5/2014	11/2014	5/2015	4/2016	3/2017	11/2017	5/2018
Question 1.2: The facility's local operating procedures/policies are not all in compliance with the IMSP&P.	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Pass	Fail	Fail	Fail
Question 1.4: The facility's patient orientation handbook/manual does not adequately explain the health care grievance process.	n/a	n/a	Pass	Pass	Pass	Pass	Fail	Pass	Fail	Pass	Fail	Pass	Fail
Question 1.8: The facility is not consistently documenting the release of health care information on the CDCR form 7385, *Authorization for Release of information when a patient or third party requests the release of health care information*.	n/a	Fail	Pass	n/a	n/a	Pass	Pass	Pass	Pass	Fail	Pass	n/a	Fail
Question 2.4: The facility did not submit all weekly monitoring logs within the specified time frames during the audit review period.	n/a	n/a	n/a	n/a	n/a	n/a	Fail	n/a	n/a	Fail	Pass	n/a	Fail
Question 2.13: The facility does not process first level health care grievances (formerly appeals) in the specified time frames.	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Pass	Pass	Fail	Fail	Pass	Fail
Question 4.7: The patients' chronic care follow-up visits are not completed as ordered.	Pass	Pass	Pass	Fail	Fail	Fail	Fail	Pass	Fail	Pass	Pass	n/a	Fail
Question 4.8: The Facility does not regularly conduct and adequately document a Daily Care Team Huddle During all business days.	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Fail	Fail	Fail
Question 5.2: The facility does not consistently complete the patient diagnostic test within the time frame specified by the primary care provider.	Pass	Fail	Pass	Pass	Fail	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail
Question 5.3: The primary care provider does not consistently review, sign and date the patient diagnostic test report(s) within two business days of receipt of results.	Pass	Fail	Pass	Fail	Fail	Fail	Fail	Pass	Pass	Pass	Pass	Pass	Fail
Question 5.4: The facility does not consistently provide patients with written notification of their diagnostic test results within two business days of receipt of results.	Fail	Fail	Fail	Fail	Fail	Fail	Pass	Pass	Pass	Pass	Pass	Pass	Fail

Question 8.1: The chronic care medications are not consistently received by the patient within the required time frame.	Pass	Pass	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Pass	Fail	Fail	Fail
Question 10.2: Upon the patients' return from specialty service appointments, the facility RN does not complete a face-to-face assessment prior to the patients' return to their assigned housing units.	Pass	n/a	n/a	Fail	n/a	n/a	n/a	Pass	Pass	Fail	Pass	n/a	Fail
Question 11.1: The facility's nursing staff failed to timely complete the patients' annual screening for signs and symptoms of tuberculosis and administer a Tuberculin Skin Test if indicated.	Pass	Fail	Pass	Pass	Fail	Pass	Pass	Pass	Pass	Fail	Pass	n/a	Fail
Question 12.1: The facility is not conducting emergency medical response drills quarterly on each shift.	Fail	Fail	Fail	Pass	Pass	Pass	Pass	Pass	Fail	Pass	Pass	n/a	Fail
Question 12.4: The EMRRC failed to perform timely incident package reviews utilizing the required review documents.	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Pass	Fail	Fail	Pass	Fail

Note: A question with n/a indicates it was not scored because 1) it was not part of the audit at the time, or 2) the sample randomly selected did not satisfy the rating criteria.

While the auditors found the overall delivery of health care at GSMCCF to be adequate, continued training of health care staff is needed. It is imperative executive and health care management work together to update the facility's health care policies and provide training to health care staff to bring the eight inadequate components to an adequate level of health care services.

APPENDIX A – QUANTITATIVE REVIEW RESULTS

Golden State Modified Community Correctional Facility Range of Summary Scores: 46.7% - 100.0%	
Audit Component	**Quantitative Score**
1. Administrative Operations	74.1%
2. Internal Monitoring & Quality Management	75.3%
3. Licensing/Certifications, Training & Staffing	100.0%
4. Access to Care	84.4%
5. Diagnostic Services	78.6%
6. Emergency Services & Community Hospital Discharge	Not Applicable
7. Initial Health Assessment/Health Care Transfer	85.7%
8. Medical/Medication Management	85.4%
9. Observation Cells (out-of-state facilities only)	Not Applicable
10. Specialty Services	60.7%
11. Preventive Services	46.7%
12. Emergency Medical Response/Drills & Equipment	79.4%
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?	9	6	60.0%
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?	0	1	0.0%
1.5	Does the facility's provider(s) access the California Correctional Health Care Services patient electronic medical record system regularly?	Not Applicable		
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?	14	3	82.4%
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?	13	4	76.5%
	Overall Percentage Score:			**74.1%**

Comments:

Question 1.2 Six of the facility's 15 health care policies were not in compliance with IMSP&P. Please refer to the Administrative Operations component beginning on page seven of this report for a listing of the deficient policies.

Question 1.4 The Inmate Orientation Handbook did not include the revised name of the CDCR Form 602 HC (Rev. 6/17), *Health Care Grievance*, and introduction of the new CDCR Form 602 HC A (6/17), *Health Care Grievance Attachment*.

Question 1.5 N/A. The facility PCP was not available during the onsite audit to determine if he was able to access CCHCS' electronic health records.

Question 1.7 Three of 17 patient requests for health records were not provided within the required time frame.

Question 1.8 The electronic health record was missing a completed CDCR Form 7385 for 4 of 17 patient requests recorded on the ROI Log.

2. Internal Monitoring & Quality Management		Yes	No	Compliance
2.1	Did the facility hold a Quality Management Committee meeting a minimum of once per month?	4	0	100.0%
2.2	Did the Quality Management Committee's review process include documented corrective action plan for the identified opportunities for improvement?	4	0	100.0%
2.3	Did the Quality Management Committee's review process include monitoring of defined aspects of care?	4	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?	47	12	79.7%
2.5	Is data documented on the sick call monitoring log accurate?	14	3	82.4%
2.6	Is data documented on the specialty care monitoring log accurate?	12	0	100.0%
2.7	Is data documented on the hospital stay/emergency department monitoring log accurate?	0	3	0.0%

2.8	Is data documented on the chronic care monitoring log accurate?	16	3	84.2%
2.9	Is data documented on the initial intake screening monitoring log accurate?	19	1	95.0%
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?	0	1	0.0%
2.13	Are institutional level health care grievances being processed within specified time frames?	1	1	50.0%
	Overall Percentage Score:			**75.3%**

Comments:

Question 2.4 The facility did not submit six weekly monitoring logs during the audit review period. The facility did not submit the Sick Call, Specialty Care and Hospital Stay/ED logs for the weeks of January 9 and 16, 2018. The three weekly monitoring logs were submitted late during the weeks of December 19, 2017 and January 24, 2018. The monthly logs were received timely.

Question 2.5 The HPS I auditor reviewed 17 entries within the Sick Call Monitoring Log for the audit review period and found three entries with erroneous data. Two entries had the wrong CDCR number for the patient, and one entry incorrectly spelled the patient's last name.

Question 2.7 The HPS auditor found three entries on the Hospital/ED Monitoring Log for the audit review period which incomplete. The facility did not document the date the patient returned to GSMCCF from an ED visit, the date of the RN assessment, nor the date of the PCP follow-up.

Question 2.8 The HPS auditor found 19 entries on the Chronic Care Monitoring Log, three of which contained erroneous data; namely, missing chronic care clinic name, wrong date of chronic care visit on the log, and no documentation in the comment section explaining why the patient's chronic care visit was not accomplished.

Question 2.9 The HPS auditor found 20 entries on the Intake Screening Monitoring Log, of which one entry contained erroneous data. The entry had the wrong CDCR number for the patient.

Question 2.10 Auditors surveyed a total of eight housing units for the availability of CDCR Forms 602-HC, and 602 HC A. The auditor found Housing Unit B, Dorm 1 did not have any 602 HC A forms readily available for patients at the time of the onsite audit.

Question 2.12 The facility's Health Care Grievance Log did not contain the field "Date of RN Triage of the CDCR Form 602-HC" and updated "type of disposition" in the "Disposition Column."

Question 2.13 The facility received two health care grievances during the audit review period. One grievance response was not completed and given to the patient within the required 45 business days. The grievance response was dated 13 days after the date it was due to the patient.

3. Licensing/Certifications, Training, & Staffing		**Yes**	**No**	**Compliance**
3.1	Are all health care staff licenses current?	8	0	100.0%
3.2	Are health care and custody staff current with required emergency medical response certifications?	108	0	100.0%
3.3	Does the facility provide the required training to its health care staff?	8	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?	2	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?	15	1	93.8%
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?	15	1	93.8%
4.3	Was the focused subjective/objective assessment conducted based upon the patient's chief complaint?	16	0	100.0%
4.4	Did the registered nurse implement appropriate nursing action based upon the documented subjective/objective assessment data within the nurse's scope of practice or supported by the standard Nursing Protocols?	16	0	100.0%
4.5	Did the registered nurse document that effective communication was established and that education was provided to the patient related to the treatment plan?	15	1	93.8%
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?	10	6	62.5%
4.8	Did the Care Team regularly conduct and properly document a Care Team Huddle during business days?	2	20	9.1%
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:			**84.4%**

Comments:

Question 4.1 During the review of 16 electronic health records, the nurse auditor found one record in which the RN did not review the patient's sick call request on the day it was received.

Question 4.2 During the nurse auditor's review of 16 electronic health records, one record did not have documentation of the RN completing a face-to-face evaluation of the patient within the specified time frame and in the appropriate format.

Question 4.5 During the review of 16 electronic health records, the nurse auditor identified one where the RN did not document whether effective communication was established with the patient.

Question 4.6. During the electronic health record review, 11 records met the criteria for this question. The nurse auditor found one patient was not seen within the specified time frame when referred to the PCP by the RN.

Question 4.7 During the electronic health record review, 6 out of 16 records indicated the chronic care follow-up appointment was not completed within the time frame ordered by the PCP.

Question 4.8 The Daily Care Team Huddle was documented on all required days for the month of March 2018. The nurse auditor found the documentation for 2 out of 22 days was adequate.

Question 4.9 N/A. 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?	11	1	91.7%
5.2	Was the diagnostic test completed within the time frame specified by the primary care provider?	8	3	72.7%
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?	9	3	75.0%
5.4	Was the patient given written notification of the diagnostic test results within two business days of receipt of results?	9	3	75.0%
	Overall Percentage Score:			**78.6%**

Comments:

Question 5.1 The nurse auditor reviewed 12 electronic health records meeting the criteria for this question. One record indicated the PCP did not complete a Physician's Order Form for the diagnostic service ordered.

Question 5.2 The nurse auditor reviewed 11 electronic health records meeting the criteria for this question and found in three patient records the facility failed to complete diagnostic tests within the time frame specified by the PCP.

Questions 5.3 Of the same 12 records in Question 5.1, three records revealed the PCP failed to review, sign, and date diagnostic test reports within two business days of receipt.

Question 5.4 Of the same 12 records in Question 5.1, three records indicated the patient was not provided written notification of their diagnostic test results within two business days of receipt.

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?	Not Applicable		
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?	Not Applicable		
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?	Not Applicable		

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?	Not Applicable
	Overall Percentage Score:	**N/A**

Comments:

Questions 6.1 through 6.4 N/A. These questions were unable to be rated because none of the patients were sent to the emergency room and/or admitted to a community hospital.

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	0	100.0%
7.3	If the patient required referral to an appropriate provider based on the registered nurse's disposition, was the patient seen within the required time frame?	5	0	100.0%
7.4	If upon arrival, the patient had a scheduled or pending medical, dental, or a mental health appointment, was the patient seen within the time frame specified by the sending facility's provider?	Not Applicable		
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?	5	0	100.0%
7.8	Does the Inter-Facility Transfer Envelope contain all the required transfer documents and medications?	0	1	0.0%
	Overall Percentage Score:			**85.7%**

Comments:

Question 7.4 N/A. During the electronic health record review, the nurse auditor reviewed 16 records. This question was unable to be rated because none of the records indicated the patient was scheduled or pending medical, dental, or mental health appointments to be scheduled upon arrival to the facility during the audit review period.

Question 7.8 The nurse auditor interviewed the facility RN during the onsite audit regarding this requirement. The RN was not able to identify all the items and documents to be included in the transfer envelope; specifically the Patient Summary, medications, and Disability or Accommodation Chrono if applicable.

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?	1	15	6.3%
8.2	If the patient refused his/her keep-on-person medications, was the refusal documented on the CDCR Form 7225, *Refusal of Examination and/or Treatment*, or similar form?	Not Applicable		

8.3	If the patient did not show or refused the nurse administered/direct observation therapy medication(s) for three consecutive days or 50 percent or more doses in a week, was the patient referred to a primary care provider?	Not Applicable		
8.4	*For patients prescribed anti-Tuberculosis medication(s):* Did the facility administer the medication(s) to the patient as prescribed?	Not Applicable		
8.5	*For patients prescribed anti-Tuberculosis medication(s):* Did the facility monitor the patient monthly while he/she is on the medication(s)?	Not Applicable		
8.6	Did the prescribing primary care provider document that the patient was provided education on the newly prescribed medication(s)?	12	0	100.0%
8.7	Was the initial dose of the newly prescribed medication administered to the patient as ordered by the provider?	11	1	91.7%
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?	Not Applicable		
8.10	Did the medication nurse directly observe the patient taking nurse administered/direct observation therapy medication?	Not Applicable		
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?	Not Applicable		
8.12	Is nursing staff knowledgeable on the Medication Error Reporting procedure?	2	0	100.0%
8.13	Are refrigerated drugs and vaccines stored in a separate refrigerator that does not contain food or laboratory specimens?	1	0	100.0%
8.14	Does the health care staff monitor and maintain the appropriate temperature of the refrigerators used to store drugs and vaccines twice daily?	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:			**85.4%**

Comments:

Question 8.1 Sixteen electronic health records were reviewed by the nurse auditor for this question. The documentation in 15 records revealed the facility failed to administer chronic care medications within the required time frame.

Question 8.2 and 8.3 N/A. These questions were unable to be rated because none of the patients had refused either KOP or nurse administered medication.

Question 8.4 and 8.5 N/A. These questions were unable to be rated because none of the patients were prescribed anti-TB medications

Question 8.7 The nurse auditor reviewed 12 electronic health records of patients who were prescribed new medications and found one record to be non-compliant. There was no MAR found in the electronic health record to document the PCP changed the patient's medication order.

Questions 8.9 through 8.11 N/A. There were no patients taking Direct Observation Therapy or Nurse Administered medication during the onsite audit.

Questions 8.15 through 8.17 N/A. 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 observation cell using the appropriate format for order entry?	Not Applicable		
9.2	Does the health care provider document the need for the patient's placement in the observation cell within 24 hours of placement?	Not Applicable		
9.3	Does the registered nurse complete and document an assessment on the day of a patient's assignment to the observation cell?	Not Applicable		
9.4	Does the health care provider review, modify, or renew the order for suicide precaution and/or watch at least every 24 hours?	Not Applicable		
9.5	Does the treating clinician document daily the patient's progress toward the treatment plan goals and objectives?	Not Applicable		
9.6	Does nursing staff conduct rounds in observation unit once per watch and document the rounds in the unit log book?	Not Applicable		
	Overall Percentage Score:			**N/A**

Comments:

Questions 9.1 through 9.6 N/A. 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 the specified time frame?	6	1	85.7%
10.2	Upon the patient's return from the specialty service appointment, did the registered nurse complete a face-to-face assessment prior to the patient's return to the assigned housing unit?	5	2	71.4%
10.3	Upon the patient's return from the specialty services appointment, did the registered nurse notify the primary care provider of any immediate medication or follow-up requirements provided by the specialty consultant?	0	3	0.0%
10.4	Did the primary care provider review the specialty consultant's report/discharge summary and complete a follow-up appointment with the patient within the required time frame?	6	1	85.7%
	Overall Percentage Score:			**60.7%**

Comments:

Question 10.1 The nurse auditor reviewed seven electronic health records and found for one record the routine specialty services appointment occurred beyond 90 days from the date of the provider's request (order) submission.

Question10.2 The nurse auditor reviewed seven electronic health records of patients who returned from specialty care appointments and found two records did not have documentation of the RN's face-to-face assessment of the patient upon return from a specialty care appointment.

Question 10.3 The nurse auditor reviewed seven health records of patients who returned from specialty care appointments. Three of the seven records indicated the patient required immediate medication or follow-up; however, there was no documentation to show the RN notified the facility PCP.

Question 10.4 The nurse auditor reviewed seven electronic health records and did not find documentation in one of the records to indicate the patient was seen by the PCP for a follow-up appointment within the required time frame.

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?	0	20	0.0%
11.2	*For all patients:* Were patients offered an influenza vaccination for the most recent influenza season?	13	2	86.7%
11.3	*For all patients 50 to 75 years of age:* Were the patients offered colorectal cancer screening?	8	7	53.3%
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:			**46.7%**

Comments:

Question 11.1 The nurse auditor reviewed 20 electronic health records and found all were missing documentation of an annual screening for signs and symptoms of TB during the patient's birth month.

Question 11.2 The nurse auditor reviewed 15 electronic health records and found the records of two patients were missing or had incomplete documentation indicating the patient was offered an influenza vaccine for the most recent influenza season.

Question 11.3 During the electronic health record review, the nurse auditor reviewed 15 records and found seven were missing or had incomplete documentation of the patient being offered colorectal cancer screening.

Questions 11.4 and 11.5 N/A. 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?	2	1	66.7%
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?	7	4	63.6%
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?	7	4	63.6%
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?	4	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?	0	1	0.0%
	Overall Percentage Score:			**79.4%**

Comments:

Question 12.1 The facility did not conduct emergency response drills on the second shift during the most recent quarter of the audit review period.

Question 12.2 Of the 11 actual emergency medical response incident packages identified for review, GSMCCF did not provide the NCPR auditor the documents for four incidents. Therefore, the NCPR auditor was unable to determine if an RN, mid-level provider, or physician arrived within eight minutes of the emergency medical alarm.

Question 12.4 The nurse auditor reviewed the facility's ERRC meeting minutes which indicated 4 of the 11 incident packages were not prepared or submitted for review. The facility did not submit the documents of the four actual emergency responses that occurred on December 15, 2017, January 5 and 6, and February 23, 2018.

Question 12.9 through 12.13. N/A. These questions do not apply to California in-state modified community correctional facilities.

Question 12.15 The facility does not have a designated Narcan Accountability Log.

13. Clinical Environment		**Yes**	**No**	**Compliance**
13.1	Are packaged sterilized reusable medical instruments within the expiration dates shown on the sterile packaging?	Not Applicable		
13.2	If autoclave sterilization is used, is there documentation showing weekly spore testing?	4	0	100.0%
13.3	Are disposable medical instruments discarded after one use into the biohazard material containers?	2	0	100.0%
13.4	Does clinical health care staff adhere to universal/standard hand hygiene precautions?	3	0	100.0%
13.5	Is personal protective equipment readily accessible for clinical staff use?	1	0	100.0%
13.6	Is the reusable non-invasive medical equipment disinfected between each patient use when exposed to blood-borne pathogens or bodily fluids?	2	0	100.0%
13.7	Does the facility utilize a hospital grade disinfectant to clean common clinic areas with high foot traffic?	1	0	100.0%
13.8	Is environmental cleaning of common clinic areas with high foot traffic completed at least once a day?	31	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?	2	0	100.0%
13.12	Does the facility store all sharps in a secure location?	1	0	100.0%
13.13	Does health care staff account for and reconcile all sharps at the beginning and end of each shift?	93	0	100.0%
13.14	Is the facility's biomedical equipment serviced and calibrated annually?	8	0	100.0%
13.15	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	18	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:

Question 13.1 The facility does not utilize sterilized reusable medical equipment.

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

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

APPENDIX B – PATIENT INTERVIEWS

The intent of this portion of the audit is to elicit substantive responses from the patient population, by utilizing each question as a springboard for discussion, with appropriate follow up to identify any areas where barriers to health care access may potentially exist. This is accomplished via interview of all the Americans with Disability Act (ADA) patients housed at the facility, the Inmate Advisory Council (IAC) executive body and a random sample of patients housed in general population (GP) and Administrative Segregation Units (ASU). The results of the interviews conducted at GSMCCF are summarized in the table below.

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

Patient Interviews (not rated)
1. Are you aware of the sick call process?
2. Do you know how to obtain a CDCR Form 7362 or sick call form?
3. Do you know how and where to submit a completed sick call form?
4. Is assistance available if you have difficulty completing the sick call form?
5. Are you aware of the health care grievance process?
6. Do you know how to obtain a CDCR Form 602-HC, *Health Care Grievance*?
7. Do you know how and where to submit a completed health care grievance form?
8. Is assistance available if you have difficulty completing the health care grievance form?
Questions 9 through 21 are only applicable to ADA patients.
9. Are you aware of your current disability/DPP status?
10. Are you receiving any type of accommodation based on your disability? (Like housing accommodation, medical appliance, etc.)
11. Are you aware of the process to request reasonable accommodation?
12. Do you know where to obtain a reasonable accommodation request form?
13. Did you receive reasonable accommodation in a timely manner?
14. Have you used the medical appliance repair program? If yes, how long did the repair take?
15. Were you provided interim accommodation until repair was completed?
16. Are you aware of the grievance/appeal process for a disability related issue?
17. Can you explain where to find help if you need assistance for obtaining or completing a form, (i.e., CDCR Form 602-HC, *Health Care Grievance*, CDCR Form 1824, Reasonable Modification or Accommodation Request, or similar forms)?
18. Have you submitted an ADA grievance/appeal? If yes, how long did the process take?
19. Do you know who your ADA coordinator is?
20. Do you have access to licensed health care staff to address any issues regarding your disability?
21. During the contact with medical staff, do they explain things to you in a way you understand and take time to answer any question you may have?

Comments:

The auditors interviewed a total of 20 patients during the onsite audit. Two IAC members and an additional 18 patients, 8 of which were designated ADA. Two patients spoke Spanish as their primary language and the facility provided an interpreter to assist with the interviews.

The IAC members reported they both experienced access to care at GSMCCF and the care delivered. The IAC members gave high praise for the medical care provided and its quality. They did not identify any issues of medication delivery and administration. However, the IAC members brought up two concerns which they voiced during previous audits: 1) the over-the-counter (OTC) medications are not made available through Canteen, and 2) patients refuse offsite health services for fear of being unnecessarily retained at the hub institution for a prolonged period.

The IAC members reported patient frustration at not being able to participate in the OTC medication program wherein the patient is able to receive three free OTC medications per month. The IAC members gave the example of a patient experiencing a headache or sore muscle. Currently, the patient must submit a sick call slip and pay a five dollar copay to see nursing staff. Based on the nursing assessment, the patient may or may not receive an OTC pain reliever, acetaminophen or non-steroidal anti-inflammatory. The auditors informed the patients of current efforts by headquarters staff to implement an OTC process at the MCCFs.

The IAC members also expressed the reluctance of patients to go to offsite medical appointments because patients are generally retained at the hub institution for a prolonged period after the offsite appointment. Members cited an example where a patient was transferred to the hub institution in January 2018 and was not returned to GSMCCF until March 2018. The physician auditor reviewed the patient's electronic health record and found the patient had been transferred to the hub on January 23, 2018 for a medical procedure. The patient refused the procedure on January 24, 2018 and signed a refusal. Instead of returning to GSMCCF immediately, the patient was not seen by a PCP at the hub until February 28, 2018, at which time the patient was cleared for return to GSMCCF, the patient was retained for unknown reasons until March 28, 2018, over two months after his initial transfer to the hub for services. The auditors discussed this information with the facility and health care management at GSMCCF during the exit conference and recommended GSMCCF health care staff begin discussing the status of all patients currently offsite during the Daily Care Team Huddles and work with the Contract Beds Unit, CDCR Transportation Unit and the hub institution to resolve this issue.

The HPS auditor interviewed eight ADA designated patients. Seven patients were hearing impaired and of those, six used hearing aids. The one patient without hearing aids wears a vest identifying him as hearing impaired. The HPS auditor established effective communication by speaking slowly and at times loudly, confirming the patient's understanding of the question. During the interviews, the hearing impaired patients stated they had no difficulty in receiving new batteries when needed; however, expressed frustration with often having to wait a day to receive the batteries. The patient must submit a sick call slip in order to receive new batteries. The HPS auditor spoke with the facility HSA regarding the patients' concerns. The HSA acknowledged she would work on streamlining the battery exchange process. The eighth ADA designated patient was mobility impaired and utilized a cane to walk. All patients were satisfied with the accommodations provided to them by health care staff at the facility.

Ten additional randomly selected patients were interviewed regarding their knowledge of the sick call and health care grievance processes. Nine of the ten patients interviewed were aware of the facility's process for requesting health services. One patient reported he was not and the HSP auditor explained how to request health services. The patient was able to verbalize his understanding of the sick call process. All ten patients were aware of the health care grievance process including the utilization of the revised Health Care Grievance and Health Care Grievance Attachment forms. All patients reported they have never experienced problems obtaining a sick call slip or health care grievance form from staff when needed.

APPENDIX C – BACKGROUND and AUDIT METHODOLOGY

1. BACKGROUND AND PROCESS CHANGES

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

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

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

2. OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

Quantitative Review

The *quantitative* review uses a standardized audit instrument, which measures compliance against established standards at each facility. The audit instrument calculates an overall percentage score for each of the chapters in the *Administrative* and *Medical Component* sections as well as individual ratings for each component of the audit instrument.

To maintain a metric-oriented monitoring program that evaluates medical care delivery consistently at each correctional facility, CCHCS identified 12 medical and three administrative components of health care to measure. The *Medical* components cover clinical categories directly relating to the health care provided to patients, whereas the *Administrative* components address the organizational functions that support a health care delivery system.

The 12 medical program components are: *Access to Care, Diagnostic Services, Emergency Services and Community Hospital Discharge, Initial Health Assessment/Health Care Transfer, Medical/Medication Management, Observation Cells, Specialty Services, Preventive Services, Emergency Medical Response/Drills and Equipment, Clinical Environment, Quality of Nursing Performance* and *Quality of Provider Performance.* The three administrative components are: *Administrative Operations, Internal Monitoring and Quality Management and Licensing/Certifications, Training and Staffing.*

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

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

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

The component scores are calculated by taking the average of all the compliance scores for all applicable questions within that component. The outcome is expressed as a percentage rounded to the nearest tenth. The qualitative rating for each component is described as *proficient*, *adequate*, or *inadequate* according to whether standards were met more than 90%, more than 80% or less than 80%. See Table below for the breakdown of percentages and its respective quality ratings.

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

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

Qualitative Review

The *qualitative* portion of the audit consists of case reviews conducted by clinician auditors. The auditors 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 clinicians review 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 clinical case reviews are comprised of the following components:

1. *Nurse Case Review*

   The nurse auditor performs two types of case reviews:

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

   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 auditor 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% - 100.0%	Proficient
80.0% - 89.9%	Adequate
0.0% to 79.9%	Inadequate

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

Scoring for Non-Applicable Questions and Double-Failures:

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

Resolution of Critical Issues

Although the facility will not be required to submit a corrective action plan to the Private Prison Compliance and Monitoring Unit for review, the facility will be required to address and resolve all standards rated by the audit that have fallen below the 80.0% compliance or as otherwise specified in the methodology. The facility will also be expected to address and resolve any critical deficiencies identified during the clinical case reviews and any deficiencies identified via the observations/inspections conducted during the onsite audit.