October 3, 2018

Chief Paul Lozano
Shafter Modified Community Correctional Facility
1150 East Ash Avenue
Shafter, CA 93263

Dear Chief Lozano,

The staff from California Correctional Health Care Services (CCHCS) completed an annual Private Prison Compliance and Health Care Monitoring Audit at Shafter Modified Community Correctional Facility (SMCCF) on June 12 through 14, 2018. The purpose of this audit was to ensure SMCCF is providing a level of care consistent with the standards set forth in the Federal Receiver's *Turnaround Plan of Action* dated June 8, 2006.

On September 17, 2018, a draft report was provided to allow you the opportunity to review and dispute any findings presented in the report. The due date for SMCCF to submit a rebuttal to PPCMU was October 1, 2018. Since PPCMU did not receive a response by the due date, the draft report is considered final.

Attached is the final audit report in which SMCCF received an overall audit rating of ***Adequate*** with a compliance score of 88.4%. This compliance score is an increase of 4.6 percentage points from the prior June 2017 annual audit score of 83.8%. The health care standards associated with this audit are grouped into 14 components. As a result of this audit, nine components were rated proficient, one was rated adequate, and four were rated inadequate. The report contains an Executive Summary, list of critical issues, findings detailed by component, prior critical issue resolution, and an explanation of the methodology behind the audit.

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

The areas requiring improvement are *Administrative Operations, Licensure/Certifications, Training and Staffing, Preventive Services,* and *Emergency Medical Response Drills and Equipment*. The facility needs to update their policies and procedures in order to remain compliant with Inmate Medical Services Policies and Procedures, conduct timely peer reviews for the Primary Care Provider (PCP), facilitate shadow training for the PCP at the hub institution, provide training to nursing staff hired from the registry on new and updated policies, ensure administration of chronic care medications to patients as prescribed, and ensure the PCP maintains communication with the specialist consultants, hub institution providers, and community hospital providers for continuity of care.

Thank you for your assistance and please extend my gratitude to your staff for their professionalism and cooperation. Should you have any questions or concerns, you may contact Anastasia Bartle, Staff Services Manager II, Private Prison Compliance and Monitoring

Unit, Field Operations, Corrections Services, CCHCS, at (916) 691-4921 or via email at Anastasia.Bartle@cdcr.ca.gov.

Sincerely,

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

Enclosures

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

Shafter Modified Community Correctional Facility

Annual Audit

June 12 – 14, 2018

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DATE OF REPORT

October 3, 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 Shafter Modified Community Correctional Facility (SMCCF), located in Shafter, California, for the review period of January through April 2018. At the time of the onsite audit, CDCR's *Weekly Population Count Report*, dated June 8, 2018, the patient population was 630, with a budgeted capacity of 640.

EXECUTIVE SUMMARY

From June 12 through 14, 2018, the CCHCS audit team conducted an onsite health care monitoring audit at SMCCF. The audit team consisted of the following personnel:

B. Barnett, Medical Doctor, Retired Annuitant
L. Pareja, Nurse Consultant, Program Review (NCPR)
K. Srinivasan, 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 SMCCF. The end product of the quantitative and qualitative reviews is expressed as a compliance score, while the overall audit rating is expressed both as a compliance score and an associated quality rating.

The audit rates each of the components based on case reviews conducted by an NCPR and physician, health record reviews conducted by registered nurses (RN), and onsite reviews conducted by a physician, NCPR, and HPS. The compliance score for each component is derived from the results of the clinical case

reviews, the health record reviews, and the onsite audit as reflected in the *Executive Summary Table* below.

Based on the findings for each component, SMCCF achieved an overall compliance score of **88.4%,** 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 SMCCF, and Appendix C for additional information regarding the methodology utilized to determine the facility's compliance for each requirement and overall audit score and rating. Comparatively speaking, during the previous annual SMCCF audit conducted June 6 through 8, 2017, the overall compliance rating was 83.8%, indicating an increase of 4.6 percentage points.

This report includes a summary of the clinical case reviews and the critical issues identified during the quantitative health record and administrative reviews. The *Executive Summary Table* below lists the operational areas by component, assessed by the audit team, 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	74.4%	74.4%	Inadequate
2.	Internal Monitoring & Quality Management	N/A	N/A	N/A	82.9%	82.9%	Adequate
3.	Licensing/Certifications, Training & Staffing	N/A	N/A	N/A	74.1%	74.1%	Inadequate
4.	Access to Care	93.3%	91.7%	92.5%	93.1%	92.7%	Proficient
5.	Diagnostic Services	100.0%	100.0%	100.0%	95.8%	98.6%	Proficient
6.	Emergency Services & Community Hospital Discharge	100.0%	100.0%	100.0%	90.0%	96.7%	Proficient
7.	Initial Health Assessment/Health Care Transfer	94.1%	100.0%	97.1%	83.3%	92.5%	Proficient
8.	Medical/Medication Management	94.6%	88.2%	91.4%	97.5%	93.5%	Proficient
9.	Observation Cells	N/A	N/A	N/A	N/A	N/A	N/A
10.	Specialty Services	96.8%	100.0%	98.4%	76.6%	91.1%	Proficient
11.	Preventive Services	N/A	N/A	N/A	78.3%	78.3%	Inadequate
12.	Emergency Medical Response/Drills & Equipment	N/A	N/A	N/A	75.8%	75.8%	Inadequate
13.	Clinical Environment	N/A	N/A	N/A	99.9%	99.9%	Proficient
14.	Quality of Nursing Performance	95.3%	N/A	N/A	N/A	95.3%	Proficient
15.	Quality of Provider Performance	N/A	91.7%	N/A	N/A	91.7%	Proficient
	Overall Audit Score and Rating					**88.4%**	**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 sections 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. The table also includes any *qualitative* critical issues or concerns identified by the audit team which rise to the level at which they have the potential to adversely affect patient's access to health care services.

Critical Issues – Shafter Modified Community Correctional Facility	
Question 1.2	The facility's policies/local operating procedures are not all in compliance with the *Inmate Medical Services Policies and Procedures.* ***This is a new critical issue.***
Question 1.4	The facility's inmate orientation handbook does not adequately explain the health care grievance process. ***This is a new critical issue.***
Question 2.10	The CDCR Forms 602 HC *Health Care Grievance* and 602 HC-A *Health Care Grievance Attachment,* are not readily available in the housing units. ***This is a new critical issue.***
Question 2.12	The facility's log for tracking health care grievances does not contain all the required information. ***This is a new critical issue.***
Question 3.3	The facility does not consistently provide training to the RNs hired from the registry. ***This is a new critical issue.***
Question 3.6	The facility did not complete a peer review for its primary care provider (PCP) within the required time frame. ***This is an unresolved critical issue since the June 2016 audit.***
Question 4.7	The facility does not consistently complete patient chronic care visits as ordered by PCP. ***This is a new critical issue.***
Question 7.8	The facility's nursing staff is not knowledgeable about the documents to be included in a patient Transfer Envelope. ***This is a new critical issue.***
Question 8.1	The facility does not consistently provide patients chronic care medications within the specified time frame. ***This is an unresolved critical issue since the June 2017 audit.***
Question 8.5 *(formerly Question 8.6*)	The facility does not monitor the patient monthly while the patient is on anti-Tuberculosis medications. ***This is an unresolved critical issue since the June 2016 audit.***
Question 10.4	The facility's PCP does not consistently review the specialty consultant's report/discharge summary and complete a follow-up appointment with the patients within the required time frame. ***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 an unresolved critical issue since the June 2017 audit.***
Question 12.6	The facility nursing staff does not re-supply and re-seal the Emergency Medical Response (EMR) bag after use during an EMR incident. ***This is a new critical issue.***
Question 12.7	The facility does not consistently inventory its EMR bag at least once every month. ***This is a new critical issue.***
Question 12.15	The facility's health care staff does not account for Narcan at the beginning and end of each shift. ***This is a new critical issue.***
Qualitative Issue # 1	The facility's health care staff do not document the date of receipt and date of Registered Nurse (RN) triage on the CDCR Form 602 HC *Health Care Grievance*. ***This is a new critical issue.***

Qualitative Issue # 2	The facility does not consistently update the staff licensure and training log to reflect all training provided to health care staff. ***This is a new critical issue.***
Qualitative Issue # 3	The facility's PCP has not received shadow training from the facility's hub, Wasco State Prison. ***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 audit is included in the *Prior Critical Issue Resolution* portion of this report.

AUDIT FINDINGS – DETAILED BY COMPONENT

1. ADMINISTRATIVE OPERATIONS

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

Case Review Score: *Not Applicable*
Quantitative Review Score: *74.4%*

Overall Score: 74.4%

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

Quantitative Review Results

Shafter Modified Community Correctional Facility received a compliance score of 74.4% *(Inadequate)* with two new critical issues identified. A total of eight questions were reviewed; four were rated proficient, two were rated inadequate, and two were not rated. The facility did not receive any release of information requests from patients and/or third parties during the audit review period January through April 2018, therefore Questions 1.7 and 1.8 were rated as non-applicable.

Prior to the onsite audit, the facility's 15 policies were reviewed. Eight were found non-compliant with the IMSP&P guidelines and/or the facility contract with CDCR (Question 1.2). The deficiencies identified are as follows:

- Access to Care - In SMCCF Policy No. 4.05, *Sick Call* (Rev. 4/18), there is no reference to the requirement to conduct Daily Care Team Huddles and document the actions and attendance of each huddle. (Reference: IMSP&P, Vol 4, Chapter 1.2, *Care Teams and Patient Panels Procedure;* City of Shafter's executed agreement with CDCR, Standard Agreement, C5607882, Scope of Work, Section I *Daily Care Team Huddle*, page 52.)
- Aerosol Transmissible Diseases Exposure Control Plan - The facility did not submit a policy for this policy requirement. Instead, SMCCF submitted Policy No. 7.24, *Aerosol Weapons Procedure* initially, which was related to the facility's Use of Force process with chemical agents. When the NCPR auditor informed the facility this policy was not the one requested for review, SMCCF forwarded the *CDCR/CCHCS Aerosol Transmissible Disease Exposure Control Plan.* This document provides instructions and a template on how to create a facility specific plan and does not satisfy the requirement. (Reference: IMSP&P, Vol 1, Chapter 27, *Aerosol Transmissible Diseases Exposure Control Plan Policy;* City of Shafter's executed agreement with CDCR, Standard Agreement, C5607882, Scope of Work, Section P *Infection Control*, page 57.)

- Durable Medical Equipment (DME) - In SMCCF policy No. 4.11, *Hospital Facilities and Equipment* (Rev. 4/18), section *Durable Medical Equipment*, the process described on pages 7 through 21, is specific to a CDCR institution and not the facility. The facility is required to create a policy specific to the facility's process, such as: how medical supplies are requested and distributed, how DME is procured and furnished to the patient, and how it is tracked by medical staff and inspected by custody staff. However, the facility failed to do so. (Reference: Per IMSP&P, Volume 4, Chapter 32.1, *Durable Medical Equipment and Supply Procedure.*)
- Health Care Staff Licensure and Training – The facility's policies are non-compliant due to the following deficiencies:
    - The SMCCF Policy No. 4.01, *Facility Physician* (Rev. 4/18) does not discuss physician peer review and annual performance appraisals. The policy does not reference the PCP is required to maintain a current Drug Enforcement Administration license and Advance Cardiac Life Support certification. Additionally, the policy does not state the physician credentialing process.
    - The SMCCF Policy No. 4.01 A, *Facility Nurse* (Rev. 4/18) does not state the Registered Nurse (RN) is required to maintain a current Basic Life Support (BLS) certification.
    - The SMCCF Policy No. 4.01 B, *Facility LVN* (Rev. 4/18) does not state the Licensed Vocational Nurse (LVN) is required to maintain a current BLS certification.
    - The SMCCF Policy No. 2.12, *Minimum Training Requirements* (Rev. 2/18) does not reference the requirement to schedule all newly hired health care staff for training at the facility's hub institution, Wasco State Prison (WSP). The policy also does not state the specifics regarding the facility's process for training its health care staff. Additionally, it does not discuss the process for tracking health care staff licenses, certifications, and training.

  (References: IMSP&P, Volume 1, Chapter 31.3, *Licensed Medical Provider Credentialing and Privileging Procedure*; City of Shafter's executed agreement with CDCR, Standard Agreement, C5607882, Scope of Work, Section Q *Credentialing, Privileging and Peer Review*, Page 57.)
- Maintenance and Management of Health Records and Release of Information (ROI) – The SMCCF Policy No. 4.14, *Access to Health Care Information & Release of Information* (Rev. 4/18), is non-compliant due to the following deficiencies identified:
    - The policy does not indicate patient health records are available within CCHCS electronic Unit Health Record (e-UHR) and Electronic Health Record System (EHRS) and reference the requirement for all health care staff to access patient's historical medical information from one or both sources as necessary.
    - The specific time frame (15 business days) for completion of the ROI requests and the copying charges of 10 cents per page is not specified in the policy and it also does not state a withdrawal slip, CDC 193, needs to be completed for the amount charged to the patient.
    - There is no reference to SMCCF's process for handling patients' requests for their mental health records, Olsen reviews, and processing requests received from Attorney's office and other third parties.

- The policy does not list all steps to be followed when collecting and processing an ROI request, namely, health care staff should date stamp the original request and CDCR Form 7385 *Authorization for Release of Information* and document the completed date on the CDCR Form 7385 upon completion of the request, submit the patient's written request and the completed original CDCR Form 7385 to WSP for scanning into the patient's electronic health record, and file copies of both documents in the patient's "shadow" file.

(Reference: IMSP&P, Volume 6, Chapters 4.1 and 4.2, *Release of Information Policy and Procedure*; City of Shafter's executed agreement with CDCR, Standard Agreement, C5607882, Scope of Work, Section W *Maintenance of Medical Records*, Page 59.)

- Medication Management – The SMCCF Policy No. 4.19, *Medication Management* (Rev. 4/18), does not state the medication availability process and time frames; medication availability refers to the time frame when the patient should receive renewed/refilled medications and newly ordered medications (Reference: IMSP&P, Volume 4, Chapter 11.2 - *Medication Orders-Prescribing Procedure.*)
- Quality Management Program – The SMCCF Policy No. 4.26, *Quality Management Program Overview* (Rev. 4/18), is not specific to the facility. The policy also does not state the frequency of the Quality Management Committee (QMC) meetings conducted at the facility. (Reference: IMSP&P, Volume 3, Chapter 1, *Quality Management Program, Institution.*)
- Tuberculosis Surveillance Program – The facility is non-compliant due to not submitting a policy. (Reference: IMSP&P, Volume 10, Chapter 3.2 – *Tuberculosis Surveillance Program Procedure.*)

The HPS auditor reviewed the facility's inmate orientation handbook and found the health care grievance information was not updated to reflect implementation of the new Health Care Grievance regulations effective September 2017 (Question 1.4). The auditors recommended the facility update all non-compliant policies in order to meet IMSP&P guidelines and contractual requirements, and update the health care grievance process in the handbook to achieve compliance. The HPS auditor noted most of the patients interviewed during the onsite audit were not aware of the health care grievance process. The auditor recommended the facility provide an orientation for all patients on the new health care grievance regulations soon after this information is updated in the handbook. The Chief agreed to implement the process as recommended.

2. INTERNAL MONITORING & QUALITY MANAGEMENT

Case Review Score: *Not Applicable*
Quantitative Review Score: *82.9%*

Overall Score: 82.9%

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

timely submission to CCHCS. Lastly, auditors evaluate whether the facility promptly processes and appropriately addresses health care grievances.

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

Shafter Modified Community Correctional Facility received an overall compliance score of 82.9% (*Adequate*) with two new critical issues identified. This is a decrease of 12.3 percentage points from the previous score of 95.2% achieved during the June 2017 annual audit. During the current audit, the facility scored 100% compliance for 8 of the 13 questions evaluated, and did not meet the compliance threshold of 80.0% for 2 questions. The remaining three questions were rated as follows: one proficient, and two adequate.

During the current audit, the facility was successful in submitting all 58 monitoring logs timely during the audit review period thus achieving 100% compliance for Question 2.4. The facility also received 100% for submitting accurate data on the specialty care monitoring log (Question 2.6) which is an increase of 10.7 percentage points from the previous score of 89.3%. The data in the chronic care monitoring log also was complete and accurate (Question 2.8) resulting in 100% compliance which is an increase of 15 percentage points from the previous compliance score of 85.0%. However, the facility received a significantly inadequate score of 12.5% for Question 2.10 due to the housing units not having CDCR Forms 602 HC and HC-A readily available for patient use. A considerable decrease of 87.7 percentage points from the previous score of 100.0% received during the June 2017 annual audit.

While inspecting the eight housing units during the onsite audit, the HPS and physician auditors observed the CDCR Forms 602 HC and HC-A readily accessible in one housing unit (Question 2.10). The auditors also noted the forms were locked inside the custody officer's desk in all housing units. When the auditors inquired about the reason for this, the custody officers and the acting Assistant Chief stated this was done to prevent the forms from being misused by the patients for their craft work and making contraband items since the forms were blue in color. The staff also informed auditors they were not receiving enough forms to replenish their supply. They had been told the new forms were back ordered.

The auditors informed the custody staff, Chief, and acting Assistant Chief of the requirement to place the forms in the housing units in a way the patients do not have to go through the custody officer. Later, during the course of the onsite audit, the HPS auditor provided the electronic CDCR Form 602 HC and HC-A to the acting Assistant Chief via email with the recommendation to print the forms on blue color paper and place them in the housing units until such time the original forms are received. The HPS auditor encouraged the facility staff and the Chief to bring up issues, such as this, to PPCMU and CBU's attention during the monthly calls. The Chief confirmed understanding and agreed to report such issue in the future.

The HPS auditor found the facility is not using an updated version of the health care grievance tracking log. (Question 2.12). The log was missing a column for the date of the RN Triage. The screening disposition drop down field on the log was not updated to the current disposition criteria, "Intervention" and "No Intervention". The log utilized by the facility lists the outdated options; "Granted", "Partially Granted", and "Denied". Additionally, the grievance response due dates documented on the log do not reflect the new 45-business day time frame. As a result, SMCCF received 0.0% compliance which is a significant

decline from the previous June 2017 annual audit score of 100%. Subsequent to the audit, PPCMU provided the facility with an updated heath care grievance log and supporting documents on July 13, 2018.

During the onsite review, the HPS auditor reviewed the health care grievances received by the facility. One grievance showed the patient sent the grievance directly by mail to the CCHCS Health Care Correspondence and Appeal Branch (HCCAB) instead of submitting it to staff at SMCCF. This caused a substantial delay in processing this grievance. Per the date stamp on the grievance, it was received by HCCAB on December 26, 2017. Since the grievance was required to be processed by the facility, HCCAB rejected it on January 17, 2018. There is no receipt date documented on the grievance or on the facility's tracking log to indicate when the facility received the grievance from HCCAB. The grievance was forwarded by the facility to the hub institution for review and for entry into the CCHCS Health Care Appeals and Response Tracking (HCART) system. The facility's date on the grievance showed it was assigned to health care staff for processing on February 7, 2018. The facility documented this as the assigned date on their grievance tracking log instead of documenting the date it received the grievance from HCCAB. The facility also failed to date stamp the receipt date and RN triage date on the grievance (Qualitative Critical Issue #1).

The second health care grievance reviewed by the HPS auditor showed the facility failed to document the date of receipt and date of RN triage on the grievance. It was reviewed by the hub's Health Care Grievance Coordinator (HCGC) on January 17, 2018, per the date documented by the HCGC. The facility's date on the grievance showed it was assigned to health care staff for processing on February 14, 2018. The date entered on the tracking log was this assigned date, instead of the date when the grievance was initially received from the patient. The HPS auditor discussed with the acting Assistant Chief the requirement for staff to document the original date of receipt and triage on both the 602HC Form and the tracking log.

Additionally, the HPS auditor noted SMCCF filed copies of the health care grievances and responses in the patient's health record. The auditor informed the staff this was an incorrect practice since the grievances are not considered a part of the patient's health record. The HPS auditor recommended the facility utilize a separate binder to file the health care grievances and file them in chronological order for tracking purposes.

3. LICENSING/CERTIFICATIONS, TRAINING & STAFFING

This component will determine whether the facility adequately manages its health care staffing resources by evaluating whether: job performance reviews are completed as required; professional licenses and certifications are current; and training requirements are met. The auditors will also determine whether clinical and custody staff are current with their emergency medical response certifications and if the facility is meeting staffing requirements specified in the contract.

Case Review Score: *Not Applicable*
Quantitative Review Score: *74.1%*

Overall Score: 74.1%

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

Quantitative Review Results

Shafter Modified Community Correctional Facility achieved an overall compliance score of 74.1% *(Inadequate)* with one prior critical issue found unresolved and three new critical issues identified. The current score shows a decrease of 25.9 percentage points from the previous score of 100% achieved during the June 2017 annual audit. Six questions for this component were reviewed; four were found 100% compliant, one was 44.4% compliant, and the remaining one achieved 0.0% compliance.

During the previous annual audit conducted in June 2017, SMCCF did not complete the peer review for its PCP within the required time frame (Question 3.6). This question was not rated during the limited review conducted in December 2017 because the facility recently hired a new PCP whose peer review was not due during the review period. During the current audit, the auditors found the facility again failed to conduct the four month peer review for the PCP which was due to be completed on November 6, 2017. SMCCF completed the peer review two months later on January 5, 2018. The auditors informed the facility Chief it is important the peer reviews are conducted timely.

Additionally the physician auditor determined the two month and four month peer reviews of the PCP failed to address the PCP's poor documentation practices. According to the physician auditor, the PCP's documentation in the patient medical records does not meet CCHCS standards and the PCP frequently leaves some areas in the medical forms blank where more information should be provided. There has not been any further reviews conducted by the facility to address this discrepancy. There are no weekly or monthly quality assurance programs currently utilized at SMCCF to address this or any other lapses. The auditors informed the PCP was due for an annual review on July 6, 2018, and urged the Chief to ensure the peer review is conducted timely and submitted to PPCMU.

During the current annual audit, one new quantitative critical issue was identified. The auditor noted although the facility frequently utilized registry staff for weekend and vacancy coverage, the facility did not provide any training to registry staff on the health care delivery processes (Question 3.3). During the month of the onsite audit, June 2018, the facility had four registry RNs scheduled to provide weekend coverage and one RN to provide vacancy coverage. The documentation on the facility's licensure and training tracking log showed none of these five staff received training. The HPS auditor informed the facility's Chief all training provided to the full time health care staff shall also be provided to registry staff since the facility utilizes these staff routinely to provide coverage.

Two qualitative critical issues were identified for this component during the current audit. The facility did not document all training provided to health care staff on a log utilized to track health care staff licensing and training (Qualitative Issue #2). While reviewing the staff training sign-in sheets, the HPS auditor noted seven staff training sessions were not documented on the log. The facility also did not document the hub institution training provided to the RNs on the training log.

The facility PCP who was hired on July 6, 2017, has not received orientation and training at the hub institution (Qualitative Issue #3). The facility failed to bring this to CBU's and PPCMU's attention although they were afforded the opportunity to do so during the monthly CBU conference calls when hub training is one of the primary items on the agenda. The auditors inquired with the Chief why this was never reported. The Chief replied the hub did not work with them cohesively to facilitate this training. The

auditors recommended the Chief and the acting Assistant Chief report issues such as this to CBU during the monthly conference calls in order for prompt resolution. The Chief agreed to report as recommended.

The facility refuses to hire a Health Service Administrator (HSA) or a Director of Nursing who can supervise and manage the nursing care staff. The facility's Assistant Chief, a peace officer, continues to function as the manager of the medical clinic. Although the Chief of the facility realizes the absence of a nursing supervisor could be detrimental to the nurses' performance, the Chief stated he is unable to hire an HSA due to the facility's budgetary constraints.

At the time of the audit, the facility had two full time RNs who are permanent employees of the City of Shafter. A third full time RN position has been vacant since April 9, 2018, and a registry RN is providing coverage until such time the position is filled. The three full time RNs provide coverage Monday through Friday, 8 hours a day. The facility does not have permanent staffing for weekend coverage. These shifts are covered by registry RNs. During the current audit, SMCCF was utilizing five registry RNs both for weekend and vacancy coverage. Subsequent to the audit, the facility informed they were in the process of conducting a background check on an RN candidate in order to fill the vacant position.

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: *92.5%*
Quantitative Review Score: *93.1%*
Overall Score: 92.7%

Shafter Modified Community Correctional Facility received an overall compliance score of 92.7% (*Proficient*), an increase of 12.8 percentage points from the previous score of 79.9%. Specific findings related to the nurse and physician case reviews, and the electronic health record and onsite quantitative reviews are documented below.

Case Review Results

The facility received an overall case review compliance score of 92.5% for this component. The clinical auditors reviewed a combined total of 57 encounters.

Nurse Case Reviews

The NCPR auditor reviewed a total of 45 nursing encounters and identified three deficiencies detailed below.

- In **Case 22**, the patient refused treatment on February 1, 2018, by signing the CDCR Form 7225, *Refusal of Examination and/or Treatment.* However, the nursing staff failed to document the specific treatment the patient was refusing. There was no related documentation, a sick call request, or PCP order for this date in the EHRS. The NCPR auditor could not identify the treatment being refused.
- In **Case 25**, two deficiencies were identified. The patient submitted sick call requests on February 11, 18, and 19, 2018, for the same respiratory complaint. The nurse saw the patient on February 11 and 18, 2018, and provided medications per Nursing Protocol. The patient refused the appointment on February 19, 2018. Despite the patient's persistent respiratory complaint which was not responding to Nursing Protocol medications, the nurse did not refer the patient to the PCP for further evaluation.

Physician Case Reviews

The physician auditor reviewed a total of 12 encounters for this component and identified only one deficiency.

- In **Case 1,** the 35-year old overweight African American patient was seen by the PCP for a follow-up appointment for lab results. The patient's creatinine was noted as 1.7 and GFR[1] was within normal limits. However, the PCP misdiagnosed the patient as having Diabetes Mellitus (DM) and renal insufficiency. The physician auditor determined the PCP's findings as a misdiagnoses. The PCP noted in his progress notes on December 2017 the patient's elevated creatinine was likely due to the medication Metformin which the patient was taking at the time. The PCP also acknowledged the patient's blood sugar was within normal limits and thus did not have DM. There was no need to prescribe Metformin. The physician auditor determined borderline elevation of serum creatinine is insufficient by itself to diagnose renal insufficiency in a black male, and a GFR calculation which considers age and weight should have been performed. The GFR values for this patient were within normal range. The PCP's documentation in the medical record was incomplete and the PCP did not educate the patient regarding his obesity and did not provide instructions regarding diet.

Quantitative Review Results

The facility received a quantitative compliance score of 93.1% (*Proficient*) with one prior critical issue found resolved. Ten questions were reviewed; seven were rated proficient, two were adequate, and one was inadequate.

During the June 2016 annual audit, the facility achieved 54.2% compliance for Question 4.5 (previously Question 4.8) due to facility nursing staff not consistently establishing effective communication with patients during nursing encounters. During the June 2017 annual audit, the facility failed to achieve a compliance threshold of 80.0%, and was found 58.3% compliant. The facility slightly improved the score to 75.0% in the December 2017 Limited Review, but did not resolve this issue. During the current audit, the nurse auditor found this critical issue resolved. Thirteen of the 16 health records reviewed showed

[1] GFR - an acronym used for glomerular filtration rate. GFR is a test used by physicians and other medical professionals to see if the kidneys are working correctly. In basic terms, it is a measurement of how much liquid and waste is passing from the blood through the tiny filters in the kidney, called the glomeruli, and out into the urine during each minute.

the facility nurses established effective communication with the patient during a nursing encounter. As a result, the facility achieved 81.3% compliance.

One new critical issue was identified for Question 4.7. A review of the health record indicated chronic care follow up appointments were not consistently completed as ordered by the PCP. Twelve out of 16 patient medical records reviewed were non-compliant for this requirement.

The audit team attended the facility's Daily Care Team Huddle, which the facility regularly conducts at 0700 hours daily. In comparison to the June 2017 annual audit, the NCPR auditor noted significant improvement in the facility's daily huddle documentation (Question 4.8). A review of the documentation showed 17 out of 21 days were completed correctly, resulting in 81.0% compliance. The NCPR auditor, however, provided a copy of the Daily Care Huddle Script to the nurse assigned for completing huddle documentation. The Daily Care Huddle Script describes the actions to be taken related to issues identified. A sample of a completed Daily Care Huddle Activity Sheet was also provided for reference. The NCPR auditor emphasized the importance of the PCP providing mini lectures to nursing staff regarding current trends on any medical issue impacting patient health care.

5. DIAGNOSTIC SERVICES

For this component, the clinical 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 if the results were communicated to the patient within the required time frame. Information regarding the appropriateness, accuracy and quality of the diagnostic tests ordered, and the clinical response to the results is evaluated via the case review process.

Case Review Score: *100.0%*
Quantitative Review Score: *95.8%*

Overall Score: 98.6%

Shafter Modified Community Correctional Facility received an overall compliance score of 98.6% (*Proficient*), an increase of 14.2 percentage points from the previous score of 84.4% (*Adequate*). Specific findings identified by the clinical auditors during case reviews, and electronic health record quantitative review are documented below.

Case Review Results

The facility received an overall case review compliance score of 100% (*Proficient*). The clinician auditors reviewed a combined total of 11 encounters for this component and did not identify any deficiencies with the physician and nursing care provided to patients during the audit review period.

Quantitative Review Results

The facility received a quantitative compliance score of 95.8% (*Proficient*) with no new critical issues identified. Three out of the four questions scored 100% and one scored 83.3%. The facility did not have any previous unresolved critical issue for this component.

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: *100.0%*
Quantitative Review Score: *90.0%*

Overall Score: 96.7%

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

Shafter Modified Community Correctional Facility received an overall compliance score of 96.7% (*Proficient*), an increase of 18.9 percentage points from the previous audit score of 77.8% (*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 an overall case review compliance score of 100% (*Proficient*). The clinician auditors reviewed a combined total of 11 encounters for this component and did not identify any deficiencies with the physician and nursing care provided to patients during the audit review period.

Quantitative Review Results

The facility received a quantitative compliance score of 90.0% (*Proficient*) with no new critical issues identified. Out of four questions reviewed, two questions achieved 100% compliance, and the remaining two questions achieved 80.0% compliance.

The facility had one unresolved critical issue from the previous December 2017 Limited Review. Patients were not consistently receiving their prescribed medications timely upon their return to the facility following discharge from a community hospital (Question 6.4). At the time, out of five patient health records reviewed, only two patients had prescribed medications to be filled upon arrival at the facility. However, only one record had documentation reflecting the patient received their medication timely. During the current audit, three out of six patients who returned from the community hospital had medications prescribed. The nurse auditor's review of these three patient health records showed all patients received their prescribed medications timely, achieving 100% compliance for this question. This issue is considered resolved.

7. INITIAL HEALTH ASSESSMENT/HEALTH CARE TRANSFER

Case Review Score: *97.1%*
Quantitative Review Score: *83.3%*

Overall Score: 92.5%

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.

Shafter Modified Community Correctional Facility received an overall compliance score of 92.5% (*Proficient*) with one new critical issue identified. Specific findings related to the nurse and physician case reviews, electronic health record and onsite quantitative reviews are documented below.

Case Review Results

The facility received an overall case review compliance score of 97.1%. The clinician auditors reviewed a combined total of 22 encounters.

Nurse Case Reviews

The NCPR auditor reviewed 17 nursing encounters related to this component and identified only one deficiency.

- In **Case 25**, the patient was transferred on March 6, 2018, to WSP for psychological evaluation. The patient also had a pending optometry consultation per the referral documented on the PCP's progress note dated February 23, 2018. However, the transfer nurse did not document the patient's pending optometry consult on the CDCR Form 7371, *Health Care Transfer Information*.

Physician Case Reviews

The physician auditor reviewed a total of five provider encounters related to this component and did not identify any deficiencies.

Quantitative Review Results

Shafter Modified Community Correctional Facility received a quantitative compliance score of 83.3% with one new critical issue identified. Five out of eight questions scored 100% compliance, one question scored 0.0% compliance, and two questions were not rated due to the unavailability of valid samples for evaluation. There were no previous unresolved critical issues for this component.

Since there were no patients scheduled to be transferred out of SMCCF at the time of the onsite audit, the NCPR auditor interviewed the RN regarding the facility's transfer process and the documents required

for the patient's Transfer Envelope. The RN was not knowledgeable about all the documents needed to be included; namely, the Transfer Summary, CDCR Form 1845, *Disability Placement Program Verification,* and CDCR Form 7410 *Comprehensive Accommodation Chrono.* This resulted in 0.0% compliance for Question 7.8. Since the nurse auditor did not find any patients requiring a referral to the provider during initial intake screening (Question 7.3) and did not have a scheduled or pending medical, dental or mental health appointment upon arrival (Question 7.4) within the samples randomly selected for review, these questions were not rated.

8. MEDICAL/MEDICATION MANAGEMENT

Case Review Score: *91.4%*
Quantitative Review Score: *97.5%*
Overall Score: 93.5%

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

Shafter Modified Community Correctional Facility received an overall compliance score of 93.5% (*Proficient*), an increase of 9.1 percentage points from the previous score of 84.4% (*Adequate*). Specific findings related to the nurse and physician case reviews, electronic health record and onsite quantitative review are documented below.

Case Review Results

The facility received an overall case review compliance score of 91.4%. The clinician auditors reviewed a combined total of 73 encounters related to this component.

Nurse Case Reviews

The NCPR auditor reviewed 56 nursing encounters for this component and identified three deficiencies, of which two deficiencies were related to patients not receiving their prescribed medications or not receiving them timely. The third deficiency resulted from the patient receiving a refill for a discontinued medication.

- In **Case 17**, the Medication Administration Record (MAR) posted on January 30, 2018, showed the patient received a 30-day supply of 10 milligram (mg) amlodipine. However, the PCP had ordered to discontinue this medication on January 24, 2018.
- In **Case 19**, two deficiencies were identified, both related to the patient not receiving prescribed medications within the required time frame. On February 7, 2018, the PCP ordered Tylenol

325 mg, omeprazole 20 mg, and selenium lotion 25% as Keep-on-Person (KOP) medications. The patient received the selenium lotion in a timely manner. However, the patient received Tylenol on February 26, and omeprazole on March 8, 2018. Both these medications were received very late. Per policy, all non-urgent new medication orders received by pharmacy on any business day must be available to the patient no later than four business days unless otherwise ordered. The same patient received a 30-day supply of his chronic care medication loratadine on February 8, 2018. The previous 30-day supply was provided on December 13, 2018. There was no MAR for the month of January 2018 showing the patient received a 30-day supply of the medication during the month. The facility is required to provide routine chronic care medications to the patient at least one day prior to the exhaustion of the 30-day supply.

Physician Case Reviews

The physician auditor reviewed 17 provider encounters and identified two deficiencies.

- In **Case 1**, the patient was seen on January 25, 2018, for DM management and complaint of sore throat. The PCP failed to complete adequate documentation in the patient's health record. The physician auditor found it mostly blank. A complete examination should have been documented in light of the patient's past diagnosis of DM. The PCP also failed to conduct a physical exam and did not document if education was provided to the patient regarding diet and self-care.
- In **Case 9**, the 31 year old patient was seen by the PCP on March 28, 2018, for abdominal pain. The PCP's exam showed the left lower quadrant of the abdomen to be tender. However, there was no other history or clinical evidence of acute abdomen. The PCP's diagnosis indicated diverticulitis[2] and the patient was prescribed Cipro and Flagyl for 10 days. The PCP did not provide instructions to the patient regarding drinking clear fluids and did not order a Computerized Tomography (CT) scan or a surgical consultation for the patient. The physician auditor found the diagnosis questionable since diverticulitis rarely occurs in 31 year olds. Moreover, constipation also can present with similar symptoms. In situations where diverticulitis is considered, the patient is at risk for perforations and other complications. Standard of care requires close follow up including CT scan and further consultation depending on CT findings. The physician auditor determined the PCP's follow up with the patient in four days, and failure to institute clear liquid diet to be below the established standards of care.

Quantitative Review Results

The facility received a quantitative compliance score of 97.5% for this component. Of a total of 14 questions, ten were evaluated of which nine questions received 100% compliance and one received 75.0% compliance. Four questions were unable to be rated because none of the patients in the sample population met the rating criteria.

The nurse auditor found chronic care medications were not consistently received by the patient within the required timeframe (Question 8.1). This critical issue was first identified during the June 2017 annual audit. At the time, 24 patient health records were reviewed, of which 14 were found non-compliant

[2] Diverticulitis - Inflammation of the diverticula (small outpouchings) along the wall of the colon, the large intestine. They are formed by increased pressure on weakened spots of the intestinal walls by gas, waste, or liquid. Diverticula can form while straining during a bowel movement, such as with constipation.

resulting in 41.7% compliance. During the December 2017 Limited Review, 9 out of 16 health records were found non-compliant. The facility did not achieve compliance during the current audit, with 4 out of 16 health records found non-compliant. This issue remains unresolved.

Subsequent to the audit, the NCPR auditor emphasized the importance of complying with the physician's order regarding the timeline for the medication administration. Additionally, for refill medications, if the facility receives the medication from the pharmacy earlier than one day prior to the exhaustion of the 30-day supply, the nursing staff should wait until one day prior to administer the medication per policy. This may hopefully result in resolution of this long standing critical issue.

It is also recommended the facility create a tracking tool for patients on KOP medications, by logging the patient's name and CDCR number, name of medication, the administration due date (this is the date stamped next to the fill date on the medication package), date facility administered the medication, and date the medication is due to be refilled (this will be 30 days from the fill date stamped on the medication package). The nursing staff shall refer to these dates in the tracking log to ensure refills are provided one day before the date next refill is due. This will help in synchronizing the administration dates with the fill dates noted in Central Fill Pharmacy's system. This tracking log will also serve as an internal quality control mechanism for the facility to detect problems with refill administration of and address all issues promptly.

During the pre-audit review of health records for patient medication refusals and the administration and monitoring of TB medications, the nurse auditor found none of the patients selected for the sample met the rating criteria and therefore was unable to rate Questions 8.2 through 8.5. During the June 2016 annual audit, the nurse auditor found the facility was not consistently monitoring the patients on anti-Tuberculosis (TB) medications monthly. This critical issue could not be evaluated for compliance during the June 2017 audit, December 2017 Limited Review and current audit, because the facility did not have any patients on anti-TB medications during all three audit review periods.

9. OBSERVATION CELLS (California Out of State Correctional Facilities 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 specialists' reports are communicated to the patients. For those patients who transferred from another facility, the auditors assess whether the approved or scheduled specialty service appointments are received and/or completed within the specified time frame.

Case Review Score: *98.4%*
Quantitative Review Score: *76.6%*

Overall Score: 91.1%

Shafter Modified Community Correctional Facility received an overall compliance score of 91.1% (*Proficient*), an increase of 29.4 percentage points from the previous score of 61.7% (*Inadequate*) received during the June 2017 annual audit. Specific findings related to the nurse and physician case reviews, and the electronic health record quantitative review are documented below.

Case Review Results

The facility received an overall case review compliance score of 98.4%. The clinician auditors reviewed a combined total of 39 encounters related to this component.

Nurse Case Reviews

The NCPR auditor reviewed a total of 31 nursing encounters related to this component and identified one deficiency.

- In **Case 25**, the PCP ordered an optometry consult for myopia/hyperopia for the patient on February 23, 2018. However, the NCPR auditor could not find documentation in the patient's health record showing the optometry consult was completed as ordered.

Physician Case Reviews

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

Quantitative Review Results

The facility received a quantitative compliance score of 76.6% with one new critical issue identified. Four questions were reviewed; one scored 100%, two were rated adequate, and one was rated inadequate.

During the June 2017 annual audit, the facility's nursing staff were not consistently notifying the PCP of any immediate medication or follow-up requirements provided by the specialty care consultant upon the patient's return from a specialty care appointment (Question 10.3). The facility failed to resolve this issue during the December 2017 Limited Review by scoring 0.0% compliance. However, during the current audit, the nurse auditor reviewed five health records of which four contained documentation showing the

nursing staff notified the PCP regarding the medications and/or follow up orders provide by the specialty care consultant. The facility achieved 80.0% compliance, thus resolving this prior critical issue.

During the current audit, the nurse auditor found the facility PCP did not consistently review the specialty consultant's report and/or discharge summary and complete a follow-up appointment with the patient within the required time frame (Question 10.4). Eight health records were reviewed of which three were compliant. As a result, the facility achieved 37.5% compliance.

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: *78.3%*

Overall Score: 78.3%

Quantitative Review Results

Shafter Modified Community Correctional Facility received a compliance score of 78.3% (*Inadequate*) with one previously identified critical issue unresolved. During the current audit, a total of three questions were reviewed; two were rated proficient and one was inadequate.

A review of five patient electronic health records revealed SMCCF did not offer a colorectal screening to three of these patients which resulted in 40.0% compliance (Question 11.3). This critical issue was initially identified during the June 2017 annual audit at which time only 7 out of 18 patients were offered the screening resulting in 38.9% compliance. This critical issue remains unresolved.

12. EMERGENCY MEDICAL RESPONSE/DRILLS and EQUIPMENT

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

Case Review Score: *Not Applicable*
Quantitative Review Score: *75.8%*

Overall Score: 75.8%

Quantitative Review Results

Shafter Modified Community Correctional Facility received an overall compliance score of 75.8% (*Inadequate*) with three new critical issues identified. This is a decrease of 14.3 percentage points from the previous June 2017 audit score of 90.1% (*Proficient*). Ten questions were reviewed; six were rated proficient, one was adequate, and three were inadequate.

During the onsite audit, while reviewing the EMR Bag Checklist, the NCPR auditor found the facility staff did not re-inventory and re-seal the EMR bag following its use during the EMR drill conducted on March 5, 2018 (Question 12.6). Out of the twelve incidents reviewed, this was the only EMR incident that warranted opening of the EMR bag. As a result, the facility scored 0.0% compliance. The facility failed this question during the June 2016 annual audit (0.0%) and the June 2017 annual audit (66.7%). Although SMCCF was successful in resolving this issue during the December 2017 Limited Review, it was unable to maintain compliance for this requirement during this audit.

The NCPR auditor also found during the review of the EMR Bag Checklist for the months of January through April 2018, and noted the facility did not inventory the EMR bag during the month of March 2018 (Question 12.7), which resulted in 75.0% compliance. While discussing this issue with the facility RN, the NCPR auditor was informed that a registry nurse who only works on weekends is assigned to perform the routine monthly inventory of the EMR bag. If the registry nurse fails to complete it on a weekend, she has to complete the check the following weekend, which may fall outside the time frame for the monthly inventory. The NCPR recommends the routine monthly checks and inventory of the EMR bag should be the responsibility of nursing staff on regular shifts.

The third new critical issue identified during the audit was related to the facility not having a designated Narcan Log, which resulted in 0.0% compliance (Question 12.15). During the onsite audit, the NCPR auditor found the facility stored Narcan in the EMR bag which was kept inside a locked room. However, the health care staff did not account for the Narcan at the beginning and end of each shift and it was not listed on the EMR Bag Checklist.

13. CLINICAL ENVIRONMENT

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

Case Review Score: *Not Applicable*
Quantitative Review Score: *99.9%*

Overall Score: 99.9%

Quantitative Review Results

Shafter Modified Community Correctional Facility received an overall compliance score of 99.9% (*Proficient*) with one prior qualitative issue found resolved. Thirteen questions were reviewed and all rated proficient; 12 received 100% compliance, and 1 received 98.9%. Two questions were not rated because the facility does not utilize re-usable medical instruments. The auditors found the clinical space was clean and organized with excellent access to hand washing, sanitizing, sharps disposal, and appropriate biohazard disposal.

During the December 2017 Limited Review, auditors found nursing staff were conducting patient assessments in the clinic's hallway and not in a location that provides auditory and visual privacy. This was reported as Qualitative Critical Issue #1. During the current audit, the NCPR auditor observed the patient assessments are currently conducted in the nurse examination room, which maintains auditory and visual privacy for the patients. This issue is considered resolved.

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: 95.3%
Quantitative Review Score: *Not Applicable*
Overall Score: 95.3%

Case Review Results

Shafter Modified Community Correctional Facility received a compliance score of 95.3% (*Proficient*). This determination is based upon the NCPR auditor's review of nursing services provided to ten patients housed at SMCCF during the audit review period of January through April 2018. Of the ten detailed case reviews, eight were found proficient, one was found adequate, and one was inadequate. Of the 154 total nursing encounters assessed within the ten detailed case reviews, eight deficiencies were identified related to nursing care and performance. Details are documented in the previous components: *Access to Care, Initial Health Assessment/Health Care Transfer and Community Hospital Discharge, Medical/Medication Management, and Specialty Services*.

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

Case Number	Deficiencies
Case 25	***Inadequate (77.8%).*** This is a 53-year-old male patient with diagnoses of bipolar disorder and illnesses resulting from opioid use. During the review period, the patient complained of knee pain, upper respiratory infection, and mood swings. The nurse auditor reviewed a total of 18 nursing encounters and identified four deficiencies: Two deficiencies are related to inappropriateness of nursing action as evidenced by the

	nursing staffs' failure to refer the patient to the PCP when the patient complained of the same respiratory problem for almost two weeks with no response to Nursing Protocol medications. The third deficiency pertains to a lack of nursing documentation showing an optometry consult was completed as ordered. The fourth deficiency is related to nursing staffs' failure to-document a pending optometry consult on the CDCR Form 7371 at the time of the patient's transfer to WSP.

During the onsite audit, the NCPR auditor inspected two examination rooms, observed three pill passes, interviewed nursing staff, observed the Daily Care Team Huddle, nursing sick call line, and LVN line for PCP visits, and participated in the interview of the Inmate Advisory Council members. The facility has shown significant improvement in the quality of their nursing staff's performance as evidenced by a 17.3 percentage point increase over the previous June 2017 audit score of 78.0% (*Inadequate*).

Recommendations

- The facility should work towards hiring an HSA to supervise nursing staff performance.
- Registry nurses should have an adequate orientation and training on the IMSP&P relating to nursing functions prior to working in the clinic. The facility shall maintain proof of practice of such training and routinely track training for all registry staff.
- Receipt of chronic care medications should be monitored and internal validation audits need to be conducted periodically to measure the effectiveness of the corrective action plan implemented.
- Expiring chronic care medications need to be discussed regularly during Daily Care Team Huddles.
- The facility should continue collaborating and communicating with the CFP and the hub pharmacy regarding timely refill of chronic care medications.
- Routine monthly checks and inventory of the EMR bag should not be assigned to registry nurses. This responsibility needs to be assigned to nursing staff on regular shifts.

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: 91.7%
Quantitative Review Score: *Not Applicable*

Overall Score: 91.7%

Case Review Results

Based on the detailed review of 15 cases conducted by the physician auditor, the facility received a compliance score of 91.7% (*Proficient*). Fifteen detailed case reviews were conducted; 13 were found proficient and 2 were found inadequate. Out of a total of 49 PCP encounters/visits assessed, three deficiencies were identified.

Health care services at SMCCF are currently delivered by one PCP, who was interviewed and observed by the physician auditor while providing patient care during the onsite audit. Health care is provided to patients in one small medical unit with separate nursing and physician exam rooms. Exam rooms are immaculate, roomy, and well equipped. The patients appear to have ready access to the physician or nurse for medical complaints. Patients' privacy is respected as they are seen behind closed doors with custody standing by for security. The physician findings and recommendations are based upon the observations made during the tour of the facility, conversations with medical staff, patient interviews, and review of selected health records.

The physician auditor determined the overall quality of provider performance meets or exceeds applicable standards of care. During the onsite audit, the physician auditor discussed his case review findings with the PCP and during this discussion, realized that the PCP has received no formal training in regards to CCHCS protocols and guidelines. He has also not received any "shadow" training at the facility's hub, WSP, where he could shadow a CCHCS physician while the physician provides health care services to patients. The CCHCS guidelines found in the PCP's office were not updated. For instance, the PCP has been following outdated guidelines from January 2017 instead of the guidelines that were revised in December 2017. The physician auditor showed the PCP how to access CCHCS guidelines on his computer and the PCP bookmarked the link for easy access in future. The physician auditor discussed with the PCP regarding application of Title 15 to provision of adequate medical care to the patient population.

The PCP's documentation in the health record does not meet CCHCS standards insofar as the PCP frequently leaves forms blank where more information should be provided. The physician auditor found the PCP's two month and four month peer reviews did not address these lapses. The facility has not conducted any further internal reviews of the PCP's performance. Currently, the facility does not have weekly or monthly quality assurance programs in place to address these deficiencies or any other lapses in provider care. The PCP's work is not regularly monitored by the facility. The auditor discussed the deficiencies identified in the health records with the PCP. The PCP confirmed his understanding of the requirements for adequate documentation in the medical records. The physician auditor discussed with the Chief regarding the deficiencies identified with the PCP's documentation and training, and recommended to hold more internal reviews to mitigate these issues. The physician auditor informed the Chief about completing the PCP's annual performance review in a timely manner since the review was due on July 6, 2018. The facility failed in the current annual audit and the December 2017 Limited Review due to its failure to conduct PCP's peer reviews within the specified time frame.

The physician auditor also found the nursing entries in the health record were inaccurate with regards to Basic Metabolic Index (BMI) which is frequently reported as 27+ for patients exceeding 215 pounds weight. The auditor informed the PCP about providing education to the nursing staff on accurate calculation of patient's BMI so any immediate health concerns could be addressed promptly. The physician auditor also realized there is room for improvement in the communication between the PCP and nursing staff. The auditor encouraged the PCP to use available huddle time for education as well as discussion regarding management of more challenging patients. The physician auditor determined the PCP appeared to prescribe appropriately and in accord with community standards. The auditor discussed the risks of polypharmacy with the PCP.

Patients at SMCCF currently have no access to preventive mental health services on-site; instead, they are transferred out for mental health crises. In the absence of on-site mental health services, the physician auditor recommended the facility's Chief facilitate basic mental health training for the PCP and nursing

staff so they could identify some of the common mental health issues usually seen in patients, such as recognizing severe depression and/or psychoses.

While conducting case reviews, the physician auditor noted the patients were appropriately sent for emergency care, with proper documentation and follow up from community hospital discharges. The patients also appeared to receive timely assessments and were transferred appropriately for urgently needed care. While reviewing cases for the *Specialty Services* component, the physician auditor identified the PCP was not in the habit of contacting specialists to discuss patient care.

The physician auditor discussed the importance of reconciling differences in opinions from specialists who may have recommended care that differs from the services provided to patients. This was evidenced by the physician auditor during the onsite audit, while discussing with the PCP about a patient who complained of hip pain in association with a bone cyst (diagnosed as enchondroma[3]) in his left femur; there was a vague reference in the specialist's report about conducting a biopsy or surgery to address the patient's complaint. Upon inquiring with the PCP, the auditor was informed the PCP has not yet consulted with the specialist regarding this report. The patient seems to be confused as to whether he should be undergoing a biopsy or if his bone cyst is diagnosed as benign. It appears that radiology, orthopedics and PCP concur that best course for this patient is to look at plain X-rays regularly for any sign of growth or change in the cyst, rather than perform a biopsy or surgery at this time. The physician auditor recommended the PCP to discuss his treatment plan by conversing with the surgeon, and to ensure the discussion is documented. The auditor also recommended the PCP explain the treatment plan to the patient so that the patient understood.

Overall, the physician auditor saw the medical care provided by the current PCP at SMCCF meets applicable standards in most parameters. The physician auditor found the current PCP's performance better than the services provided by prior physicians at SMCCF. However, the PCP's documentation in the health records do not meet CCHCS standards. The PCP understands he is required to discuss patient care with the specialists co-managing his patients. The PCP should receive further education and monitoring to ensure compliance with best CCHCS practices.

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

Case Number	Deficiencies
Case 1	***Inadequate (0.0%).*** This is a 35-year old overweight African American patient with a diagnosis of DM who was seen for upper respiratory infection and DM management during the audit review period. The physician auditor identified two deficiencies in the care provided. The first deficiency was related to the PCP's failure to document a complete examination of the patient given the patient's past history of DM and not documenting that education was provided to the patient on managing his obesity. The second deficiency was related to the PCP wrongly diagnosing the patient as having DM and renal insufficiency during the follow-up appointment for lab results although the results show creatinine level at 1.7

[3] Enchondroma is a type of benign (noncancerous) tumor that begins in the cartilage found inside the bones: rarely cause pain or other symptoms, so most remain undiagnosed until x-rays are taken for an unrelated injury or condition.

	and blood sugars levels between 72 - 92, both of which are within normal range and do not support the PCP's diagnoses. The PCP once again failed to educate the patient regarding his obesity during the appointment and failed to complete adequate documentation in the patient's chart.
Case 9	***Inadequate (75.0%).*** This is a 31-year old patient monitored for Hepatitis C (HCV) and was seen for chronic care follow-up and complaints of abdominal pain during the audit review period. The provider care was determined to be inadequate due to the PCP misdiagnosing the patient's abdominal pain as diverticulitis. If diverticulitis is considered then the patient is at risk for perforation and other complications. Standard of care for diverticulitis requires close follow up including CT scan and further consultation depending on CT findings. The physician auditor determined PCP's inadequate follow up, and failure to institute clear liquid diet to be below the established standards of care.

Recommendations

- The PCP's progress notes should include documentation of patient's examination and education provided to the patient.
- The PCP's medical care should be monitored by supervising physician(s) from the hub on a regular basis.
- The PCP should familiarize himself with current practice guidelines issued by CCHCS. The HCV guidelines in the PCP's office is not current.
- The PCP should be scheduled to "shadow" CCHCS provider(s) for at least one day, preferably two days with different providers at the hub (Wasco) as soon as practical.
- The PCP should participate in the Daily Care Team Huddle as a medical leader, and provide education on pertinent medical issues to the nursing staff.
- Patients should have reliably easy access to educational materials, notices regarding their right to receive medical care, forms for requesting medical services and forms by which to grieve about medical services in their housing units. Currently, notices are posted differently and inconsistently. The 602 HC and 602 HC-A forms are not readily available, but provided to patients only upon their request to custody staff.
- The PCP should participate in quality assurance meetings held at the hub on a weekly or at least on a monthly basis.

PRIOR CRITICAL ISSUE RESOLUTION

The previous audit conducted on December 12 through 13, 2017, resulted in the identification of seven quantitative critical issues and one qualitative critical issue. During the current audit, auditors found four of the eight issues resolved, and three issues not resolved within the established compliance threshold. One quantitative critical issue was not evaluated due to unavailability of valid samples that met the criteria for evaluation. Below is a discussion of each previous critical issue:

Critical Issue	Status	Comment
Question 3.6 – THE PEER REVIEW OF THE FACILITY'S PROVIDER IS NOT BEING COMPLETED WITHIN THE REQUIRED TIME FRAMES.	**Unresolved**	The issue was initially identified during the June 2016 audit. The facility did not complete the 10-day and 60-day peer reviews for the provider resulting in 0.0% compliance. This requirement was not rated during June 2017 annual audit because no peer reviews were due for completion during the audit review period. During the December 2017 Limited Review, the peer review for the facility's PCP was completed 20 days after the due date of October 1, 2017, resulting in 0.0% compliance. During the current audit, the PCP's four month review was completed 61 days after the due date of November 5, 2017, resulting in 0.0% compliance. **This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.**
Question 4.5 – THE REGISTERED NURSE DOES NOT CONSISTENTLY DOCUMENT EFFECTIVE COMMUNICATION WAS ESTABLISHED AND EDUCATION WAS PROVIDED TO THE PATIENT RELATED TO THE TREATMENT PLAN.	**Resolved**	The issue was initially identified during the June 2016 audit. At the time, the facility was found 54.2% compliant. During the June 2017 audit, SMCCF failed to resolve this issue, and was found 58.3% compliant. During the December 2017 Limited Review, although the facility showed marginal improvement by scoring 75.0%, it failed to achieve the established compliance threshold. During the current audit, 13 of the 16 patient electronic health records reviewed had documentation showing the RN established effective communication and provided education to the patients related to the treatment plan resulting in 81.3% compliance. **This critical issue is resolved.**
Question 6.4 – THE PATIENTS RETURNING TO THE FACILITY FROM A COMMUNITY HOSPITAL DISCHARGE OR HUB INSTITUTION, WITH EXISTING MEDICATION ORDERS, DO NOT CONSISTENTLY RECEIVE THEIR PRESCRIBED MEDICATIONS TIMELY.	**Resolved**	The issue was initially identified during the December 2017 Limited Review. At the time, only two of the five patients had prescribed medications to be filled and of the two health records reviewed only one had documentation that the patient received their prescribed medication timely resulting in 50.0% compliance. During the current audit, all three patient health records reviewed showed the patients received their prescribed medications timely and the facility achieved 100% compliance. **This critical issue is resolved.**
Question 8.1 – CHRONIC CARE MEDICATIONS ARE NOT CONSISTENTLY RECEIVED BY THE PATIENT WITHIN THE REQUIRED TIME FRAME.	**Unresolved**	The issue was initially identified during the June 2017 audit. At the time, the facility was found 41.7% compliant. During the December 2017 Limited Review, the facility failed to resolve this issue and was found 43.8% compliant. During the current audit, a review of 16 patient health records showed 12 of the patients received their chronic care medications timely, resulting in 75.0% compliance. Although the facility showed significant improvement in this area, SMCCF failed to achieve the established compliance threshold of 80.0% compliance. **This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.**

Question 8.5 (formerly Question 8.6) – THE FACILITY DOES NOT MONITOR THE PATIENT MONTHLY WHILE THE PATIENT IS ON THE ANTI-TUBERCULOSIS MEDICATION.	**Unresolved**	The issue was initially identified during the June 2016 audit. At the time, SMCCF was found 75.0% compliant. During the June 2017 audit and December 2017 Limited Review, this issue was not rated. No patients who met the criteria for evaluation were identified. During the current audit, the auditor could not evaluate this issue because none of the patients housed in the facility were on anti-tuberculosis medications during the audit review period. Therefore, this requirement was not rated. **This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.**
Question 10.3 – THE RN DOES NOT CONSISTENTLY NOTIFY THE PROVIDER OF ANY IMMEDIATE ORDERS OR FOLLOW-UP INSTRUCTIONS PROVIDED BY THE SPECIALTY CARE CONSULTANT.	**Resolved**	The issue was initially identified during the June 2017 audit. At the time, the facility was found 0.0% compliant. During the December 2017 Limited Review, the facility again was found non-compliant and received a score of 0.0% compliance. During the current audit, four out of five patient health records reviewed were found compliant, resulting in 80.0% compliance. **This critical issue is resolved.**
Question 11.3 – THE FACILITY DOES NOT CONSISTENTLY OFFER COLORECTAL CANCER SCREENING TO THE PATIENT POPULATION 50-75 YEARS OF AGE.	**Unresolved**	The issue was initially identified during the June 2017 audit. At the time, 7 out of 18 patient health records reviewed were compliant for this requirement resulting in 38.9% compliance. This question is reviewed yearly during the annual audits and was not rated during the December 2017 Limited Review. During the current audit, the RN auditor reviewed five patient health records and found two patients were offered colorectal screening during the audit review period resulting in 40.0% compliance. **This critical issue remains unresolved and will be evaluated for compliance during subsequent audits.**
Qualitative Critical Issue # 1 – REGISTERED NURSES DO NOT CONDUCT FACE-TO-FACE EXAMS AND ASSESSMENTS IN A LOCATION THAT PROVIDES AUDITORY AND VISUAL PRIVACY FOR PATIENTS.	**Resolved**	The issue was initially identified during the December 2017 Limited Review. During the onsite audit, the auditors observed the facility RNs conducting face to face assessments of patients in the clinic hallway which did not offer visual and auditory privacy to the patients. During the current audit, the auditors observed the RN conduct face to face assessments of patients in the nurse's examination room that offers visual and auditory privacy for the patients. **This critical issue is resolved.**

CONCLUSION

The audit findings discussed in this report are a result of a thorough evaluation of the health care services provided by SMCCF to the patient population during the audit review period of January through April 2018. The facility's overall performance during this time frame was rated as *Adequate.* Of the 14 components evaluated, the auditors found 9 components to be proficient, 1 adequate, and 4 inadequate (refer to the *Executive Summary Table* on page four). The facility resolved four of the eight prior critical issues. Four issues remain unresolved of which two issues were initially identified during the June 2016 audit, and two were identified during the June 2017 audit. In addition, 11 new quantitative critical issues and 3 new qualitative critical issues were identified during the current audit.

Shafter Modified Community Correctional Facility made significant improvements by resolving the majority of its past critical issues and streamlining the medical processes. This is evidenced in the improvement of the facility's overall score from 83.8% (*Adequate)* achieved during the previous June 2017 audit to 88.4% (*Adequate)* achieved during the current audit. The clinician auditors found significant improvements in the quality of nursing and physician services at SMCCF. However, the current audit identified seven critical issues, five of which the facility has struggled with resolving. The five critical issues are listed in the table below and explained in the individual component sections.

Critical Issues	Annual Audit July 2014	Annual Audit August 2014	Annual Audit March 2015	Limited Review November 2015	Annual Audit June 2016	Annual Audit June 2017	Limited Review December 2017	Annual Audit June 2018
Question 3.6 – The facility did not complete the peer review for its provider within the required time frame.	N/A	N/A	N/A	N/A	Fail	N/A	Fail	Fail
Question 4.7 – The facility does not consistently complete the patients' chronic care visits as ordered by the primary care provider.	Fail	Fail	Fail	Fail	Pass	Pass	N/A	Fail
Question 8.1 – The facility does not consistently provide the patients their chronic care medications within the specified time frame.	Pass	Pass	Pass	N/A	Pass	Fail	Fail	Fail
Question 10.4 – The facility's PCP does not consistently review the specialty consultant's report/discharge summary and complete a follow-up appointment with the patients within the required time frame.	Fail	Fail	Pass	N/A	Pass	Fail	Pass	Fail
Question 12.6 – The facility nursing staff does not re-supply and re-seal the Emergency Medical Response (EMR) bag following its use during EMR incidents.	Pass	N/A	Pass	N/A	Fail	Fail	Pass	Fail

N/A - Questions with a documented N/A score in the above table were not rated due to either a) the sample not containing patients meeting the criteria, b) the question not being applicable during the audit review period, or c) the question not being a part of the audit tool at the time of the audit.

The failure to update policies has impeded the facility's ability to train its medical staff on revised procedures resulting in some of the critical issues identified under the clinical components. Although the facility provides annual training to its full time medical staff, it does not provide training to most of its part-time nursing staff hired from the Registry. This is very problematic since night shifts are handled by these staff and it is required that they provide services to patients per the health care standards set forth by CCHCS.

The current audit also found the PCP was not knowledgeable of the current CCHCS guidelines for treatment, and had not completed "shadow training" at the hub. This has to be immediately corrected in order to ensure health care provided by the PCP is within CCHCS standards. Going forward, the facility is urged to review the IMSP&P revisions as soon as they are received from CCHCS staff and complete updating the policies ensuring to include only those processes that are currently applicable to the facility's medical operational areas/functions. Additionally, all full time and part time medical staff should be trained on the new and updated policies in order for SMCCF to achieve compliance in this area.

The facility remains non-compliant with conducting timely peer reviews for its PCP. The one month and four month peer reviews were submitted late resulting in non-compliance during the December 2017 Limited Review and the current audit. The physician auditor also determined the peer reviews to be inadequate. The peer reviews did not address the deficiencies identified in the PCP's documentation practices as evidenced during the current audit. The PCP also has not received "shadow training" at the hub institution. PPCMU and CBU have repeatedly inquired about this during the monthly conference calls and each time the facility stated staff are all trained. The facility needs to complete peer reviews in a timely manner and collaborate with their hub to ensure the PCP receives training from the hub's providers as soon as feasible.

The facility does not consistently complete patient chronic care visits as ordered by the PCP. This has been an ongoing struggle for SMCCF since the July 2014 annual audit. The facility needs to ensure all patients are scheduled per the time frame specified by the PCP so their chronic care conditions are adequately addressed and managed by the PCP in a timely manner.

For the past three audits, June 2017, December 2017 and June 2018, the facility has not met the minimum compliance for administering patient chronic care medications timely. The staff at PPCMU discussed this issue with the facility and the hub institution during the monthly conference call with CBU on several occasions. The facility stated there are delays in receiving medication refills from their hub and they are unable to address the issue at their end. Since it appears the non-compliance occurred around the time the medication refill responsibility was transferred to the CCHCS's CFP, the HPS and NCPR auditors communicated with CFP to understand the discrepancy between the refill dates in the EHRS timeline and the timeline noted on the facility's MAR. The auditors were informed by CFP that the refill medications are automatically sent to the hub institution five days prior to the exhaustion of the 30 day supply. Since the facility is not utilizing EHRS, the system will not recognize if the facility staff dispensed the medication earlier than what was originally scheduled, and will still dispense the next 30-day supply based on the previous fill date and frequency. Over time, as the two timelines get further apart, the patient will run out of the 30-day supply before CFP dispenses the refill and the facility becomes non-compliant. This information was communicated to the facility via email on July 18, 2018. PPCMU staff will continue to monitor this issue.

Lastly, the facility's PCP has not been reviewing the specialty consultant's reports and following up with the patient upon their return from specialist appointments. During the current audit, the physician auditor discussed one such case with the PCP (described under *Quality of Provider Performance)* and recommended he follow up with the specialist to coordinate treatment plans for the patient. It is important for the facility's PCP to maintain communication with the specialist consultants, hub institution providers, and community hospital providers to ensure continuity of care for patients. The PCP is encouraged to discuss challenging cases with his peers and be receptive to their advice and/or recommendations so adequate and effective care is provided to patients.

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

APPENDIX A – QUANTITATIVE REVIEW RESULTS

Shafter Modified Community Correctional Facility Range of Summary Scores: 74.4% - 99.9%	
Audit Component	**Quantitative Score**
1. Administrative Operations	74.4%
2. Internal Monitoring & Quality Management	82.9%
3. Licensing/Certifications, Training & Staffing	74.1%
4. Access to Care	93.1%
5. Diagnostic Services	95.8%
6. Emergency Services & Community Hospital Discharge	90.0%
7. Initial Health Assessment/Health Care Transfer	83.3%
8. Medical/Medication Management	97.5%
9. Observation Cells (COCF)	Not Applicable
10. Specialty Services	76.6%
11. Preventive Services	78.3%
12. Emergency Medical Response/Drills & Equipment	75.8%
13. Clinical Environment	99.9%
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?	3	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?	7	8	46.7%
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?	1	0	100.0%
1.6	Does the facility maintain a Release of Information log that contains ALL the required data fields and all columns are completed?	1	0	100.0%
1.7	Did the facility provide the requested copies of medical records to the patient within 15 business days from the date of the initial request?	Not Applicable		
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?	Not Applicable		
	Overall Percentage Score:			**74.4%**

Comments:

Question 1.2 Seven of the facility's health care policies reviewed, namely, the *Access to Care*, *Aerosol Transmissible Disease Exposure Control Plan*, *Durable Medical Equipment and Medical Supplies*, *Health Care Staff Licensure, Training and Staffing, Maintenance and Management of Health Records and Release of Information*, *Medication Management*, and *Quality Management Program* were found to be non-compliant with the IMSP&P. The facility did not submit a policy for *Tuberculosis Program Surveillance.*

Question 1.4 The facility's inmate orientation handbook does not describe the details of the revised health care grievance process.

Questions 1.7 and 1.8 The facility did not receive any patient and/or third party requests for health care information during the audit review period.

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?	58	0	100.0%
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?	15	0	100.0%
2.7	Is data documented on the hospital stay/emergency department monitoring log accurate?	7	1	87.5%
2.8	Is data documented on the chronic care monitoring log accurate?	20	0	100.0%
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?	1	7	12.5%
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?	2	0	100.0%
	Overall Percentage Score:			**82.9%**

Comments:

Question 2.5 The HPS auditor reviewed 17 entries within the Sick call monitoring log for the audit review period and found 3 entries with missing/erroneous data; namely, (a) misspelled last name of patient (one entry and (b) wrong PCP appointment dates (two entries).

Question 2.7 The HPS auditor reviewed all eight entries within the Hospital/ED monitoring log for the audit review period and found one entry with erroneous data, namely, misspelled last name of the patient.

Question 2.9 The HPS auditor reviewed 20 entries within the Hospital/ED monitoring log for the audit review period and found 1 entry with erroneous data, namely, misspelled last name of the patient.

Question 2.10 During the onsite audit, the HPS auditor found CDCR Forms 602 HC and CDCR 602-A were not readily available to patients in seven out of eight housing units inspected.

Question 2.12 The screening disposition drop down field in the facility's grievance log was not updated to the current requirements *CCHCS Health Care Grievances Operational Standards and California Code of Regulations, Title 15, Article 8.6, Health Care Grievances.* The current disposition criteria is to be stated as "Intervention" and "No Intervention"; however, the drop down boxes in the log listed the options "Granted", "Partially Granted", and "Denied". Additionally, the "Date Appeal Received" column had incorrect dates listed and the log was missing the "date of RN triage" column on the log. The column "Date Due to Inmate" contained dates calculated based on the 30-day time frame instead of the 45-day time frame for institutional responses per the revised requirements.

3. Licensing/Certifications, Training, & Staffing		**Yes**	**No**	**Compliance**
3.1	Are all health care staff licenses current?	16	0	100.0%
3.2	Are health care and custody staff current with required emergency medical response certifications?	81	0	100.0%
3.3	Does the facility provide the required training to its health care staff?	4	5	44.4%
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?	0	1	0.0%
	Overall Percentage Score:			**74.1%**

Comments:

Question 3.3 The facility did not provide health care training to five registry staff who were scheduled to provide weekend and vacancy coverage during June 2018.

Question 3.6 The facility provider's four month peer review was not completed within the required time frame, November 5, 2017. The facility completed the peer review two months later, on January 5, 2018.

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?	16	0	100.0%
4.3	Was the focused subjective/objective assessment conducted based upon the patient's chief complaint?	16	0	100.0%
4.4	Did the registered nurse implement appropriate nursing action based upon the documented subjective/objective assessment data within the nurse's scope of practice or supported by the standard Nursing Protocols?	16	0	100.0%
4.5	Did the registered nurse document that effective communication was established and that education was provided to the patient related to the treatment plan?	13	3	81.3%
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?	6	0	100.0%
4.7	Was the patient's chronic care follow-up visit completed as ordered?	12	4	75.0%
4.8	Did the Care Team regularly conduct and properly document a Care Team Huddle during business days?	17	4	81.0%
4.9	Does nursing staff conduct daily rounds in segregated housing units and collect CDCR Form 7362, *Health Care Services Request*, or similar forms? (COCF only)	Not Applicable		
4.10	Are the CDCR Forms 7362, *Health Care Services Request,* or similar form, readily accessible to patients in all housing units?	8	0	100.0%
4.11	Are patients in all housing units able to submit the CDCR Forms 7362, *Health Care Services Request*, or similar form, on a daily basis?	8	0	100.0%
	Overall Percentage Score:			**93.1%**

Comments:

Question 4.1 The nurse auditor reviewed 16 electronic health records of which 1 record showed the patient's CDCR Form 7362 was not reviewed by the RN on the day it was received.

Question 4.5 The nurse auditor reviewed 16 electronic health records of which 3 records did not have RN's documentation of establishing effective communication and providing education to the patients regarding their treatment plan.

Question 4.7 The nurse auditor reviewed 16 electronic health records of which 4 records showed the patients' chronic care visits were not completed as ordered.

Question 4.8 The nurse auditor reviewed the Daily Huddle documentation for 21 business days in April 2018, and found the Daily Care Team Huddle was not properly documented for 4 days.

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

5. Diagnostic Services		Yes	No	Compliance
5.1	Did the primary care provider complete a Physician's Order for each diagnostic service ordered?	12	0	100.0%
5.2	Was the diagnostic test completed within the time frame specified by the primary care provider?	10	2	83.3%
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?	12	0	100.0%
5.4	Was the patient given written notification of the diagnostic test results within two business days of receipt of results?	12	0	100.0%
	Overall Percentage Score:			**95.8%**

Comments:

Question 5.2 The nurse auditor reviewed 12 electronic health records of which 2 showed the diagnostic tests were not completed within the time frame specified by the provider.

6. Emergency Services & Community Hospital Discharge		Yes	No	Compliance
6.1	*For patients discharged from a community hospital:* Did the registered nurse review the discharge plan/instructions upon patient's return?	4	1	80.0%
6.2	*For patients discharged from a community hospital:* Did the RN complete a face-to-face assessment prior to the patient being re-housed?	5	0	100.0%
6.3	*For patients discharged from a community hospital:* Was the patient seen by the primary care provider for a follow-up appointment within five calendar days of return?	4	1	80.0%
6.4	*For patients discharged from a community hospital:* Were all prescribed medications administered/delivered to the patient per policy or as ordered by the primary care provider?	3	0	100.0%
	Overall Percentage Score:			**90.0%**

Comments:

Question 6.1 The nurse auditor reviewed five electronic health records and found one record was missing documentation of the RN's review of the discharge plans/instructions upon the patient's return from the community hospital.

Question 6.3 The nurse auditor reviewed five electronic health records and found one record missing documentation of the patient's follow- up visit/ appointment with the provider within the specified time frame following the patient's return from the 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?	Not applicable		
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?	3	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:			**83.3%**

Comments:

Questions 7.3 None of the patients randomly selected for the sample required a referral to a provider during initial intake screening.

Questions 7.4 None of the patients randomly selected for the sample had a scheduled or pending medical, dental or mental health appointment upon arrival at the facility.

Question 7.8 During the onsite audit, the NCPR auditor interviewed the facility RN regarding the transfer process and the documents to be included in the Transfer Envelope. The auditor determined the RN was not knowledgeable about the documents to be included, namely, the *Transfer Summary*, CDCR Form 1845, *Disability Placement Program Verification*, CDCR Form 7410, *Comprehensive Accommodation Chrono*.

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?	12	4	75.0%
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?	12	0	100.0%
8.8	Did the nursing staff confirm the identity of a patient prior to the delivery or administration of medication(s)?	3	0	100.0%
8.9	Did the same medication nurse who administers the nurse administered/direct observation therapy medication prepare the medication just prior to administration?	2	0	100.0%
8.10	Did the medication nurse directly observe the patient taking nurse administered/direct observation therapy medication?	2	0	100.0%
8.11	Did the medication nurse document the administration of nurse administered/direct observation therapy medications on the *Medication Administration Record* once the medication was given to the patient?	2	0	100.0%
8.12	Is nursing staff knowledgeable on the Medication Error Reporting procedure?	2	0	100.0%

8.13	Are refrigerated drugs and vaccines stored in a separate refrigerator that does not contain food or laboratory specimens?	1	0	100.0%
8.14	Does the health care staff monitor and maintain the appropriate temperature of the refrigerators used to store drugs and vaccines twice daily?	60	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:			**97.5%**

Comments:

Question 8.1 The nurse auditor reviewed 16 electronic health records of patients who were prescribed chronic care medications, of which 4 patient records indicated the facility failed to administer the patients' chronic care medications within the required time frame. All four patients had run out of their first 30 day supply before they received their refills.

Question 8.2 and 8.3 None of the patients randomly selected for the sample refused their KOP, or nurse administered/direct observation therapy medications during the audit review period.

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

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

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

Comments:

Question 9.1 through 9.6 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?	8	1	88.9%

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?	8	0	100.0%
10.3	Upon the patient's return from the specialty services appointment, did the registered nurse notify the primary care provider of any immediate medication or follow-up requirements provided by the specialty consultant?	4	1	80.0%
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?	3	5	37.5%
	Overall Percentage Score:			**76.6%**

Comments:

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

Question 10.3 The nurse auditor reviewed ten electronic health records of patients who returned from specialty care appointments of which five did not meet the criteria for evaluation. Of the remaining five records reviewed, one record was missing documentation of the nursing staff contacting the specialty care provider for the missing consultation report.

Question 10.4 The nurse auditor reviewed eight electronic health records of which five showed the primary care provider did not complete follow-up appointments with the patients 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?	19	1	95.0%
11.2	*For all patients:* Were patients offered an influenza vaccination for the most recent influenza season?	10	0	100.0%
11.3	*For all patients 50 to 75 years of age:* Were the patients offered colorectal cancer screening?	2	3	40.0%
11.4	*For female patients 50 to 74 years of age:* Were the patients offered a mammography at least every two years?	Not Applicable		
11.5	*For female patients 21 to 65 years of age:* Were the patients offered a Papanicolaou test at least every three years?	Not Applicable		
	Overall Percentage Score:			**78.3%**

Comments:

Question 11.1 The nurse auditor reviewed 20 electronic health records and found 1 was missing CDCR Form 7331, *Tuberculin Testing/Evaluation Report* showing results of a tuberculosis symptom screening.

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

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

12. Emergency Medical Response/Drills & Equipment		**Yes**	**No**	**Compliance**
12.1	Did the facility conduct emergency medical response drills quarterly on each shift when medical staff was present during the most recent full quarter?	3	0	100.0%

12.2	Did a registered nurse, a mid-level provider, or a primary care provider respond within eight minutes after emergency medical alarm was sounded?	12	0	100.0%
12.3	Did the facility hold an Emergency Medical Response Review Committee meeting a minimum of once per month?	4	0	100.0%
12.4	Did the Emergency Medical Response Review Committee perform timely incident package reviews that included the use of required review documents?	10	2	83.3%
12.5	Is the facility's clinic Emergency Medical Response Bag secured with a seal?	90	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?	0	1	0.0%
12.7	Was the Emergency Medical Response Bag inventoried at least once a month?	3	1	75.0%
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:			**75.8%**

Comments:

Question 12.4 A review of the EMRRC meeting minutes for 12 EMRRC meetings held during the audit review period of January through April 2018 showed the facility failed to discuss two actual emergency medical responses that occurred on February 24 and 25, respectively, during the EMRRC meeting on February 26, 2018. Actual emergency medical responses or drills should be discussed at EMRRC meetings immediately following the incidents. These incidents were discussed late, during the EMRRC meeting held on March 12, 2018.

Question 12.6 During the onsite audit, the NCPR auditor reviewed the EMR bag check log for the audit review period and found the facility staff did not re-supply and re-seal the EMR bag on the same day following an EMR drill on March 5, 2018, that warranted opening of the EMR bag.

Question 12.7 During the onsite audit, the NCPR auditor's review of the EMR bag log for the audit review period showed the facility staff failed to inventory the EMR bag during March 2018.

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

Question 12.15 The facility does not have a designated Narcan log to document a count for Narcan at the beginning and end of each shift.

13. Clinical Environment	**Yes**	**No**	**Compliance**

13.1	Are packaged sterilized reusable medical instruments within the expiration dates shown on the sterile packaging?	Not Applicable		
13.2	If autoclave sterilization is used, is there documentation showing weekly spore testing?	Not Applicable		
13.3	Are disposable medical instruments discarded after one use into the biohazard material containers?	2	0	100.0%
13.4	Does clinical health care staff adhere to universal/standard hand hygiene precautions?	3	0	100.0%
13.5	Is personal protective equipment readily accessible for clinical staff use?	1	0	100.0%
13.6	Is the reusable non-invasive medical equipment disinfected between each patient use when exposed to blood-borne pathogens or bodily fluids?	2	0	100.0%
13.7	Does the facility utilize a hospital grade disinfectant to clean common clinic areas with high foot traffic?	1	0	100.0%
13.8	Is environmental cleaning of common clinic areas with high foot traffic completed at least once a day?	30	0	100.0%
13.9	Is the biohazard waste bagged in a red, moisture-proof biohazard bag and stored in a labeled biohazard container in each exam room?	2	0	100.0%
13.10	Is the clinic's generated biohazard waste properly secured in the facility's central storage location that is labeled as a "biohazard" area?	1	0	100.0%
13.11	Are sharps disposed of in a puncture resistant, leak-proof container that is closeable, locked and labeled with a biohazard symbol?	2	0	100.0%
13.12	Does the facility store all sharps in a secure location?	1	0	100.0%
13.13	Does health care staff account for and reconcile all sharps at the beginning and end of each shift?	89	1	98.9%
13.14	Is the facility's biomedical equipment serviced and calibrated annually?	6	0	100.0%
13.15	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	19	0	100.0%
13.16	*For Information Purposes Only (Not Scored):* Does the clinic visit location ensure the patient's visual and auditory privacy?	Not Scored		
	Overall Percentage Score:			**99.9%**

Comments:

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

Question 13.13 During the onsite audit, the NCPR auditor's review of 90 (30 days x 3 shifts) entries in the sharps log for April 2018 showed the sharps were not accounted for and reconciled by the nursing staff at the end of second watch on April 14, 2018.

14. Quality of Nursing Performance	Yes	No	Compliance
The quality of nursing performance is assessed during case reviews, conducted by NCPR auditor and is not applicable for the quantitative review portion of the health care monitoring audit. The methodology used 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 physician auditor and is not applicable for the quantitative review portion of the health care monitoring audit. The methodology used 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 patients housed at the facility, the IAC executive body, and a random sample of patients housed in general population (GP). The results of the interviews conducted at SMCCF 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:

During the onsite audit, the clinicians and HPS auditor interviewed four IAC members and ten patients, of which three were designated as part of the Disability Placement Program (DPP). The physician auditor interviewed the IAC members regarding their overall opinion of the quality of health care services provided at SMCCF. The IAC members described the medical access to care, delivery and provider, and nursing interaction as excellent. There was no expression of problems with medication delivery, access

to outside services, and overall health care delivery. When inquired by the physician auditor regarding mental health services at the facility, the IAC members stated all mental health services are provided offsite and stated it would be really beneficial if the facility could provide this service at least weekly onsite. The auditors also asked the members if the education literature pinned on the walls in the housing units was helpful to the patients. This was asked because while visiting the housing units, the auditors noted these materials were not presented in an orderly manner and not all literature was clearly visible. The IAC members stated it would be beneficial to some patients if these were displayed in an orderly manner.

The HPS auditor interviewed the three DPP patients housed at SMCCF. One patient was mobility impaired and had a metal plate implanted in his shin. He has been provided with a cane and mobility vest, both of which were utilized at the time of the interview. The other two patients were hearing impaired and used hearing aids. The auditor established effective communication by speaking slowly and at times loudly, confirming the two hearing impaired patients understood the questions being asked. During the interview, the hearing impaired patients stated, they have never had problems in receiving new batteries for their hearing aids upon request. All three patients interviewed did not express any concern and were satisfied with the accommodations provided to them by health care staff at SMCCF. The DPP patients also stated they were aware of the health care grievance, sick call, and request for reasonable accommodation processes at SMCCF.

Seven additional patients were interviewed for their knowledge of the facility's sick call and health care grievance processes. All seven patients were aware of the sick call process; however, five of the seven patients were not knowledgeable of the health care grievance process. The auditor explained the process to all five patients and informed them about the forms to use in order to submit a grievance, and the assistance available to them from health care staff in case they have difficulty in completing the forms. The patients were also informed about the grievance response time frames. None of the seven patients expressed any concerns with the quality of services provided to them by SMCCF health care staff.

APPENDIX C – BACKGROUND and AUDIT METHODOLOGY

1. BACKGROUND AND PROCESS CHANGES

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

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

In accordance with the Receiver's directive, the CCHCS Field Operations and Private Prison Compliance and Monitoring Unit's (PPCMU) management plan on conducting two rounds of audits in a calendar year for the private facilities Modified Community Correctional Facilities (MCCF) and the California out-of-state correctional facilities (COCF) currently in contract with CDCR. During the first six months of the calendar year, the PPCMU audit team will conduct an annual 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 clinical auditors. The clinical 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 NCPR auditors perform two types of case reviews:

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

   b. Focused reviews – Five cases are selected from the audit review period of which three cases consist of patients who were transferred into the facility and two cases consist of patients transferred out of the facility with pending medical, mental health, or dental appointments. The cases are reviewed for appropriateness of initial nurse health screening, referral, timeliness of provider evaluations, continuity of care, and completeness of the transfer forms.

2. *Physician Case Review*

   The physician 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.