CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Contract Facility

Health Care Monitoring Audit

La Palma Correctional Center (LPCC)

December 8-10, 2014

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DATE OF REPORT

February 27, 2015

INTRODUCTION

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

As one of several means to ensure the prescribed health care standards are provided, CCHCS staff developed a means 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 (DPP) list, and other relevant health care documents, and an onsite assessment involving staff and inmate interviews, as well as, a tour of all health care services points within the facility.

This report provides the findings associated with the audit conducted from December 8 through 10, 2014, at La Palma Correctional Center (LPCC), which is located in Eloy, Arizona. At the time of the audit, CDCR's Weekly Population Count, dated December 5, 2014, indicated a budgeted bed capacity of 8,988 out-of-state beds. The LPCC has a design capacity of 3,146 population beds, of which 3,068 are occupied with CDCR inmates. This facility has an American Correctional Association accreditation.

EXECUTIVE SUMMARY

From December 8 through 10, 2014, Field Operations staff conducted an onsite audit at LPCC. The audit team consisted of the following personnel:

Grace Song, Medical Doctor, Physician, and Surgeon
Greg Hughes, Nurse Consultant Program Review
Kala Srinivasan, Health Program Specialist I (HPS I)
Christopher Troughton, HPS I

The audit included two primary components: a *quantitative* analysis of established performance measures, and a *qualitative* analysis of operational processes. The end product of the quantitative portion of the audit is a compliance percentage, while the end product of the qualitative analysis is a narrative summary of findings.

The following summary table entitled 'Quantitative Compliance Ratings' illustrates the overall compliance rating and how the rating was calculated. The overall rating represents the percentage of the total points awarded out of the total points possible. Points are awarded in three categories; Administration, Delivery, and Operations, which are broken down further into the individual chapters of the audit.

Based on the quantitative audit, LPCC achieved an overall compliance rating of **89.5%** with a rating of 96.5% in Administration, 87.0% in Delivery, and 90.5% in Operations**.** Comparatively speaking, during the previous audit (conducted May 5 through 7, 2014) the overall quantitative score for LPCC was 96.0%, indicating a decline of 6.5 percentage points. Table 2 on the following page provides a comparative overview of the facility's performance during the initial and follow-up audits, as well as a trend measurement to show improvement, decline, or sustainability.

The completed quantitative audit, summary of qualitative findings, and CAP request are attached for your review.

TABLE 1

Quantitative Compliance Ratings	Points Possible	Points Awarded	Score	CAP Required
Administration				
1. Administration	30.0	30.0	100.0%	No
2. Access to Healthcare Information	60.0	60.0	100.0%	No
6. Continuous Quality Improvement (CQI)	60.0	50.0	83.3%	Yes
13. Licensure and Training	160.0	158.7	99.2%	No
15. Monitoring Logs	150.0	140.0	93.3%	No
20. Staffing	150.0	150.0	100.0%	No
Administration Sub Score:	**610.0**	**588.7**	**96.5%**	
Delivery				
5. Chronic Care	90.0	48.0	53.3%	Yes
7. Diagnostic Services	120.0	81.0	67.5%	Yes
8. Medical Emergency Services/Drills	270.0	249.5	92.4%	No
9. Medical Emergency Equipment	530.0	523.2	98.7%	No
14. Medication Management	420.0	347.5	82.7%	Yes
17. Patient Refusal of Medical Treatment	20.0	20.0	100.0%	No
18. Sick Call	300.0	226.1	75.4%	Yes
19. Specialty/Hospital Services	240.0	236.3	98.5%	No
Delivery Sub-Score:	**1,990.0**	**1,731.6**	**87.0%**	
Operations				
3. ADA Compliance	60.0	60.0	100.0%	No
4. Chemical Agent Exposure	10.0	10.0	100.0%	No
10. Grievance/Appeal Procedure	50.0	50.0	100.0%	No
11. Infection Control	290.0	282.9	97.6%	No
12. Initial Intake Screening/Health Appraisal	240.0	177.0	73.8%	Yes
16. Observation Unit	90.0	90.0	100.0%	No
Operations Sub-Score:	**740.0**	**669.9**	**90.5%**	
21. Inmate Interviews (not rated)				
Final Score:	**3,340.0**	**2,990.2**	**89.5%**	

NOTE: For specific information regarding any non-compliance findings indicated in the chart above, please refer to the corrective action plan request (located on page 8 of this report), or to the detailed quantitative findings (located on page 10).

TABLE 2

Quantitative Performance Comparison	Audit I 05/2014	Audit II 12/2014	Variance Increase/(Decrease)
1. Administration	100.0%	100.0%	0.0%
2. Access to Health Care Information	100.0%	100.0%	0.0%
3. ADA Compliance	100.0%	100.0%	0.0%
4. Chemical Agent Exposure	100.0%	100.0%	0.0%
5. Chronic Care	100.0%	53.3%	-46.7%
6. Continuous Quality Improvement (CQI)	100.0%	83.3%	-16.7%
7. Diagnostic Services	71.1%	67.5%	-3.6%
8. Medical Emergency Services/Drills	97.2%	92.4%	-4.8%
9. Medical Emergency Equipment	99.8%	98.7%	-1.1%
10. Grievance/Appeal Procedure	100.0%	100.0%	0.0%
11. Infection Control	100.0%	97.6%	-2.4%
12. Initial Intake Screening/Health Appraisal	99.4%	73.8%	-25.6%
13. Licensure and Training	97.6%	99.2%	1.6%
14. Medication Management	89.9%	82.7%	-7.2%
15. Monitoring Logs	80.3%	93.3%	13.0%
16. Observation Unit	100.0%	100.0%	0.0%
17. Patient Refusal of Health Care Treatment/ No Show	91.5%	100.0%	8.5%
18. Sick Call	96.9%	75.4%	-21.5%
19. Specialty/Hospital Services	96.3%	98.5%	2.2%
20. Staffing	100.0%	100.0%	0.0%
Overall Score:	96.0%	89.5%	-6.5%

METHODOLOGY

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

The *quantitative* analysis uses a standardized audit instrument, which measures compliance against established standards at each facility. The audit instrument calculates an overall percentage score, as well as similar individual ratings for each chapter of the instrument. Additionally, a brief narrative is provided addressing each standard being measured which received less than a 100% compliance rating.

The *qualitative* portion of the audit evaluates areas of clinical access and the provision of clinically appropriate care which tends to defy numeric definition, but which nonetheless have a potentially significant impact on performance. Some examples of such areas are collaboration between entities, and efficiency of processes. This portion of the audit is primarily accomplished via interviews of key facility personnel, which also includes medical staff for the overall purpose of identifying staffing practices which may be adversely affecting clinical performance. The overall end product of the qualitative analysis is a summary of qualitative findings, which identifies any areas of concern, as well as any available data supporting the concern(s).

The audit utilizes the Inmate Medical Services Policies and Procedures (IMSP&P) as a means to identify a standard from which to measure health care delivery at contracted facilities. The audit consists of 20 chapters to gauge performance within the facility. Target performance benchmark for clinical access and the provision of clinically appropriate care are defined as follows:

- 85% for each chapter within the final audit instrument.

Compliance and non-compliance are defined as follows:

- Compliance - the facility is fully meeting the requirement.
- Non-compliance - the facility is *not* fully meeting the requirement.

The methodology utilized by the audit team for determining compliance with each standard measure in the audit is described in detail in the *Instruction Guide for the Contracted Facilities Health Care Operations Monitoring Audit*.

The scoring of each standard contained within the audit is weighted according to potential severity of impact should the facility be found out of compliance with the standard. The scoring standards are as follows:

Point Value	Weighting Criteria
50.0	Failing to meet the requirement poses *the greatest* medical risk to inmate-patients.
30.0	Failing to meet the requirement poses a *moderate* medical risk to inmate-patients.
10.0	Failing to meet the requirement poses *minimal* medical risk to inmate-patients.

At the conclusion of the audit, a compliance value is assigned to each question based on the data gathered during the audit. That value is expressed as a percentage. The total points possible for a given question is then multiplied by the percentage of compliance to yield the total points awarded. The final

scores for each question and the compliance value percentages are rounded to the nearest tenth. For example, for a question valued at 50.0 total possible points, where the compliance rating is 96.0%, the resultant score for that question becomes 50.0 x 0.96 = 48.0 points.

The full point value is awarded only in cases of 100% compliance. Any questions for which the facility demonstrates compliance of less than 100% are assigned partial compliance scores by the method shown above.

Chapter scores are calculated by dividing the total points assessed in each chapter by the total points possible for that chapter, and multiplying by 100 to yield an overall percentage. For example, a chapter with 10 questions may have a total of 180.0 possible points. If during an audit a facility earns 140.0 of those points, the chapter score will be calculated as follows: 140.0 ÷ 180.0 = 0.777 × 100 = 77.8%.

A CAP will be required for all deficiencies within any chapter with a final score below 85.0%, as well as for qualitative concerns which rise to a level at which they are tangibly affecting Clinical performance.

The 20 ratable chapters of the *Final Audit Report* have been categorized into three major operational areas: **administration**, **delivery,** and **operations**. These overall operational areas are sub-totaled, and sub-scored, on the Qualitative Analysis Findings section of the final report. This is provided for the informational benefit of the facility. As with individual chapter scores, the compliance percentage for each operational area is calculated by dividing the total points earned by the total points available in that area, and multiplying by 100 to yield a percentage. The final overall quantitative score is calculated by the same method.

Scoring for Non-Applicable Questions and Double-Failures:
For questions that are not applicable to the facility being audited, or where a single deviation from policy would result in multiple question failures, the weighted values of such questions are subtracted from the applicable points for the component.

CORRECTIVE ACTION PLAN REQUEST

The chart below reflects all quantitative analysis items where the facility was rated non-compliant, as well as any qualitative analysis items requiring a response from the facility. The audit results for LPCC require the facility to develop a CAP for the following specific items. The facility's response must be received no later than 30 days from the date of this report; specifically **March 30, 2015.**

Corrective Action Items – La Palma Correctional Center, Eloy, AZ	
Chapter 5, Question 1	The inmate-patients' chronic care (CC) follow up visits are not consistently completed within the 90-day timeframe, or as ordered by the Licensed Independent Provider (LIP).
Chapter 5, Question 3	The inmate-patients who are a no-show or those that refuse chronic care medications half of the time or more, in a one week period are not being referred to the LIP.
Chapter 6, Question 2	The facility's Continuous Quality Improvement (CQI) committee meeting minutes do not identify a quorum per the approved CQI Plan.
Chapter 7, Question 1	The diagnostic tests for inmate-patients are not consistently completed within the timeframe specified by the LIP.
Chapter 7, Question 2	The LIP is not consistently reviewing, initialing, and dating all inmate-patient diagnostic reports within the specified timeframe.
Chapter 7, Question 4	Inmate-patients are not consistently receiving written notification of diagnostic test results within the specified timeframe.
Chapter 12, Question 1	The inmate-patients are not consistently receiving an initial intake screening by licensed health care staff upon arrival at the facility.
Chapter 12, Question 2	Inmate-patients, referred to the LIP by the nursing staff during initial intake screening, are not consistently seen within the specified timeframes.
Chapter 12, Question 3	Inmate-patients arriving at the facility with existing medication orders are not consistently being seen by the LIP or their medications are not being ordered within eight hours of their arrival.
Chapter 12, Question 5	Inmate-patients are not consistently receiving a complete health appraisal by the LIP within 14 days of arrival at the facility.
Chapter 12, Question 6	Inmate-patients, who were enrolled in a Chronic Care (CC) clinic at a previous facility, are not consistently referred by the Registered Nurse (RN) to the LIP for a CC follow-up.
Chapter 12, Question 7	Inmate-patients are not consistently receiving a complete screening for the signs and symptoms of Tuberculosis upon their arrival at the facility.
Chapter 14, Question 2	The prescribing LIP is not documenting that they explained the medication to the inmate-patient.
Chapter 14, Question 3	Inmate-patients, who do not show or refuse their prescribed medication 50% of the time or more, are not consistently being referred to the LIP.

Chapter 14, Question 4	Inmate-patients, referred to the LIP for medication non-compliance, are not seen by the LIP within the specified timeframe.
Chapter 14, Question 7	The Licensed Practical Nurse (LPN)/RN is not consistently documenting the medication administered on the Medication Administration Record once the medication is given to the inmate-patient.
Chapter 18, Question 2	The nursing staff is not consistently reviewing the sick call slips within one day of receipt.
Chapter 18, Question 5	The nursing staff is not following the Patient Care Protocol to address an inmate-patient's chief complaint and is not consistently documenting the chief complaint in the Progress Note on the inmate-patient's sick call form.
Chapter 18, Question 7	Inmate-patients referred by the RN to the LIP for follow-up are not consistently seen by the LIP within the specified timeframes.
Chapter 18, Question 9	Inmate-patients who present to sick call three or more times in a month for the same complaint are not being referred by the RN to the LIP.
*Qualitative Action Item #1 (Chapter 8, Question 4)	When inmate-patients return from a community hospital emergency department, RN is not consistently documenting that they reviewed the inmate-patient's discharge plan.
*Qualitative Action Item #2 (Chapter 8, Question 11)	The Emergency Medical Response Review Committee meeting minutes indicate that The Advanced Cardiac Life Support (ACLS) certified health care staff is not consistently arriving on-site within eight minutes of sounding the emergency medical alarm.
*Qualitative Action Item #3 (Chapter 9, Question 12)	Oxygen tank in compound three was only one fourth full, rendering it non-operational.
*Qualitative Action Item #4 (Chapter 11,Question 12)	Environmental cleaning of all "high touch surfaces" is not being completed at least once per day in the medical clinics.
Qualitative Action Item #6 (Chapter 13, Question 3)	One of the newly hired RN did not have a current ACLS certification. Per the CCA contractual guidelines, all RNs hired at this facility are required to maintain their ACLS certifications current.
* Qualitative Action Item #5 (Chapter 15, Question 4)	Documentation in the *Chronic Care Monitoring Log* shows that the inmate-patients are not consistently seen by the LIP within the specified timeframes set forth in the Chronic Care policy.

*Qualitative action items 1 through 5 are failed questions within passing (85% or higher) quantitative chapters.

QUANTITATIVE FINDINGS - DETAILED BY CHAPTER

Chapter 1: Administration	Point Value	Points Awarded
1. Do all health care staff have access to the contractor's health care policies and procedures?	10.0	10.0
2. Do all health care staff have access to health care operational procedures?	10.0	10.0
3. Do health care staff know where and how to access the contractor's health care policies and procedures and health care operational procedures?	10.0	10.0
Final Scoring:	30.0	30.0
		100%

CHAPTER 1 COMMENTS

None.

Chapter 2: Access to Health Care Information	Point Value	Points Awarded
1. Does the treating physician have access to the inmate-patient's CCHCS Electronic Unit Health Record (eUHR)?	10.0	10.0
2. Are loose documents filed and scanned into the health record daily?	10.0	10.0
3. Does the facility have and maintain a Release of Information (ROI) log?	10.0	10.0
4. Does the ROI log contain all required information?	10.0	10.0
5. Are all written inmate-patient requests for health care information documented on a *Patient Access to Medical Record Form* or similar form?	10.0	10.0
6. Are all written inmate-patient requests for health care information filed into the Medico-Legal or Miscellaneous section of the health record?	10.0	10.0
7. Are all written requests for release of health care information from a third party authorized by a current *Authorization for ROI Form* or similar form?	10.0	N/A
8. Are all written requests for release of health care information from a third party filed in the Medico-Legal or Miscellaneous section of the health record?	10.0	N/A
Final Scoring:	80.0	60.0 (60.0)
		100%

CHAPTER 2 COMMENTS

1. Questions 7 and 8 – Not applicable. There were no third party requests received during the audit review period; therefore, these questions could not be evaluated.

Chapter 3: ADA Compliance	Point Value	Points Awarded
1. Is there a local operating procedure to track and monitor Disability Placement Program (DPP) inmate-patients and their accommodation(s) to ensure the needs of disabled inmate-patients are being addressed?	10.0	10.0
2. Is there a local operating procedure for tracking the provision of health care appliances for all DPP inmate-patients to ensure health care appliances are provided in a timely manner?	10.0	10.0
3. Is there a local operating procedure for tracking the repair of health care appliances for all DPP inmate-patients to ensure health care appliances are provided in a timely manner?	10.0	10.0

4. Is there a local operating procedure to provide an interim accommodation while an appliance is ordered, repaired, or in the process of being replaced?	10.0	10.0
5. Is there a local operating procedure explaining how the facility adds or removes an inmate-patient from the DPP list?	10.0	10.0
6. Is there a local operating procedure explaining how the facility ensures and documents the establishment of effective communication between health care staff and an inmate-patient during each clinical encounter?	10.0	10.0
Final Scoring:	60.0	60.0
		100%

CHAPTER 3 COMMENTS

None.

Chapter 4: Chemical Agent Exposure	**Point Value**	**Points Awarded**
1. Does custody staff consult with a Registered Nurse (RN) or Licensed Independent Practitioner (LIP) before using a controlled chemical agent on an inmate?	10.0	N/A
2. Was the inmate-patient offered decontamination by the facility staff?	10.0	10.0
3. Does facility staff provide directions on how to self-decontaminate if inmate-patients refuse decontamination by facility staff?	10.0	N/A
4. If the inmate-patient refused decontamination, did health care staff document that he was monitored every 15 minutes for a minimum of 45 minutes?	10.0	N/A
Final Scoring:	40.0	10.0 (10.0)
		100%

CHAPTER 4 COMMENTS

1. Question 1 – Not applicable. There was no controlled use of a chemical agent on an inmate during the audit review period; therefore, this question was not evaluated.
2. Questions 3 and 4 – Not applicable. There were no inmate-patients who refused decontamination during the audit review period; therefore, these questions were not evaluated.

Note: Question 2– This question has been evaluated based on incidents of uncontrolled use of chemical agent on inmate-patients during the audit period.

Chapter 5: Chronic Care	**Point Value**	**Points Awarded**
1. Was the inmate-patient's chronic care follow-up visit completed within the 90-day or less timeframe, or as ordered by the LIP?	30.0	18.0
2. Did the LIP provide health care education to inmate-patients regarding their chronic care condition during the last Chronic Care Clinic (CCC) follow-up visit?	30.0	30.0
3. If an inmate-patient did not show or refused their chronic care medication half of the time or more in a one-week period during the audited month was a referral made to a LIP?	30.0	0.0

4. If an inmate-patient did not show or refused their chronic care medication half of the time or more in a one-week period during the audited month did the LIP see the inmate-patient within seven days of the referral?	30.0	N/A
Final Scoring:	120.0	48.0 (90.0)
		53.3%

CHAPTER 5 COMMENTS

1. Question 1 – Out of five inmate-patient Electronic Medical Records (EMRs) reviewed for chronic care follow-up visits, three inmate-patients were seen within the 90 day timeframe. This equates to 60.0% compliance. This is a significant decline from the previous audit rating of 100% compliance.
2. Question 3 – Out of five inmate-patient EMRs reviewed, two inmate-patients did not show or refused their chronic care medication half of the time or more in a one-week period. None of these inmate-patients were referred to the LIP for medication non-compliance. This equates to 0.0% compliance.
3. Question 4 – Not applicable. Since the two inmate-patients were not referred to the LIP for medication non-compliance as shown in question 3, this question could not be evaluated. Under the double-failure rule, the points for this question have therefore been removed from the total available points and the question rendered non-applicable.

Chapter 6: Continuous Quality Improvement (CQI)	**Point Value**	**Points Awarded**
1. Does the facility have an approved CQI Plan?	10.0	10.0
2. Does the facility CQI Committee ensure a quorum is established per the approved CQI Plan?	10.0	0.0
3. Is there documentation to support the CQI Committee meets at least quarterly?	10.0	10.0
4. Does the documentation of the CQI monitoring activity include the *Aspects of Care Monitoring* form, or similar form?	10.0	10.0
5. Does the facility complete an analysis for each identified "opportunity for improvement" as listed on the *Aspects of Care Monitoring* form, or similar form?	10.0	10.0
6. Is there a documented action and follow-up plan for each identified "opportunity for improvement"?	10.0	10.0
Final Scoring:	60.0	50.0
		83.3%

CHAPTER 6 COMMENTS

1. Question 2 – The facility has not established a quorum per the approved CQI Plan. This equates to 0.0% compliance. This is a significant decline from the previous audit rating of 100% compliance.

Chapter 7: Diagnostic Services	**Point Value**	**Points Awarded**
1. Was the diagnostic test provided to the inmate-patient within the timeframe specified by the LIP?	30.0	12.0
2. Does an LIP review, initial, and date an inmate-patient's diagnostic reports within two days of receipt?	30.0	24.0
3. Was the inmate-patient seen by the LIP for a follow-up visit for a clinically significant diagnostic test result within 14 days, or as clinically indicated, from the date the test results were reviewed by the LIP?	30.0	30.0

4. Was the inmate-patient given written notification of the diagnostic test results within two days of receipt?	30.0	15.0
Final Scoring:	120.0	81.0
		67.5%

CHAPTER 7 COMMENTS

1. Question 1 –Of the five inmate-patients that were prescribed diagnostic tests, two inmate-patients were provided diagnostic tests within the timeframe specified by the LIP. This equates to 40.0% compliance. This is a significant decline from the previous audit rating of 100% compliance.
2. Question 2 – Of the five inmate-patients that were prescribed diagnostic tests, four inmate-patients' diagnostic reports were reviewed by LIP within two days of receipt. This equates to 80.0% compliance. Although the results indicate a marginal improvement from previous audit rating of 52.6% compliance, this finding remains unresolved from the previous two audits.
3. Question 4 – Of the five inmate-patients that were prescribed diagnostic tests, one inmate-patient was hospitalized prior to notification timeframe rendering the case non-applicable. Out of the remaining four inmate-patients, two were given written notification of diagnostic tests within two days of receipt. This equates to 50.0% compliance. Although the results indicate a marginal improvement from the previous audit rating of 31.6% compliance, this issue remains unresolved from the previous two audits.

Chapter 8: Medical Emergency Services/Drills	**Point Value**	**Points Awarded**
1. Does the facility have a current Medical Emergency Response procedure?	10.0	10.0
2. Does the facility's local operating procedure pertaining to medical emergencies/response contain instructions on how to communicate, respond, and transport inmate-patients during medical emergencies?	30.0	30.0
3. Does the facility's local operating procedure contain instructions on how to obtain Emergency Medical Services (EMS) transportation 24 hours a day, seven days a week?	30.0	30.0
4. When inmate-patients return from a community hospital emergency department, does an RN document their review of the inmate-patient's discharge plan?	30.0	17.1
5. When inmate-patients returns from a community hospital emergency department, does an RN document the completion of a face-to-face evaluation of the inmate-patient?	30.0	27.9
6. When an inmate-patient returns from a community hospital emergency department, does the inmate-patient receive a follow-up appointment with an LIP within five calendar days of discharge or sooner as clinically indicated from the day of discharge?	30.0	30.0
7. Is there documentation that the Emergency Response Review Committee has met at least once a month?	10.0	10.0
8. In the documentation of the Emergency Response Review Committee meetings, does the committee discuss and/or implement a quality improvement action after reviewing the results of an emergency medical response and/or emergency medical response drill?	10.0	10.0
9. Does the facility conduct quarterly emergency medical response (man-down) drills on each shift?	30.0	30.0
10. During emergency medical response and/or drills, is a Basic Life Support (BLS) certified staff member arriving on-site within four minutes of sounding the emergency medical alarm?	30.0	30.0
11. During emergency medical response and/or drills, is an Advanced Cardiac Life Support (ACLS) certified health care staff member arriving on-site within eight minutes of sounding the emergency medical alarm?	30.0	24.5
Final Scoring:	270.0	249.5
		92.4%

CHAPTER 8 COMMENTS

1. Question 4 – Out of 14 inmate-patients returning from a community emergency department visit, 8 inmate-patients' EMR had documentation of RN's review of the discharge plan. This equates to 57.1% compliance. This is a decline from the previous audit rating of 75% compliance. This issue remains unresolved from the previous audit.
2. Question 5 – Out of 14 inmate-patients returning from an emergency department visit, 13 inmate-patients' EMRS had documentation of a face-to-face assessment by an RN. This equates to 92.9% compliance. This is a slight decline from the previous audit rating of 100% compliance.
3. Question 11 – Out of 22 emergency medical responses/drills conducted during the previous quarter, 18 drill reports had documentation of an ACLS certified health care staff arriving onsite within 8 minutes of sounding the medical alarm. This equates to 81.8% compliance. This is a decline from the previous audit rating of 100% compliance.

Chapter 9: Medical Emergency Equipment	**Point Value**	**Points Awarded**
1. For each shift, do staff document that all Emergency Medical Response Bags in each clinic are secured with a seal?	30.0	30.0
2. Is there documentation, after each medical emergency, that all Emergency Me*dical Response Bags in each clinic are re-supplied and re-sealed?*	30.0	30.0
3. *Is there documentation, on eac*h shift, that all Medical Emergency Crash Carts are secured with a seal?	50.0	50.0
4. Is there documentation, after each medical emergency, that all Medical Emergency Crash Carts are re-supplied and re-sealed?	30.0	N/A
5. Does the facility have a functional Defibrillator with Cardiac Monitor?	50.0	50.0
6. Is there documentation that the Defibrillator with Cardiac Monitor in each clinic is checked every shift for operational readiness?	30.0	30.0
7. Does the facility have a functional 12 Lead Electrocardiogram (EKG) machine with electrode pads?	50.0	50.0
8. Is there documentation that the 12 Lead EKG machine with electrode pads in each clinic is checked every shift for operational readiness?	30.0	30.0
9. Does the facility have functional Portable suction?	50.0	50.0
10. Is there documentation that the Portable suction in each clinic is checked every shift for operational readiness?	30.0	30.0
11. Does the facility have oxygen tanks?	50.0	50.0
12. Is there documentation that the oxygen tanks in each clinic is checked every shift for operational readiness (at least three-quarters full)?	30.0	24.0
13. Does the facility have a contract for routine oxygen tank maintenance service?	30.0	30.0
14. Is there documentation that the Automated External Defibrillator (AED) in each clinic is checked every shift for operational readiness?	30.0	30.0
15. Are first aid kits located in designated areas?	10.0	10.0
16. Do the first aid kits contain all required items?	10.0	9.2
17. Are spill kits located in the designated areas?	10.0	10.0
18. Do the spill kits contain all required items?	10.0	10.0
Final Scoring:	560.0	523.2 (530.0)
		98.7%

CHAPTER 9 COMMENTS

1. Question 4 – Not applicable. The documentation in the EMRRC meeting minutes did not indicate that the crash carts were utilized during any of the emergency responses or drills that occurred during the previous quarter.
2. Question 12 – All though the facility had documentation to validate that the oxygen tanks in all clinics were checked on each shift, upon inspecting a total of five oxygen tanks for operational readiness, only four tanks were operational and more than three-fourths full. This equates to 80.0% compliance. This is a decline from the previous audit rating of 100% compliance.
3. Question 16 – Out of 24 first aid kits inspected, 22 had all the required items. The first aid kits in Pima and Hopei units did not have tape. This equates to 91.7% compliance. With regard to Hopei unit this issue remains unresolved from the previous two audits.

Chapter 10: Grievance/Appeal Procedure	**Point Value**	**Points Awarded**
1. Does the inmate-patient handbook or similar document explain the grievance/appeal process?	10.0	10.0
2. Are CDCR Forms 602 HC, *Patient-Inmate Health Care Appeal*, readily available to inmate-patients while housed in all housing units?	10.0	10.0
3. Are inmate-patients able to submit the CDCR-602 HC forms on a daily basis in secured/locked boxes in all housing units?	10.0	10.0
4. Are the First Level Health Care Appeals being processed within specified timeframes?	10.0	10.0
5. Does the Appeals Coordinator log all screened/rejected appeals?	10.0	10.0
Final Scoring:	50.0	50.0
		100%

CHAPTER 10 COMMENTS

None.

Chapter 11: Infection Control	**Point Value**	**Points Awarded**
1. Does the facility have an Infection Control Plan that meets CCHCS guidelines?	30.0	30.0
2. Does the facility have a Bloodborne Pathogen Exposure Control Plan?	30.0	30.0
3. Are packaged sterilized reusable instruments within the expiration date?	10.0	10.0
4. When autoclave sterilization is used, is there documentation showing weekly spore testing?	30.0	30.0
5. Are disposable instruments discarded after one use?	10.0	10.0
6. Are inmate-patients who come to the clinic with a potential communicable disease isolated from the rest of the inmate-patients in the clinic area?	10.0	10.0
7. Does the staff practice hand hygiene?	30.0	30.0
8. Does the facility have hand sanitizers which are maintained and available for staff use?	10.0	10.0
9. Is personal protective equipment (PPE) (i.e. gloves, masks, face shields, gowns, etc.) available for staff use?	10.0	10.0
10. Is healthcare staff following Universal Precaution measures during inmate-patient contact?	30.0	30.0
11. Is the inmate-patient clinic area cleaned after each inmate-patient use?	10.0	10.0
12. Is environmental cleaning of "high touch surfaces" completed within the medical clinic at least once a day?	10.0	2.9

13. Are biohazard materials placed in biohazard material labeled containers?	10.0	10.0
14. Are the central storage biohazard material containers emptied on a regularly scheduled basis?	10.0	10.0
15. Is the central storage area for biohazard materials labeled and locked?	10.0	10.0
16. Are sharps placed into a puncture resistant, leak-proof container that is closeable, locked, and labeled with the biohazard symbol?	10.0	10.0
17. Does the facility account for all sharps (needles, scalpels, etc.) by documenting the number at the end of each shift?	10.0	10.0
18. Does the facility have a process to reconcile the sharp count if needed?	10.0	10.0
19. Does the facility secure sharps?	10.0	10.0
Final Scoring:	290.0	282.9
		97.6%

CHAPTER 11 COMMENTS

1. Question 12 –Of the seven clinic areas inspected, only two areas had documentation showing that they were cleaned daily. This equates to 28.6% compliance. This is a significant decline from the previous audit rating of 100% compliance.

Chapter 12: Initial Intake Screening/ Health Appraisal	**Point Value**	**Points Awarded**
1. Did the inmate-patient receive an Initial Intake Screening upon arrival at the facility by licensed health care staff?	30.0	20.0
2. If an inmate-patient was referred to a LIP by nursing staff during the Initial Intake Screening, was the inmate-patient seen in the specified time frame? (Immediately, within 24 hours, or within 72 hours)	30.0	15.0
3. If the inmate-patient had an existing medication order upon arrival at the facility, was the inmate-patient seen by a LIP or had their medications ordered within 8 hours of arrival?	30.0	25.0
4. If the inmate-patient was referred for a follow-up medical, dental or mental health appointment, was the appointment completed within the time frame specified by the LIP?	30.0	30.0
5. Did the inmate-patient receive a complete Health Appraisal by the LIP ≤ 14 calendar days of arrival at the facility?	30.0	15.0
6. If the inmate-patient was enrolled in a Chronic Care Clinic at a previous facility, did the RN refer the patient to LIP or Primary Care Primary Care Physician (PCP) for chronic care follow-up?	30.0	20.0
7. Did the inmate-patient receive a complete screening for the signs and symptoms of Tuberculosis (TB) upon arrival?	30.0	22.0
8. Did the inmate-patient receive a Tuberculin Skin Test (TST) evaluation upon arrival?	30.0	N/A
9. Does the initial intake screening take place in a manner that ensures inmate-patient confidentiality both visually and orally?	30.0	30.0
Final Scoring:	270.0	177.0 (240.0)
		73.8%

CHAPTER 12 COMMENTS

1. Question 1 – Out of 15 inmate-patient EMRs reviewed, 10 had documentation of the inmate-patients receiving an initial intake screening upon arrival. This equates to 66.7% compliance. This is a significant decline from the previous audit rating of 100% compliance.

2. Question 2 – Out of 15 inmate-patient EMRs reviewed, only 2 inmate-patients were referred for follow-up appointments. One inmate-patient's appointment was completed within the timeframe specified by the LIP. This equates to 50.0% compliance.

3. Question 3 – Out of 15 inmate-patient EMRs reviewed, 6 inmate-patients had existing medication orders upon arrival at the facility. Five inmate-patients' medications were ordered within the specified timeframe. This equates to 83.3% compliance. This is a decline from the previous audit rating of 100% compliance.

4. Question 5 – Out of 16 inmate-patient EMRs reviewed, 8 had documentation of the inmate-patients receiving an initial health appraisal by the LIP within 14 calendar days of arrival at the facility. This equates to 50.0% compliance. This is a significant decline from the previous audit rating of 96.6% compliance.

5. Question 6 – Out of 15 inmate-patient EMRs reviewed, only 3 inmate-patients were enrolled in a Chronic Care Clinic at a previous facility. Of the three, only two inmate-patients were referred to LIP for chronic care follow up. This equates to 66.7% compliance. This is a significant decline from the previous audit rating of 100% compliance.

6. Question 7 – Out of 15 inmate-patient EMRs reviewed, 11 received a complete screening for the signs and symptoms of TB upon arrival. One inmate-patient's screening was conducted by a LPN and the RN did not review and sign the documentation completed by the LPN. This equates to 73.3% compliance. This is a significant decline from the previous audit rating of 100% compliance.

   Question 8 – Not applicable. Due to a change in departmental policy, inmate-patients are not required to receive a Tuberculin (TB) skin Test evaluation upon arrival. Inmate-patients receive a TB Skin Test upon arrival at the CDCR reception center and then annually thereafter.

Chapter 13: Licensure and Training	**Point Value**	**Points Awarded**
1. Are copies of current licenses maintained for all health care staff?	30.0	30.0
2. Is there a centralized system for tracking expiration of license for all health care staff?	30.0	30.0
3. Are the ACLS certifications current for the Physician, Nurse Practitioner (NP), Physician Assistant (PA) and RN?	30.0	28.7
4. Are the BLS certifications current for the LPN/Custody Staff?	30.0	30.0
5. Is there a method in place to address expired certifications/licenses?	10.0	10.0
6. Is there a centralized system in place to track training provided to health care staff?	10.0	10.0
7. Is there a system in place to ensure that health care staff receives training for new or revised policies that are based on Inmate Medical Services Policy and Procedures IMSP & P requirements?	10.0	10.0
8. Did the CCA Management (on-site supervisors) receive training for new or revised policies that are based on IMSP & P requirements?	10.0	10.0
Final Scoring:	160.0	158.7
		99.2%

CHAPTER 13 COMMENTS

1. Question 3 – Out of the 23 medical staff requiring ACLS certification, 22 medical staff have current ACLS certifications. One of the recently hired RN did not have an ACLS certification at the time of the audit. Per the CCA contractual guidelines, all RNs at this facility are required to maintain current ACLS certification. Therefore, this issue must be corrected immediately. The appropriate certification documents must be presented to CDCR/CCHCS as proof of certification. This equates to 95.7% compliance. This is a slight improvement from the previous audit rating of 87.5% compliance.

Chapter 14: Medication Management	Point Value	Points Awarded
1. Was the medication administered to the inmate-patient as ordered by the LIP?	30.0	30.0
2. Did the prescribing LIP document that they explained the medication to the inmate-patient?	30.0	10.0
3. If a patient did not show or refused their prescribed medication 50% of the time or more during the audit period was a referral made to an LIP?	30.0	15.0
4. If a patient did not show or refused their prescribed medication 50% of the time or *more* during the audit period did the LIP see the patient within 7 days of the referral?	30.0	0.0
5. Does the same LPN/RN who prepares the inmate-patient medication also administer the medication?	30.0	30.0
6. Are inmate-patient medications administered on the same day that the medications are prepared?	30.0	30.0
7. Does the LPN/RN document the medication is administered on the Medication Administration Record (MAR) once the medication is given to the inmate-patient?	30.0	22.5
8. Are medication errors documented on the Incident Report-Medication Error Form?	30.0	30.0
9. Does the LPN/RN directly observe an inmate-patient taking DOT medication?	30.0	30.0
10. Does the LPN/RN check every inmate-patient's mouth, hands and cup after administering DOT medications?	30.0	30.0
11. Does the inmate-patient take all Keep on Person (KOP) medications to the designated LPN/RN prior to transfer?	30.0	30.0
12. Does the LPN/RN verify the KOP medications against the current pharmacy medication profile prior to transfer?	30.0	30.0
13. Does the transfer envelope contain a current pharmacy medication profile?	30.0	30.0
14. Does the transfer envelope contain a sufficient supply of prescription medications to cover the period of the inmate-patient transport?	30.0	30.0
Final Scoring:	420.0	347.5
		82.7%

CHAPTER 14 COMMENTS

1. Question 2 – Out of 12 inmate-patient EMRs reviewed, 4 included documentation showing that the LIP explained the new medications. This equates to 33.3% compliance. This is a significant decline from the previous audit rating of 78.6% compliance. This finding remains unresolved from the previous audit.
2. Question 3 – Out of two inmate-patients who did not show or refused their prescribed medications, only one inmate-patient was referred to the LIP. This equates to 50.0% compliance.
3. Question 4 – Out of two inmate-patients who did not show or refused their prescribed medications, none were seen by the LIP. This equates to 0.0% compliance.
4. Question 7 – Out of four medication passes (pill lines) observed, the RN documented on the MAR after administering the medication to the inmate-patient during three medication pass sessions. This equates to 75.0% compliance. This is a significant decline from the previous audit rating of 100.0% compliance.

Chapter 15: Monitoring Log	Point Value	Points Awarded
1. Are inmate-patients seen within timeframes set forth in the sick call policy?	30.0	29.8
2. Are inmate-patients seen within the timeframes set forth in the specialty care policy?	30.0	30.0
3. Are inmate-patients seen within the timeframes set forth in the emergency/hospital services policy?	30.0	27.6

4. Are inmate-patients seen within timeframes as it relates to chronic care policy?	30.0	23.0
5. Are inmate-patients seen within timeframes set forth in the initial intake screening/health appraisal policy?	30.0	29.6
Final Scoring:	150.0	140.0
		93.3%

CHAPTER 15 COMMENTS

1. Question 1 – Out of the 1,651 inmate-patients referred for a sick call appointment, 1,638 were seen within the required timeframe. This equates to 99.2% compliance. This is an improvement from the previous audit rating of 84.1% compliance.

Routine		Urgent		Emergent		Totals	
#	# within timeframe	#	# within timeframe	#	# within timeframe	#	# within timeframe
1,633	1,633	11	10	4	4	**1,651**	**1,638**

2. Question 2 – Out of 107 inmate-patients referred for a specialty care appointment, all were seen within the required timeframe. This equates to 100.0% compliance. This is a significant improvement from the previous audit rating of 54.1% compliance.

Routine		Urgent		Emergent		Totals	
#	# within timeframe	#	# within timeframe	#	# within timeframe	#	# within timeframe
104	104	3	3	0	0	**107**	**107**

3. Question 3 – Out of 37 inmate-patients sent out to community hospital for emergency services, 34 inmate-patients were seen by a LIP within the specified timeframe. This equates to 91.9% compliance. This is a slight decline from the previous audit rating of 93.8% compliance.
4. Question 4 – Out of 496 inmate-patients referred to an LIP for Chronic Care Clinic, 380 were seen within the required timeframe. This equates to 76.6% compliance. This is a decline from the previous audit rating of 89.3% compliance.
5. Question 5 – Out of 484 inmate-patients scheduled for initial health appraisal by an LIP, 477 were seen within the required timeframe. This equates to 98.6% compliance. This is a decline from the previous audit rating of 100% compliance.

Chapter 16: Observation Unit	**Point Value**	**Points Awarded**
1. Are inmate-patients checked by the nursing staff every eight hours or more as ordered by an LIP?	30.0	30.0
2. Did the LIP document daily face-to-face encounters with all inmate-patients housed in the Observation Unit?	30.0	30.0
3. Is there a functioning call system in all Observation Unit rooms?	30.0	30.0
Final Scoring:	90.0	90.0
		100%

CHAPTER 16 COMMENTS

None.

Chapter 17: Patient Refusal of Health Care Treatment/No Show	Point Value	Points Awarded
1. If an inmate-patient refuses a health care appointment/treatment, did an RN/LIP complete the CDCR Form 7225, *Refusal of Examination and/or Treatment* Form?	10.0	10.0
2. If an inmate-patient refuses a health care appointment/treatment, did an RN/LIP document their discussion of risk and benefits of refusing the appointment/treatment in the inmate-patient's Progress Notes section of the Electronic Medical Record?	10.0	10.0
3. If an inmate-patient did not show for their medical appointment, did the RN/LIP contact the housing unit supervisor to have the inmate-patient escorted to medical to speak with health care staff?	10.0	N/A
4. If an inmate-patient was a no show for a medical appointment/treatment, did the RN contact the LIP to determine if/when the inmate-patient should be rescheduled?	10.0	N/A
Final Scoring:	40.0	20.0 (20.0)
		100.0%

CHAPTER 17 COMMENTS

1. Questions 3 and 4 – Not applicable. There were no inmate-patient no-shows for medical appointments during the audit review period; therefore, these questions were not evaluated.

Chapter 18: Sick Call	Point Value	Points Awarded
1. Does the inmate-patient handbook or similar document explain the sick call process?	10.0	10.0
2. Is an RN reviewing all sick call request forms within one day of receipt?	30.0	22.5
3. Are inmate-patients seen and evaluated face-to-face by an RN/LIP if the sick call request form indicates an emergent health care need?	30.0	30.0
4. Are inmate-patients seen and evaluated by an RN/LIP within the next business day if the sick call request indicated a non-emergent health care need?	30.0	30.0
5. Does an RN/LIP follow the Patient Care Protocol to address an inmate-patient's chief complaint, and is the chief complaint documented in the Progress Note on the sick call request form?	30.0	15.0
6. Is the Subjective-Objective-Assessment-Plan-Education (S.O.A.P.E) section of the Patient Care Protocol/Progress Note completed by an LPN/RN?	30.0	30.0
7. If an inmate-patient was referred for follow-up to the LIP by the RN, was the inmate-patient seen within the specified timeframe?	30.0	8.6
8. If an inmate-patient was referred for follow-up by the LIP, was the inmate-patient seen within the ordered timeframe?	30.0	N/A
9. Are all inmate-patients referred to an LIP by an RN if they presented to sick call three or more times in a month for the same complaint?	30.0	0.0
10. Do the sick call visit locations provide for inmate-patient confidentiality both visually and orally in General Population (GP), Administrative Segregation (Ad Seg), and Lockdown?	30.0	30.0
11. Does nursing staff conduct daily rounds in Administrative Segregation Housing Units?	30.0	30.0
12. Are the sick call request forms readily available to inmate-patients in all housing units?	10.0	10.0
13. Are inmate-patients able to submit sick call request forms on a daily basis in secured/locked boxes in all housing units?	10.0	10.0
Final Scoring:	330.0	226.1 (300.0)
		75.4%

CHAPTER 18 COMMENTS

1. Question 2 – Out of the 20 sick call request slips reviewed, 15 were reviewed on the day of receipt. This equates to 75.0% compliance. This is a decline from the previous audit rating of 100.0% compliance.
2. Question 5 – Out of 10 inmate-patient EMRs reviewed, 5 had the chief complaint documented on the progress note and the documentation showed that the RN had addressed the inmate-patients' chief complaints. This equates to 50.0% compliance. This is a significant decline from the previous audit rating of 100.0% compliance.
3. Question 7 – Out of seven inmate-patients referred to a LIP by an RN, only two received a follow-up appointment with a LIP in a timely manner. This equates to 28.6% compliance. This is a significant decline from the previous audit rating of 78.4% compliance. This finding remains unresolved from the previous audit.
4. Question 8 – Not applicable. Out of 10 inmate-patient EMRs reviewed, none were referred for a follow-up by the LIP; therefore, this question was not evaluated.
5. Question 9 – Out of 10 inmate-patient EMRs reviewed, 1 inmate-patient had submitted 3 sick call slips for the same complaint in a month. This inmate-patient was not referred to the LIP by the RN. This equates to 0.0% compliance. This is a significant decline from the previous audit rating of 100.0% compliance.

Chapter 19: Specialty/Hospital Services	**Point Value**	**Points Awarded**
1. Are LIP requests for urgent specialty services approved or denied within 72 hours of being requested?	30.0	30.0
2. Are LIP requests for routine specialty services approved or denied within seven days of being requested?	30.0	30.0
3. Are LIPs evaluating an inmate-patient every 30 days or as specified until the routine specialty appointment occurs?	30.0	30.0
4. Are inmate-patients seen by a specialist within the timeframe specified by an LIP? (Emergent=immediately, Urgent < 14 days or Routine < 90 days)	30.0	30.0
5. Upon return from a specialty consult appointment, does an RN/LIP complete a face-to-face evaluation prior to the inmate-patient returning to their assigned housing unit?	30.0	30.0
6. When and inmate-patient returns from a specialty consult appointment, does an RN notify an LIP of any immediate medication orders or follow-up instructions provided by the specialty consultant?	30.0	26.3
7. Does an LIP review the consultant's report and see the inmate-patient for a follow-up appointment within the specified timeframe? (≤ 3 days for emergent/urgent and ≤ 14 days for routine)	30.0	30.0
8. Does all pertinent health care information accompany the inmate-patient to their specialty consult appointment?	30.0	30.0
9. When an inmate-patient is discharged from a community hospital, does an RN document their review of the inmate-patient's discharge plan?	30.0	N/A
10. When an inmate-patient is discharged from a community hospital, does the RN document their face to face evaluation of the inmate-patient prior to the inmate-patient being re-housed?	30.0	N/A
11. When an inmate-patient is discharged from a community hospital, does the inmate-patient receive a follow-up appointment with an LIP within five calendar days from the day discharged or sooner as clinically indicated?	30.0	N/A
Final Scoring:	330.0	236.3 (240.0)
		98.5%

CHAPTER 19 COMMENTS

1. Question 6 – Out of eight inmate-patients who returned with follow-up instructions or medication orders provided by the specialty consultant, the RN notified the LIP of seven inmate-patients' follow-up instructions. This equates to 87.5% compliance. This is a decline from the previous audit rating of 100.0% compliance.
2. Questions 9 through 11 – Not applicable. Out of 10 inmate-patient EMRs reviewed, none of the inmate-patients had a hospital admission; therefore, these questions were not evaluated.

Chapter 20: Staffing	**Point Value**	**Points Awarded**
1. Does the facility have the required LIP staffing complement?	30.0	30.0
2. Does the facility have the required management staffing complement?	30.0	30.0
3. Does the facility have the required RN staffing complement?	30.0	30.0
6. Does the facility have the required LPNS staffing complement?	30.0	30.0
7. Does the facility have the required Certified Medical Assistant (CMA) staffing complement?	30.0	30.0
Final Scoring:	150.0	150.0
		100%

CHAPTER 20 COMMENTS

None.

QUALITATIVE FINDINGS

As stated earlier in the report, the qualitative analysis portion of this audit attempts to specifically explore the efficacy of the facility's processes for delivering health care services. By their very nature, such processes often defy objective measurement, but are nonetheless worthy of attention and discussion. It bears repeating that although *this portion of the audit is not rated*, any concerning issues identified during the qualitative process may result in additional CAP items (see CAP request for further detail).

The audit team conducted the qualitative analysis primarily via interview of key facility personnel. At LPCC the personnel interviewed included the following:

Jim MacDonald – Warden
William Crane- Regional Medical Director
Anne Diggs – Chief Nursing Executive
James Giovino – Medical Director
J. Kristin Olson- Garewal – Licensed Independent Provider (LIP)
Melisa Clayton – Nurse Practitioner (NP)
Joseph Spizzirri – Physician Assistant (PA)
Edwin Burnett – Health Services Administrator (HSA)/Health Care Appeals Coordinator
Cecelia Fernandes – Clinical Nurse Supervisor
Brian Menghini – Clinical Nurse Supervisor
Wendy Wier – Clinical Nurse Supervisor
Jodie Clark – Registered Nurse/Continuous Quality Improvement
Benjamin Pearce – Registered Nurse/ Chronic Care
Ruth Williams- Grievance /Appeal Coordinator
Andrew Snyder – Health Information Specialist
Margaret Lopez – Medical Records Supervisor
Yvonne Lopez – Medical Records Clerk

The following narrative represents a summary of the information gleaned through interview of the above-listed personnel, as well as conclusions and inferences drawn from correlating observations and data collected during other portions of the audit. The findings are loosely categorized into two themes: *Personnel,* which focus on the collaborative/cooperative relationship between essential offices and departments within the facility; and *Operations*, which focuses on operational efficiencies, inefficiencies, best practices, and challenges observed during the audit.

SUMMARY OF QUALITATIVE FINDINGS

Subsequent to the completion of the previous audit in May 2014, there have been changes in LPCC's staffing. One of the major medical issues identified during this audit focused on an inmate-patient with testicular cancer who was misdiagnosed by the newly appointed nurse practitioner and LIP. The staff exhibited gross negligence, both in diagnosis and treatment of this inmate-patient in a timely manner. This resulted in the inmate's cancer metastasizing to other areas of his body. This issue has lead to great concern regarding the well being of the inmate population housed at LPCC. The findings related to this incident are described in the pages to follow. Although LPCC was successful in addressing many of the previous CAP items, some key deficiencies identified during the previous audit have not been resolved.

These include non-compliance with meeting timeframes, inconsistent and incomplete documentation in areas like diagnostic services, LIP sick call and chronic appointments and medication management.

Personnel

LPCC has one main clinic located adjacent to the administrative building and three satellite clinics located in compounds one, two and three. All three Administrative Segregation Units (ASU) have separate in unit clinics. The nurse auditor commenced the onsite audit by observing sick call processes, medication passes and infection control processes in all clinic locations. The nurse-auditor also interviewed the facility RNs on various medical processes. The physician-auditor observed the facility physicians and nurse practitioners' assessment of the inmate-patients during sick call and chronic care appointments and conducted a comprehensive review of clinical documentation completed by each provider in the EMR of several inmate-patients.

The HPS I-auditor visited each housing unit and interviewed the medical and custody staff to assess their knowledge of sick call and grievance/ appeal procedures. The auditor observed that the medical staff and custody staff in all housing units were knowledgeable about the sick call and grievance appeal processes and could identify the CDCR 602-HC grievance/appeal forms and the sick call forms.

All housing units had DPP binders which listed the details on DPP inmate-patients housed in the respective housing units. The custody officers could identify the DPP inmate-patients in their housing units by name and were familiar with their required accommodations.

Operations

The audit team interviewed several clinical and custody staff, as well as inmate-patients, regarding the daily operations of the facility. Below is a summary of those interviews.

Health Services Administrator (HSA): The auditors found the HSA to be knowledgeable in the areas of the daily operations of the medical clinic, emergency response and drills, health care grievance/appeals and the sick call processes. The HSA demonstrated a solid understanding of the requirements for each of these areas as specified in policy. The HSA is responsible for processing all first level health care appeals. The HSA maintains a log for all health care appeals that includes date of receipt, tracking numbers and response dates. The HSA advised the audit team that his approach to ensuring all first level health care appeals are processed in a timely manner is by scheduling inmate-patient interviews two days per week to solicit information required for responses. The HSA mentioned that recently there has been an increase in health care appeals received due to the providers denying hernia repairs. The physician-auditor advised the PA and HSA that if the inmate-patient does not appear to be in severe pain, is not disabled and/or if the condition does not impact the inmate-patient's ability to carry out his daily activities, the inmate-patient does not require surgery. However, the physician auditor emphasized the fact that the facility provider needs to make this determination only on a case by case basis after conducting appropriate clinical evaluation of the inmate-patient's symptomology.

Grievance/Appeals Coordinator: The Grievance/Appeals Coordinator exhibited a thorough understanding of the grievance/appeals process when interviewed. The Grievance/Appeals Coordinator collects and processes all inmate-patient grievances/appeals. The Coordinator maintains an electronic grievance/appeals tracking log which is used to track all inmate-patient appeals and ensure timely response. The audit team's review of the log maintained by the facility's Grievance/Appeals Coordinator confirmed that all first level health care appeals are processed and responded to in a timely manner.

ADA Coordinator: The ADA Coordinator was on vacation during this audit; however, upon the auditor's request, he presented himself for the interview. The ADA Coordinator was knowledgeable about the DPP requirements and the facility LOP for tracking and monitoring DPP inmate-patients and their accommodations. The ADA Coordinator conducts bi-monthly checks on all DPP inmate-patients to ensure their needs are being met. The Coordinator maintains a Health Care Appliance (HCA) tracking log which lists all DPP inmate-patients housed in the facility and the health care appliances issued to these inmate-patients. The medical staff maintains a HCA repair log to track all health care appliances that are sent to vendors for repair or replacement. Interim accommodations are provided to the inmate-patients until such time the facility receives the repaired or replacement appliance. The facility submits the HCA repair log to PPCMU on a monthly basis. The auditor reviewed the HCA repair log and found that the documentation in the log was complete and current. While onsite the auditor conducted DPP inmate-patient interviews which confirmed that the ADA Coordinator was performing the duties as stated.

LPCC Health Care Staff: The main medical facility is staffed twenty-four hours, seven days a week, mainly focusing on inmate intake and processing, transfer of inmates and providing routine and emergency medical services. The CCHCS physician-auditor conducted an interview with the supervising LIP, Regional Medical Director (RMD), PA and the HSA to discuss the key elements of the intake and flow of new inmate-patient arrivals, staffing issues, chronic care, sick call, emergency response and formulary restrictions and overrides.

The physician-auditor discussed the key elements of tracer audit methodology with the supervising LIP and the RMD. The tracer audit includes assessing quality of provider care, quality of nursing care, medical appointments and scheduling, emergency services, specialized medical housing and pharmacy and medication management.

The physician-auditor conducted the tracer audit on an inmate-patient who had developed testicular cancer but was misdiagnosed as having epididymitis (inflammation of the tube that connects the testicle with the vas deferens) and/or Orchitis (inflammation of one or both of the testicles). This misdiagnosis resulted in significant delay in providing appropriate care and treatment for his condition. The tracer audit revealed that the facility RNs, NP, and the LIP were extremely negligent in providing adequate care in a timely manner to the inmate-patient. They failed to do their due diligence by not employing the necessary diagnostic tools to identify the cause of inmate-patient's symptoms, in spite of the inmate-patient placing sick call requests five times for the same complaint over a period of three months.

The RNs demonstrated deficient performance in the following areas:

- Triaging the inmate-patient;
- Failure to conduct physical examinations of the inmate-patient during appointments;
- Failure to notify the HSA of inmate-patient's no-show for the appointment and;
- Insufficient documentation in EMR regarding inmate-patient's no show for the scheduled appointment.

The NP prescribed antibiotics and pain medications for the inmate-patient without ever conducting a urinalysis or ultrasound to confirm the presence of an infection. The physician-auditor did not find any documentation in the medical record that substantiated the antibiotic prescription. The tracer audit also showed that this inmate-patient had never been transported to receive a higher level of care based on his signs and symptoms.

The physician-auditor interviewed the LIP and discussed the tracer audit findings. The physician-auditor expressed serious concern over the delay in adequately assessing the inmate-patient's symptoms with the LIP. The LIP stated that she did not think that there was ever any delay in diagnosis and treatment of the inmate-patient's condition. When the physician-auditor queried the LIP of the reason for not requesting the necessary tests to identify a possible cancer; The LIP stated, "She had not prescribed the tests because she didn't want the inmate-patient to think that there had been a delay in providing appropriate care to him". The LIP also mentioned that since the inmate-patient's hormone test results were high, she did not think it was necessary to run additional tests to diagnose cancer.

The physician-auditor inquired with the facility RNs as to why the HSA had not been notified when the inmate failed to show for his appointment. The HSA mentioned that it is very unusual for custody to state their inability to bring the inmate to medical. The auditor recommended to the facility RNs that they inform the HSA per facility's protocols when there is an inmate-patient that fails to show for an appointment and document the reason for the no-show in the EMR. The HSA assured the physician-auditor that he will investigate the issue promptly and ensure the inmate-patients are brought to the clinic promptly if they don't show up. This issue will continue to be monitored during subsequent audits to ensure compliance.

The physician-auditor also expressed grave concern over the nursing staff's inability to triage the inmate-patient adequately. The physician-auditor strongly advised the supervising LIP to educate the facility RNs regarding the importance of conducting a detailed physical assessment of inmate-patients based on inmate-patients' complaints and referring inmate-patients to LIPs in a timely manner, especially when unable to determine the reason for inmate-patient symptoms. The physician-auditor strongly advised the facility RNs to examine the affected organ system for comparison each time the inmate-patient is seen for follow up. The auditor emphasized the importance of reviewing the timely work up of testicular cancer versus infectious etiology with LIPs, NP, and the PA. The physician-auditor also advised the RMD to implement a process which will instruct the medical staff against rescheduling inmate-patients to be seen by an LIP of the same gender and will direct the clinician to conduct physical exams in the presence of a chaperone of the same gender if required. This would prevent unnecessary delay in providing care to the inmate-patients on occasions when there is a non-availability of medical staff of same gender. The physician-auditor asked the supervising LIP and HSA to investigate the medical staffs' allegations regarding custody staffs' inability to bring the inmate-patient to medical. All custody staff should be provided additional training on the importance of facilitating access to care to all inmate-patients. All medical staff should be provided additional training on the importance of fully documenting details on all inmate-patient no-shows. The RMD agreed to provide the necessary training to facility physician, NP, PA, and nursing staff to ensure all of the physician-auditor's concerns are addressed appropriately and in a timely manner.

In addition to the tracer audit, the physician-auditor also conducted a comprehensive review of clinical documentation completed by the LIPs, PA, and NP in the EMRs of several inmate-patients. The chart review clearly showed that the supervising LIP provided appropriate and timely care to all inmate-patients and no departures were noted. The physician-auditor rated the supervising LIP as a strong clinician with solid decision making skills. The physician-auditor's review of charts completed by the facility LIP indicated that although the LIP was very conscientious, the LIP ordered a number of unnecessary tests with no documentation in the EMR supporting the rationale. It has been noted that the LIP did not order sufficient tests that was vital for diagnosing a case of testicular cancer (as summarized in tracer review) in order to avoid creating an impression of a delay in the care provided to

the inmate-patient. The physician-auditor advised the LIP to refrain from ordering unnecessary tests unless absolutely needed since false positive tests could subject the inmate-patients to great risk for unnecessary procedures and put additional financial burden on the organization.

The PA was found to be meticulous and provided appropriate diagnoses and treatment to the inmate-patients; however, a few simple departures were noted in the care provided. The physician-auditor observed the PA's documentation to be brief and limited. Review of charts completed by the NP revealed that NP was not familiar with facility's policies and procedures and the different forms used for clinical documentation. The physician-auditor recorded the fact that the documentation was inadequate. The physician-auditor advised the PA to include more details when documenting their clinical findings and advised the NP to become familiar with the various forms. The auditor also recommended that additional training be provided to the NP on the facility's policies, procedures and various utilized clinical forms. Continued monitoring of the NP's performance through probation and periodic peer reviews is recommended.

Recommendations were made to the supervising LIP and RMD that additional in-service training be provided to all the clinical staff regarding assessment, diagnosis, and treatment protocols especially for testicular symptoms. The RMD assured the physician-auditor that training would be provided to the facility RNs, NP, and PA. All staff will be monitored to ensure protocols are followed and CCHCS guidelines are met.

The nurse-auditor observed several inmate-patient sick call appointments, observed medication pill passes and interviewed various medical staff. Below are the nurse-auditor's observations:

During the on-site audit, the nurse-auditor inspected all the emergency medical response (EMR) bags in all four clinics. The auditor reviewed the EMR bag logs and observed that during each shift, the medical staff checked the seals of the bags to ensure they were intact. While checking the contents of the EMR bags, the nurse-auditor noticed that the bags were disorganized and contained some items which were not listed on the facility's EMR bag checklist. The auditor notified the facility RN regarding the discrepancies, LPCC staff indicated that they will reorganize the EMR bags and remove all items from the bag that are not listed on the checklist.

The nurse-auditor selected dates of nine EMR drills from the EMRRC meeting minutes and identified the locations where the drills were conducted. The auditor then checked the EMR bag logs located at the identified locations and dates in order to determine if the staff had re-stocked and re-sealed the EMR bags following the EMR drills. It was found that the medical staff had re-supplied and re-sealed the bags following each of the nine EMR drills. All emergency medical equipment was checked and maintained on a regular basis by the medical staff. However, the oxygen tank located in the compound 3 clinic was only one fourth full. The nurse-auditor notified the facility RN about the issue and the issue was corrected immediately.

The nurse-auditor inspected the clinics, examination rooms, and medication pass locations where inmate-patient care was provided, also noted that hand sanitizers were available for staff use in all locations. While in the clinics, the nurse-auditor observed the medical staff to be practicing universal/standard precautions for hand hygiene between each inmate-patient encounter. The nurse-auditor also checked all clinic locations to ensure that Personal Protective Equipment (PPE) was readily available for staff's use. The nurse-auditor noted an example of best practice where the PPE kits were secured in zip lock bags and hung on the wall in the exam rooms for easy access. When the nurse-

auditor examined the cleaning logs to ensure cleaning of "high touch surfaces" was completed at least once a day, it was learned that out of the seven clinics inspected, only two clinics had documentation validating that the clinics were cleaned daily. None of the ASU clinics located inside compounds one, two, and three had cleaning logs. The auditor also made note that these clinic areas appeared dirty and had not been cleaned. This was brought to the attention of HSA and the medical staff with a recommendation that cleaning logs for all clinics be maintained to validate the cleaning of each clinic on a daily basis. The HSA agreed to implement a cleaning schedule promptly and create cleaning logs for all locations. The cleaning logs will be monitored during subsequent audits to ensure the clinic areas are clean and sanitary at all times when operational.

During the EMR review, the nurse-auditor found that the facility was not following IMSP&P guidelines for Medication No-Shows/Refusal cited in *Volume 4, Chapter 11-Medication Management* procedure which states:

a) *Licensed nurse shall perform a weekly review of the MARs and refer in writing via a CDCR Form 128-C any patient who has missed 3 consecutive days of medications, or fifty percent (50%) of any medication in one week either by refusal, no-show, or shows a pattern of unexplained missed medications, to the prescriber for medication follow-up counseling. The referral shall be initiated the same day as the MAR review.*
b) *Any patient who refuses or is a no-show for insulin, TB, designated HIV medications, or Clozapine shall be referred in writing via CDCR Form 128-C on an urgent basis to the prescriber, Public Health Nurse, or Physician-on-Call (POC) for medication follow-up counseling.*
c) *Patients will be seen within (7) calendar days of the date of referral for non-urgent appointments for medication follow-up counseling.*

The facility RNs are providing counseling to inmate-patients who refused or were a no-show for medications; however, per the IMSP&P guidelines, any inmate-patient who refuses or is a no show for medications must be referred to the LIP that has prescribed the medication for follow-up counseling. The facility RN is not approving and signing the completed TB evaluation forms t of inmate-patients arriving at the facility. The auditor notified the RN that policy stipulates the RN must check the form completed by the LVN for accuracy, sign and date the forms.

The nurse-auditor observed four medication passes in total; three pill lines in the mainline clinics and one inside ASU. The auditor noted that when medications were distributed in the ASU at cell front, the RN did not bring their laptop to document the medications administered. However, the facility RN documented all medications administered to the inmate-patients housed in all other locations on the MAR immediately soon after their distribution. The nurse-auditor brought this to the attention of the facility RN and advised her that all medication passes including those that are administered in ASU at cell front must be documented immediately after administering them. This will be monitored during subsequent audits to ensure compliance.

Emergency Response: The audit team reviewed Emergency Response Review Committee (EMRRC) meeting minutes and found that EMRRC meetings were conducted monthly and all issues related to emergency responses and/or drills are addressed during the monthly meetings. The meeting minutes also include the details on CAPs implemented to address the deficiencies. The auditor's review of the documentation showed that issues identified with the response time of medical staff during medical emergencies were adequately addressed and appropriate corrective action was implemented to address

the deficiency. This improvement was further evidenced during the emergency drill that occurred at the time of the audit. All medical staff was observed to respond to the site within specified timeframes.

Prior CAP Resolution: Although majority of the CAP items from the previous audit were found resolved, some items were not, the facility will take ownership in resolving these items and continue to monitor their progress toward improvement. The facility's advancement toward resolution of the previous audit CAP items is summarized below:

1. *Licensed Independent Provider (LIP) is not reviewing, initialing and dating all inmate-patient diagnostic reports within the specified timeframe.* During the May 2014 audit, auditors found 52.6% compliance. The facility's CAP stated that LIPs will be instructed to continue reviews of all available diagnostics test results, initialing and dating them daily and the CQI nurse will continue to run the CCA Lab report weekly for eight weeks and audit the report for timely completion of the initialing and dating of diagnostic test results. The audit team found that the corrective action taken by LPCC has not had the desired affect even though the facility has shown marginal improvement in this area receiving 80.0% compliance. This issue remains unresolved and will continue to be the subject of monitoring during subsequent audits.

2. *Inmate-patients are not receiving written notification of diagnostic test results within the specified timeframe.* During the May 2014 audit, auditors found 31.6% compliance. The facility's CAP stated that the night shift RN(s) will continue to run the CCA Allscripts Lab Result Notification report nightly and the CQI nurse will run copies of the CCA Allscripts Lab Result Notification report, weekly for eight weeks and complete an audit to determine the rate of compliance. The audit team found that the corrective action taken by LPCC has not had the desired affect even though the facility showed marginal improvement in this area receiving 50.0% compliance. This issue remains unresolved and will continue to be the subject of monitoring during subsequent audits.

3. *Inmate-patients are not seen within the timeframes set forth in the sick call policy.* During the May 2014 audit, auditors found 84.1% compliance. The facility's CAP stated that the clinical supervisors and the RNs will be instructed to see every inmate on sick call within 24 hours of the triaging of the inmate's sick call request; the HSA will conduct an in-service to review CCA 13-80, Sick Call and the CQI nurse will audit the sick call log, weekly for eight weeks to determine the level of compliance with this standard. The audit team found that the corrective action taken by LPCC to resolve this issue has had the desired affect and the facility has improved in this area and received 97.7% compliance. The corrective action is considered to have been effective and this issue is resolved.

4. *Inmate-patients are not seen within the timeframes set forth in the specialty care policy.* During the May 2014 audit, auditors found 54.1% compliance. The facility's CAP stated that the RNs and the clinical supervisors will receive a copy of the approved timeframes during which inmates returning from a specialty consult must be seen, as outlined in CCA 13-64, Offsite Care/Consultations. A copy will be posted at the main nursing station and at each clinical station in main medical; RNs and clinical supervisors will receive in-service training on scheduling inmate appointments after returning from specialty consults and the CQI nurse will conduct weekly audits for eight weeks to monitor compliance with this standard. The audit team found that the corrective action taken by LPCC to resolve this issue has had the desired

affect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.

5. *Registered nurses are not documenting that they are reviewing inmate-patients discharge plans when an inmate-patient returns from the emergency room visit (May 2014 audit, Qualitative Action Item #1).* During the May 2014 audit, auditors found 75.0% compliance. The facility's CAP stated that in accordance with CCA 13-64, *Offsite Care/Consultations* policy, the RNs will be instructed to specifically include in their documentation, for inmates returning from a hospital visit/stay, that the discharge plans were reviewed with the inmate and that any recommended changes in plan of care have been referred to a provider for review/approval. The clinical supervisor will complete in-service on documentation to include the elements to be included in a hospital return SOAPE notes and the CQI nurse will conduct weekly audits for eight weeks to monitor compliance with this standard. The audit team found that the corrective action taken by LPCC to remedy this issue has not had the desired affect and the facility's compliance fell drastically to 57.1% compliance. This issue remains unresolved and will continue to be the subject of monitoring during subsequent audits.

6. *The LIPs are not documenting that they are explaining medications to inmate-patients (May 2014 audit, Qualitative Action Item #2).* During the May 2014 audit, auditors found 78.6% compliance. The facility's CAP stated that the LIPs will be instructed to include in their documentation, at each inmate-patient visit, that they have discussed medications with the inmate-patient. The senior physician will complete an in-service with the LIPs to review this element of documentation and the CQI nurse will conduct weekly audits for eight weeks to monitor compliance with this standard. The audit team found that the corrective action taken by LPCC to remedy this issue has not had the desired affect and the facility's compliance fell drastically to 33.3% compliance. This issue remains unresolved and will continue to be the subject of monitoring during subsequent audits.

7. *Medication errors are not being documented on the Incident Report-Medication Error Form (May 2014 audit, Qualitative Action Item #3).* During the May 2014 audit, auditors found 0.0% compliance. The facility's CAP stated that in the event of a medication error, the assigned clinical supervisor will complete Forms 13-70B and 13-70E, and update Log 13-70G. The process of documenting medication errors, as outlined in CCA 13-70, will be reviewed with the clinical supervisors during an in-service and the results will be reviewed and reported at the next quarterly CQI meeting. The audit team found that the corrective action taken by LPCC to resolve this issue has had the desired affect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.

8. *RNs/LIPs are not documenting their discussions of the risks and benefits of refusing treatment when inmate-patients refuse health care treatments (May 2014 audit, Qualitative Action Item #4).* During the May 2014 audit, auditors found 83.3% compliance. The facility's CAP stated that the RNs and the LIPs will be instructed to specifically include in their documentation that the risks and benefits related to an inmate-patient refusal of treatment are discussed with the inmate-patient. The senior physician and the clinical supervisors during will conduct in-services on CCA 13-49, *Informed Consents/Refusals of Care*. The CQI nurse will conduct weekly audits for eight weeks to monitor compliance with this standard and failure to achieve a 90% compliance rate on this standard by the LIPs will trigger additional interventions and referral to CCA's Chief

Medical Officer. The audit team found that the corrective action taken by LPCC to resolve this issue has had the desired affect and the facility has improved in this area and received 100% compliance. The corrective action is considered to have been effective and this issue is resolved.

9. *Inmate-patients are not being seen by the LIP within the specified timeframe when referred by an RN (May 2014 audit, Qualitative Action Item #5).* During the May 2014 audit, auditors found 78.4% compliance. The facility's CAP stated that clinical supervisors will conduct in-service with the RNs reviewing criteria for, timelines of, and proper order entry for LIP referrals. Education materials to include extracts from CCA 13-64, CCA 13-80, and Allscripts How-to Manual and the CQI nurse will conduct weekly audits for eight weeks to monitor compliance with this standard. The audit team found that the corrective action taken by LPCC to remedy this issue has not had the desired affect and the facility's compliance fell drastically to 28.6%. This issue remains unresolved and will continue to be the subject of monitoring during subsequent audits.

10. *English and Spanish CDCR 7362 Health Care Services Request Forms are not available to inmate-patients in all housing units* (*(May 2014 audit, Qualitative Action Item #6).* During the May 2014 audit, the facility did not have English and Spanish sick call (CCA 13-80A3) forms available in all housing units. This was a violation of the CCA policy 13-80 which states that English and Spanish versions of sick call (CCA 13-80A3) forms shall be made available to all inmate-patients. The facility has since corrected this deficiency. Currently, all housing units have an adequate supply of sick call forms in both versions. Since the facility is fully compliant with this requirement, this CAP item is now closed.

11. *LPCC inmate-patient handbook does not include the appropriate address for the 2nd level and 3rd level health care appeals (May 2014 audit, Qualitative Action Item #7).* During the May 2014 audit, auditors found that the inmate-handbook listed the old mailing address for submitting the 2nd and 3rd level appeals. The audit team notified the HSA and provided them with the new address. The facility's CAP stated that updates to the inmate-patient handbook, to include the appropriate addresses for the 2nd and 3rd level health care appeals, have been completed on July 16, 2014. During this audit, the auditor was provided with a copy of the updated inmate handbook and the auditor verified and confirmed the address to be accurate. This issue is considered resolved.

Conclusion

The audit revealed that LPCC is struggling to provide constitutional health care as it relates to health appraisal, chronic care, diagnostic services, medication management and sick call for CDCR inmate-patients housed at this facility. Since the previous audit in May 2014, the overall compliance score decreased from 96.0% to 89.5%, within a period of just six months.

The substandard performance and gross negligence exhibited by the facility nursing and clinical staff was brought to light through the tracer audit conducted on the inmate-patient with testicular cancer. There were significant lapses noted in providing adequate and timely care to the inmate-patient; facility nursing and clinical staff lacked the clinical intuitiveness to conduct appropriate physical exams of the affected system, their inexperience in determining the appropriate diagnostic tests to identify the issue and providing treatment worsened the health condition of the inmate-patient. This inmate-patient has

since been transferred to a California institution and is currently being treated for testicular cancer. It has been confirmed that the inmate-patient's cancer has metastasized to his lymph nodes and other parts of his body due to a significant lapse in providing essential care in a timely manner and the significant delay in diagnosing his condition. According to the physician-auditor, the RN providers did not complete a physical assessment of the inmate-patient during face-to-face evaluation and deferred physical exam of the affected area each time the inmate-patient was seen for follow up. This clearly illustrates the inability of the RN providers to comprehend the significance of patient's signs and symptoms which in turn, poses a grave risk to the quality of health care provided to the inmate-patients, especially ones with testicular symptoms.

Additional deficiencies identified such as the inability of the facility health care staff to provide diagnostic tests in a timely manner, inmate-patient RN and LIP appointments not completed within specified timeframes, poor handling of inmate-patient refusals and no-shows, and insufficient documentation by the health care staff contribute to the serious concern regarding the wellbeing of the inmate-patients housed in LPCC.

Facility's inability to meet CCHCS access to care standards as outlined in the *Volume IV* of the IMPS&P requires immediate attention. Meeting these standards is at the core of an adequate health care delivery system. The deficiencies identified during this audit further emphasize the facility's need to adhere to the following standards of care when providing health care to CDCR inmate-patients which are as outlined below:

1. *Inmate-patients shall be scheduled to see the PCP for the earliest possible appointment if:*
   (i) The inmate-patient was ducated to see the RN and a medical complaint or treatment is not within the RN's scope of practice or

   (ii) This is the inmate-patient's third request for the same medical complaint following face-to-face triage by the RN.
2. *If an inmate-patient is a "no show" for a physician visit, the MTA or RN shall contact the housing unit supervisor to ascertain the reason for the "no show" and record in the UHR the reason given.*
3. *The PCP shall review, initial, and date all diagnostic reports received including radiology. The PCP shall review laboratory results within two business days of the date test was received.*
4. *The PCP or designee shall complete the CDCR Form 7393, Notification of Diagnostic Test Results, within two business days of the date of receipt of the diagnostic service lab result, forward a copy to the inmate-patient and document clinically significant diagnostic tests results, treatments and orders on a CDCR Form 7230, Interdisciplinary Progress Note, and CDCR Form 7221, to be filed in the UHR.*
5. *Licensed health care staff shall dispense, administer, monitor, and track all medications prescribed by authorized providers within their scope of licensure under California law (physician, dentist, podiatrist, nurse, mid-level practitioner).*
6. *After the medication is ingested nursing staff shall record the medication administered on the patient's MAR.*
7. *A licensed nurse shall perform a weekly review of the MARs and refer in writing via a CDC Form 128-C any patient who has missed 3 consecutive days of medications, or fifty percent (50%) of any medication in one week either by refusal, no-show, or shows a pattern of unexplained missed medications, to the prescriber for medication follow-up counseling.*

8. *The prescriber shall interview the patient, provide education regarding the implications/consequences of not taking medication, and evaluate the need for modification to the medication regimen.*
9. *Upon return from the GACH/CTC/community hospital, the inmate-patient shall be processed through the TTA. The TTA RN shall review the discharge plan and any other medical documentation.*
10. *The TTA RN shall complete an assessment for inmate-patients returning from a community hospital and shall ascertain any additional health care needs of the inmate-patient. The assessment shall be documented on a CDCR Form 7230 and filed in the UHR.*

Since the completion of the audit, CCA has informed PPCMU auditors that the facility physician, who was identified as being deficient in providing care to the inmate-patient with testicular cancer, has since been relocated to another CCA facility and the physician no longer treats CDCR inmate-patients. The facility's NP, who was identified as being negligent and not following proper nursing protocols, has been placed under probation and will be monitored closely by the supervising physician and the NP's clinical encounters with the inmate-patients will be evaluated through peer reviews and any deficiencies identified will be remedied by providing additional training to the NP.

LPCC must work conscientiously to improve the identified deficiencies. This requires LPCC staff to continue to work diligently on improving the quality of medical services being provided to the CDCR inmate-patients, develop and implement all policies/procedures identified as deficient, address all CAP items, and achieve compliance in areas with numerous deficiencies like chronic care, diagnostic services, initial intake screening /health appraisal and sick call processes by attaining a minimum passing score of 85.0%.

During the exit conference, LPCC staff was receptive to constructive feedback presented by the CCHCS audit team. Staff acknowledged their need to adhere to contractual obligations as it relates to providing a constitutional level of health care to the inmate-patients housed in LPCC. The Warden and LPCC medical staff assured the audit team that they would do whatever necessary to comply with the findings of the audit.

STAFFING UTILIZATION

Prior to the onsite audit at LPCC, the audit team conducted a paper review of all health care positions. The purpose of this review was not only to identify both budgeted (required) and filled positions on duty during this audit period, but also to provide talking points for subsequent qualitative interviews with staff during the onsite audit.

A review of the health care staff positions revealed there were no open positions at the time of the audit. The following table is a summary of the staffing and findings of the review.

La Palma, AZ/CDCR Total Population: 3,068

Primary Care	Original Contract FTE	Current Required FTE	Variance
Senior Physician	1.0	1.0	-
Physician	1.0	1.0	-
ARNP/PA	2.0	2.0	-
ARNP/PA (contract)	0.0	0.0	-
Total Primary Care	**4.0**	**4.0**	**-**
CCA Management			
Deputy Director/ Senior Health Services Administrator	0.0	0.0	-
Health Services Administrator	1.0	1.0	-
Clinical Supervisor	3.0	3.0	-
Total CCA Management	**4.0**	**4.0**	**-**
Nursing Services			
Staff RN (7 day)	9.0	9.0	-
Staff RN (5day)	5.0	5.0	-
RN-CQI	[1.0]	1.0	-
RN Health Information Specialist	[1.0]	1.0	-
Coordinator, Infectious Disease	[0.0]	0.0	-
RN Total	**14.0**	**16.0**	**-**
LPNs			
Staff LPN/LVN (5 day)	5.0	5.0	-
Staff LPN/LVN (7 day)	9.0	9.0	-
Pharmacy Tech/LPN	2.0	2.0	-
Phlebotomist	[0.0]		-
LPN Employee Health	[0.5]		-
CMA	[3.0]		-
LPN Total	**16.0**	**16.0**	
Total Nursing	**30.0**	**32.0**	**+2.0**

INMATE INTERVIEWS

The intent of this portion of the audit is to elicit substantive responses from a designated number of the inmate-patients, 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. The audit team interviewed a pool of inmates from general population and ASU to determine their knowledge of Sick Call and Grievance/Appeal process and interviewed the ADA inmate-patients selected from the *Disability and Effective Communication Roster* to determine if their accommodations were being met as it relates to their DPP disability. The results of these interviews are summarized in the chart below.

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

Chapter 21: Inmate Interviews (not rated)
1. Are the inmate-patients aware of the sick call process?
2. Does the inmate-patient know where to get a Sick Call request form?
3. Does the inmate-patient know where to place the completed Sick Call request form?
4. Is there assistance available if you have difficulty in completing the Sick Call form?
5. Are inmate-patients aware of the grievance/appeal process?
6. Does the inmate-patient know where the CDCR-620 HC form can be found?
7. Does the inmate-patient know where and how to submit the CDCR-602 HC form?
8. Is assistance available if you have difficulty completing the CDCR 602-HC form?
9. Are you aware of your current disability/ADA status?
10. Are you receiving any type of accommodation based on your disability? (Housing Accommodation, Medical Appliance)
11. Are you aware of the process to request reasonable accommodation?
12. Do you know where to obtain a request for reasonable accommodation form?
13. Did you receive reasonable accommodation in a timely manner? If no, were interim accommodations provided?
14. Have you used the medical appliance repair program?
15. If yes, how long did the repair take?
16. If yes, were you provided an interim accommodation?
17. Are you aware of the grievance/appeal process for a disability related issue?
18. Can you explain where to find help if you need assistance obtaining or completing a form (i.e. CDCR 602-HC Inmate/Parolee Health Care Appeal Form, CDCR 1824 Reasonable Modification or Request for Reasonable Accommodation Form)
19. Have you submitted an ADA Grievance/Appeal?
20. If yes, how long did the process take?
21. Do you know the name of the ADA Coordinator at this facility?
22. Do you have access to license health care staff to address any issues regarding your disability?
23. During contact with medical staff do they explain things to you in a way you understand?

COMMENTS

1. Questions 1 – 4: Auditors interviewed five inmate-patients on the sick call process. All knew how to access and submit sick call request forms, and were familiar with the sick call process.
2. Questions 5 – 8: Auditors interviewed five inmate-patients on the grievance/appeal process. All inmate-patients knew how to access and submit the grievance/appeal forms, and were very familiar with the process.
3. Questions 9 through 23 – The audit team interviewed 12 DPP inmate-patients. All of them knew the process to request reasonable accommodation. Most of the inmate-patients were unable to identify the ADA Coordinator by name. Two of the twelve indicated they had conversed with

the ADA Coordinator in the past. The auditor provided the remaining ten inmate-patients the ADA Coordinator's name for future reference.

One DPP inmate-patient expressed his frustration over the 4 am pill call explaining that the early morning pill call in the winter months took a toll on his health since he suffers from arthritis and scoliosis. He claimed that the LIP had ordered the RNs to deliver medications to his cell for an extended period of time; it was stopped after four weeks and upon inquiry, he was informed that he was not eligible for medications to be delivered to his cell since he did not have a lay-in Chrono. He requested the audit team to discuss his case with the LIP and have the LIP write a Chrono for in-cell delivery of medications. The audit team discussed this issue with the HSA and was told that there are no medical grounds to issue a lay-in Chrono for the inmate-patient. The remaining inmates stated that they had adequate access to licensed health care staff.