Sick Call (Q)

	Performance Mea ure (De cription)	Grn	Amb	Red	Notification	Level
1	Is sick call being conducted five days a week Monday through Friday (excluding holidays)? P-E-07, DO 1101, HSTM Chapter 5, Sec. 2.04.2, Chapter 7, Sec. 7.6]	X			5/31/2013 11:39 AM Entered By: Mark Haldane Length of lines and productivity varies, but sick call is being scheduled and conducted in accordance with this standard.	1
2	Are sick call inmates being triaged within 24 hours(or immediately if inmate is identified with emergent medical needs)? [P-E-07, DO 1101, HSTM Chapter 5, Sec. 3.1]		X		5/31/2013 12:42 PM Entered By: Mark Haldane This standard is being met at San Carlos and Santa Maria. At San Pedro, HNR's are not being triaged on the day they are submitted, but the nurse line for sick call was current for the charts reviewed. Lumley is a mixed custody yard and appointments are often beyond 24 hours from triage. For example, inmate put in an HNR on 5/3 but was not seen on the nurse line until 5/13. inmate put in an HNR on 5/24 and was seen on 5/30. On Santa Cruz, inmate had an HNR triaged 5/3, but was not seen until 5/8. inmate put in an HNR on 5/6 and was seen on 5/9. inmate had an HNR dated 5/3 and was seen on 5/9. inmate had a 5/3 HNR and was seen on 5/10. inmate had a 5/3 HNR and was seen on 5/14. There are dozens of HNRs as old as August 2012 that have not been filed in charts on Santa Cruz.	1
3	Are vitals signs, to include weight, being checked and documented each time an inmate is seen during sick call? [P-E-04, HSTM Chapter 5, Section 1.3]	X			5/31/2013 12:43 PM Entered By: Mark Haldane	1
4	Is the SOAPE format being utilized in the inmate medical record for encounters? [DO 1104, HSTM Chapter 5, Section 1.3]	X			5/31/2013 12:44 PM Entered By: Mark Haldane NETS are not in SOAPE format, but have been approved for use.	1
5	Are referrals to providers from sick call being een within even (7) day ? [P E 07]		X		5/31/2013 1:12 PM Entered By: Mark Haldane Referrals from sick call are not consistently seen within 7 days at any of the units. At Santa Maria, referrals from nurse lines are 4-6 weeks out. See inmate , inmate , inmate , for example. At Santa Cruz, the wait is 2-5 weeks. See inmate , inmate , inmate , for example. At San Carlos the wait is from less than a week to 6 weeks. See inmate , inmate , inmate , for example. At San Pedro, the provider lines are closest to meeting this standard. Of the cases reviewed, waits ranged from 1 day to 4 weeks. Most appointments were within 7 days. See inmate . Lumley referrals were also mostly within 7 days (the sample size was small). inmate was not.	1
6	Are nursing protocols in place and utilized by the nurses for sick call?	X			5/31/2013 1:14 PM Entered By: Mark Haldane All units began using the General Sick Call	1

					NETS form in May. SOAPE notes are still used in some cases.	

Corrective Action Plans for PerformanceMeasure: Sick Call (Q)

2 Are sick call inmates being triaged within 24 hours(or immediately if inmate is identified with emergent medical needs)? [P-E-07, DO 1101, HSTM Chapter 5, Sec. 3.1]
Level 1 Amber User: Mark Haldane Date: 5/31/2013 12:42:13 PM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
1.Process to address, to include but not limited to:
a.Daily pick up.
b.Date stamp.
c.Triage within 24 hrs, immediate triage of patient if emergent.
d.Seen within 48 hrs after date stamp or 72 hrs weekend/holiday.
e.Nurse line sees patient, then to provider line when appropriate.
f. Submit final site process to RVP.
2.In-service staff on policy titled "Routine Appointments – Request" Chapter 5, Section 3.1 ((Attachment II.2.) and per Sick Call 2.20.2.2 contract performance outcome 2 (Sick Call Attachment);
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff.
3.Monitoring (Sick Call Monitoring Tool)
a.Audit tools developed.
b.Weekly site results discussed with RVP.
c.Audit results discussed a monthly CQI meeting.
d.Minutes and audit reported monthly to Regional office for tracking and trending.
Responsible Parties = FHA/DON/RDCQI/RVP
Target Date-11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

5 Are referrals to providers from sick call being seen within seven (7) days? [P-E-07]
Level 1 Amber User: Mark Haldane Date: 5/31/2013 1:12:12 PM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
1.In-service all staff including providers on Sick Call 2.20.2.2 contract performance outcome 5 (Sick Call Attachment); Seen by Physician or Midlevel within 7 days
a.Agenda/sign off sheet to verify
2.Monitoring (Sick Call Monitoring Tool)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsible Parties = FHA/DON/Medical Director/RDCQI/RVP
Target Date- 11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

Medical Specialty Consultations (Q)

	Performance Measure (Description)	Grn	Amb	Red	Notifications	Level
1	Are urgent consultations being scheduled to be seen within thirty (30) days of the consultation being initiated? [CC 2.20.2.3]		X		5/30/2013 3:32 PM Entered By: Vanessa Headstream inmate - two urgent consults written 04/09/13, not scheduled to be seen within 30 days - 1) Breast ultrasound - completed 05/28/13, no report available 2) Dermatology - appointment scheduled for 06/18/13 5/16/2013 1:37 PM Entered By: Vanessa Headstream Review of 4 Urgent consult requests demonstrates noncompliance - The below Urgent consults were not scheduled to be seen in a timely manner - inmate - written 04/02/13, submitted to UM 04/11/13, entered into ORC 04/12/13, has not been scheduled inmate - written 04/03/13, submitted/received/entered into ORC 05/14/13, has not been scheduled	2
2	Are consultation reports being reviewed by the provider within seven (7) days of receipt? [CC 2.20.2.3]		X		5/28/2013 9:41 AM Entered By: Vanessa Headstream see below entry 5/20/2013 8:43 AM Entered By: Vanessa Headstream San Pedro - inmate, 04/23/13, signed 05/01/13 5/6/2013 11:46 AM Entered By: Vanessa Headstream Review of reports demonstrates non compliance - PU/SM/SR - inmate, 04/24/13 not signed inmate, 04/23/13 not signed inmate, 04/11/13 request for info, not completed inmate, 04/23/13 not signed, 04/24/13 not signed	2
3	Is the utilization and availability of off-site services appropriate to meet medical, dental and mental health needs? [CC 2.20.2.3]		X		5/28/2013 9:42 AM Entered By: Vanessa Headstream see below entry 5/23/2013 9:54 AM Entered By: Vanessa Headstream inmate - OT/Speech therapy services requested have not been available; PT requested & approved has not been scheduled	3
4	Are the emergent medical needs of the inmates appropriate and emergent transports ordered in a timely manner? [P-E-08, CC 2.20.2.3]	X			5/6/2013 11:47 AM Entered By: Vanessa Headstream	2
5	Do all inpatient admissions have documented utilization review of admission and evidence of	X			5/6/2013 11:47 AM Entered By: Vanessa Headstream	2

	discharge planning? [CC 2.20.2.3]				

Corrective Action Plans for PerformanceMeasure: Medical Specialty Consultations (Q)

1 Are urgent consultations being scheduled to be seen within thirty (30) days of the consultation being initiated? [CC 2.20.2.3]
Level 2 Amber User: Vanessa Headstream Date: 5/30/2013 3:32:09 PM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
1.Standardized monitoring process
2.Communicate expectations via FHA/DON at quarterly training Regional office and obtain sign off sheet to verify
3.Monitoring (UM Audit Tool)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsible Parties = ARMD/RDON/RVP/RCQI/FHA/DON
Target Date -11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.
1. Standardized process to address, to include but not limited to:
a. Approved consults scheduled/documented within 5 days by clinical coordinator
2. Schedule and conduct training for all clinical coordinators
a.Agenda/sign off sheet to verify
3. Monitoring (UM Audit Tool)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsibile Parties = DON/Clinical Systems Business Analyst II/FHA/DON/RDCQI/RVP
Target Date - 11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

1 Are urgent consultations being scheduled to be seen within thirty (30) days of the consultation being initiated? [CC 2.20.2.3]
Level 2 Amber User: Vanessa Headstream Date: 5/30/2013 3:32:09 PM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
1.Standardized monitoring process
2.Communicate expectations via FHA/DON at quarterly training Regional office and obtain sign off sheet to verify
3.Monitoring (UM Audit Tool)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsible Parties = ARMD/RDON/RVP/RCQI/FHA/DON
Target Date -11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.
1. Standardized process to address, to include but not limited to:
a. Approved consults scheduled/documented within 5 days by clinical coordinator
2. Schedule and conduct training for all clinical coordinators
a.Agenda/sign off sheet to verify

3. Monitoring (UM Audit Tool)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsibile Parties = DON/Clinical Systems Business Analyst II/FHA/DON/RDCQI/RVP
Target Date - 11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

2 Are consultation reports being reviewed by the provider within seven (7) days of receipt? [CC 2.20.2.3]
Level 2 Amber User: Vanessa Headstream Date: 5/28/2013 9:42:00 AM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
1.Standardized monitoring process
2.Communicate expectations via FHA/DON at quarterly training Regional office and obtain sign off sheet to verify
3.Monitoring (UM Audit Tool)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsible Parties =ARMD/RDON/RVP/RDCQI/DON/
Target Date-11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

3 Is the utilization and availability of off-site services appropriate to meet medical, dental and mental health needs? [CC 2.20.2.3]
Level 3 Amber User: Vanessa Headstream Date: 5/28/2013 9:42:25 AM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
1.Retrain FHA/DONs on ED management and expectations
a.Agenda/sign off sheet to verify
2.Develop a site level process to assure, but not limited to:
a.ED log completed and submitted daily to Regional office
b.Access to custody transport logs
c.Access to AIMS
3.Train site staff on ED management and expectations
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff
4.Review ED activity daily (in AM) with FHA/DON/MD (lead provider in absence of MD) to determine patient status and appropriate treatment plan
a. Agenda/sign off sheet to verify, inclusive of all pertinent staff
5.Regional staff conduct weekly review of compliance to daily submission and appropriate patient disposition
6.Monitoring tool developed for self-monitoring and submission to site management and regional CQI
7.Initiation of monitoring tools at sites
8.Monitoring (UM Audit Tool)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsible Parties = VPO/ARMD/RDON/RVP/FHA/DON/MD/RDCQI
Target Date- 11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.
10/11/13 Update – ED log sent to Regional office daily.

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Chronic Condition and Disease Management (Q)						
	Performance Measure (Description)	**Grn**	**Amb**	**Red**	**Notifications**	**Level**
1	Are treatment plans developed and documented in the medical record by a provider within thirty (30) days of identification that the inmate has a CC? [P-G-01, CC 2.20.2.4]	X			5/13/2013 10:26 AM Entered By: Vanessa Headstream	1
2	Are CC inmates being seen by the provider (every three (3) to six (6) months) as specified in the inmate's treatment plan? [P-G-01, DO 1101, HSTM Chpt. 5, Sec. 5.1, CC 2.20.2.4]		X		5/21/2013 12:46 PM Entered By: Vanessa Headstream Review of CC charts demonstrates =/- 71% compliance with this performance factor - 5/20/2013 8:55 AM Entered By: Vanessa Headstream 24 chronic care files reviewed indicate 7 to be non compliant: San Carlos - inmate cc 07/25/11, no f/u visits documented inmate cc 01/14/13, 90 day f/u not completed San Pedro - inmate cc 10/29/12, 30 day f/u not completed inmate cc 01/22/13, 90 day f/u not completed inmate cc 12/11/12, no f/u visits documented Santa Cruz - inmate cc 02/13/13, 90 day f/u not completed inmate cc 01/30/13, 90 day f/u not completed	2
3	Are CC/DM inmates being provided coaching and education about their condition / disease and is it documented in the medical record? [P-G-01, CC 2.20.2.4]		X		5/28/2013 9:54 AM Entered By: Vanessa Headstream Review of chronic care records demonstrates non compliance with this performance factor. 5/20/2013 8:59 AM Entered By: Vanessa Headstream 24 chronic care files reviewed indicate 4 to be non compliant: inmate , inmate , inmate , inmate	1
4	Have disease management guidelines been developed and implemented for Chronic Disease or other conditions not classified as CC? [P-G-01, HSTM Chpt. 5, Sec. 5.1, CC 2.20.2.4]	X			5/20/2013 3:31 PM Entered By: Vanessa Headstream under review	2
5	Has the contractor submitted his/her quarterly guideline audit results by the 15th day following the end of the reporting quarter? [CC 2.20.2.4]	X			5/20/2013 3:30 PM Entered By: Vanessa Headstream	2

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Corrective Action Plans for PerformanceMeasure: Chronic Condition and Disease Management (Q)

2 Are CC inmates being seen by the provider (every three (3) to six (6) months) as specified in the inmate's treatment plan? [P-G-01, DO 1101, HSTM Chpt. 5, Sec. 5.1, CC 2.20.2.4]
Level 2 Amber User: Vanessa Headstream Date: 5/21/2013 12:46:16 PM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
Process statewide to include, but not limited to :
1. Chronic Care inmates seen by provider every 3-6 months, as specified in the treatment plan per Chronic Condition and Disease Management Programs 2.20.2.4 contract performance outcome 2 (I.- IV.Chronic Care Attachment).
2. In-service staff on policy titled "Treatment Plans" Chapter 5, Section 1.4 (Appendix II.2.) and outcome measure .
   a. Agenda/sign off sheet to verify, inclusive of all pertinent staff .
3. Monitoring
   a. Audit tools developed.
   b. Weekly site results discussed with RVP.
   c. Audit results discussed a monthly CQI meeting.
   d. Minutes and audit reported monthly to Regional office for tracking and trending.

Responsible Parties = FHA/DON//Medical Director/RDCQI/RVP
Target Date - 11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

3 Are CC/DM inmates being provided coaching and education about their condition / disease and is it documented in the medical record? [P-G-01, CC 2.20.2.4]
Level 1 Amber User: Vanessa Headstream Date: 5/28/2013 9:54:07 AM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
1. Standardized process for documenting in medical record chronic condition education per Chronic Condition and Disease Management Programs 2.20.2.4 contract performance outcome 3.
2. In-service staff on:
   a. Documentation of chronic condition education at each visit.
   b. Agenda/sign off sheet to verify, inclusive of all pertinent staff.
3. Monitoring
   a. Audit tools developed.
   b. Weekly site results discussed with RVP.
   c. Audit results discussed a monthly CQI meeting.
   d. Minutes and audit reported monthly to Regional office for tracking and trending.

Responsible Parties = FHA/DON//Medical Director/RDCQI/RVP
Target Date - 11/30/13
Plan weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.10/11/13 Update – Documentation on education sheet located in front of chart, medical records responsible for making sure in chart.

Prescribing Practices and Pharmacy (Q)						
	Performance Measure (Description)	**Grn**	**Amb**	**Red**	**Notifications**	**Level**
1	Are recommendations made by the Pharmacy and Therapeutics Committee appropriately enacted? [CC 2.20.2.6]	X			5/31/2013 8:03 AM Entered By: Leslie Boothby	2
2	Are pharmacy polices, procedures forms, (including non-formulary requests) being followed? [NCCHC Standard P-D-01, CC 2.20.2.6]		X		5/31/2013 8:03 AM Entered By: Leslie Boothby HSTM 4.1.6 Non-Formulary Drug Requests & HSTM 4.1.1 Pharmaceutical Dispensing Procedures - Amber – will remain amber until a completed written action plan is received and implemented with weekly follow up documentation of results to ADC from each Complex Site by Corizon Health. A) HSTM 4.1.6 Non-Formulary Drug Requests: A written Action Plan is required from Julie Carter, Regional Pharmacist, Corizon, to ensure that requests for necessary non-formulary medications at each Complex Site, are received by inmate patients in a timely manner. Providers will need to provide formulary medications, if needed, to provide continuity of care while the NFDR is being processesd. This Action Plan requires documented weekly follow-up from Corizon staff that identifies that medications have been approved or denied and if denied, an appropriate therapy is instituted so that the patient will not go without medication during the approval/denial process. May 2013 Non Formulary Drug Requests - Stop Date Reports indicate: 1363 Non-formulary drugs expiring for 1171 patients B) HSTM 4.1.1 Pharmaceutical Dispensing Procedures: A written Action Plan is required from Julie Carter, Regional Pharmacist, Corizon, to ensure that all prescriptions are dispensed in a timely manner so as not to contribute to morbidity or mortality and so that the inmate population receive continuity of care. This Action Plan requires weekly documented follow-up from Corizon staff. Medications should be renewed before the expiration date to provide continuity of care. May 2013 Expired Medications - Stop Date Report indicates: 10,117 Expired Medications for 5,168 Patients. Snapshot of April 1, 2013 – May 16,2013 for Psychotropic medications (not including amitriptyline, nortriptyline and gabapentin for medical use). Stop Date Report indicates: 1051 Expired Psychotropic Medications for 694 patients. Note: not same parameter as May 2013 reporting. Some information will be duplicated in the Expired Medication reporting for May 2013. C) Julie Carter, Corizon Regional Pharmacist, implemented the Pharmacy Corrective Action Plan on May 13th, 2013. She followed up on May 20th, 2013 with a conference call to DONs/FHAs to identify problems and resolutions and discuss progress of renewals. A Status Report was submitted 05/30/13. Most, but not all findings were reported at that time. We are	2

					hoping to receive a report with all findings and a significant improvement in Continuity of Care for Non-Formulary and Expired Medications next month.	
3	Are all medications being prescribed in the therapeutic ranges as determined by the most current editions of the “Drug Facts and Comparisons" or the packet insert?	X			5/31/2013 8:03 AM Entered By: Leslie Boothby	1

Corrective Action Plans for PerformanceMeasure: Prescribing Practices and Pharmacy (Q)

2 Are pharmacy polices, procedures forms, (including non-formulary requests) being followed? [NCCHC Standard P-D-01, CC 2.20.2.6]
Level 2 Amber User: Leslie Boothby Date: 5/31/2013 8:03:12 AM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
1.Standardized process statewide, to include but not limited to (Pharmacy Appendix 1 & 2):
a.Expired Medications (Appendix I.1.a.)
b.Re-order medications
c.Invalid chart orders (Appendix I.1.c.)
i.Therapeutic dose ranges
ii.Dose changes must have supporting documentation
d.Non-formulary process (Appendix I.1.d.)
i.Reviewed for approval within 24-48 hrs
ii.Providers notified decision within 24-48 hrs
e.Manifest Reconciliation
f.Inventory control
g.Stock Medications
h.Practitioner Cards (Appendis I.1.h.)
i.Controlled Medications (Appendix I.1.i.)
2.In-service staff
a.Using information from 8/19 - 11/13 Regional office mandatory in-service and PharmaCorr policy
b.Agenda/sign off sheet to verify, inclusive of all pertinent staff (Appendix I.2.b.)
3.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsible Parties = FHA/DON/IC/RDCQI/RVP
Target Date-11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.
10/11/13 Update – Statewide in Sept Redbook and MAR audit, results reviewed; to audit pharmacy in October related to Controlled Substances and Expired meds.

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No Shows (Q)

	Performance Measure (Description)	Grn	Amb	Red	Notifications	Level
1	Are medical, dental and mental health line "no-shows" being reported and documented per policy, Department Order 1101? [DO 1101, HSTM Chpt 5, Sec. 7.1, CC 2.20.2.9]		X		5/31/2013 2:46 PM Entered By: Mark Haldane Dental reported not having no-shows during the reporting period. According to mental health staff, no-shows are reported to the HSA and re-scheduled. Missed medical appointments are handled differently on different units. For example, on Santa Cruz inmates are ticketed for resisting or disobeying a verbal or written order if they do not show up for a scheduled appointment after being advised that she needed to come to medical (see inmate). Lumley reported that they do not have no-shows and none were found. Other yards report rescheduling no-shows, but DO 1101 is often not followed. D.O. 1101.03 sec. 1.7 states that Health Services staff shall notify the shift supervisor within four hours about inmates who do not appear for their scheduled appointments. Upon being notified, the shift supervisor shall investigate and determine why the inmate failed to appear for the appointment and notify the Health Unit. If the inmate refuses to keep the on-site appointment and refuses treatment, security staff shall bring the inmate, if compliant, to the Health Unit and health staff shall counsel the inmate on risks of refusing the appointment. If he/she still refuses the appointment, ask the inmate to sign the Refusal to Submit to Treatment, Form 1101-4 (Negativa de Someterse a Tratamiento, Form 1101-4S). If the inmate refuses to sign the form, Health Services staff shall have two independent witnesses attest to the refusal by signing the form. If the inmate agrees to the appointment and there is not sufficient time for health staff to conduct the appointment the inmate shall be rescheduled. Sec 1.8 states: Health Services staff shall submit to the appropriate Deputy Warden or Administrator each workday an Information Report, Form 105-2, listing missed appointments for which the Health Unit has received no explanation or otherwise remain unresolved. Sec. 1.9 reads: The Deputy Warden or Administrator shall investigate the circumstances of each unresolved missed appointment, and take appropriate action, ensuring the information regarding the missed appointment is transmitted to the Contract Health Site Manager for inclusion in the Medical Record within seven workdays.	1

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Corrective Action Plans for PerformanceMeasure: No Shows (Q)
1 Are medical, dental and mental health line “no-shows” being reported and documented per policy, Department Order 1101? [DO 1101, HSTM Chpt 5, Sec. 7.1, CC 2.20.2.9] **Level 1 Amber User: Mark Haldane Date: 5/31/2013 2:46:27 PM**
Corrective Plan: See October action plan as submitted by Corizon.
Corrective Actions: Reinforce with staff to complete a refusal form to be signed by inmate. Continue to monitor. Responsible Parties= RN/LPN Target Date = 11/30/13

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Mental Health (Q)

	Performance Measure (Description)	Grn	Amb	Red	Notifications	Level
1	Are HNRs for Mental Health services triaged within 24 hours of receipt by a qualified Mental Health Professional, to include nursing staff? [CC 2.20.2.10]	X			5/28/2013 10:43 AM Entered By: Steve Bender All HNR's were triaged within the required (24) hour time frame.	2
2	Are inmates referred to a Psychiatrist or Psychiatric Mid-level Provider seen within seven (7) days of referral? [CC 2.20.2.10]	X			5/28/2013 10:44 AM Entered By: Steve Bender All referrals were occurring within the designated (7)day time frame.	2
3	Are MH treatment plans updated every 90 days for each SMI inmate, and at least every 12 months for all other MH-3 and above inmates? [CC 2.20.2.10]		X		5/28/2013 10:56 AM Entered By: Steve Bender A review of (50) medical records with an SMI designation revealed (8) with a treatment plan which had not been updated within the past (90)days. Of these (6) were assigned to the San Carlos Unit: [redacted] - 12/27/12, [redacted] - 1/3/13, [redacted] - 1/17/13, [redacted] 12/26/12 - 12/26/12, [redacted] - 2/27/12, [redacted] - 10/2/12 The other (2) were provided to the assigned clinician to update.	1
4	Are inmates with a mental score of MH-3 and above seen by MH staff according to policy? [CC 2.20.2.10]	X			5/28/2013 11:08 AM Entered By: Steve Bender A review of (100)medical records revealed (5) which had not been seen in the past (90)days as required by policy. These findings were were provided to the assigned clinician for corrective action.	2
5	Are inmates prescribed psychotropic meds seen by a Psychiatrist or Psychiatric Mid-level Provider at a minimum of every three (3) months (90 days)?[CC 2.20.2.10]	X			5/28/2013 11:11 AM Entered By: Steve Bender All inmates assessed to be unstable are referred for evaluation within the designated (30) day time frame.	2
6	Are reentry/discharge plans established no later than 30 days prior release for all inmates with a MH score of MH-3 and above? [CC 2.20.2.10]	X			5/28/2013 11:14 AM Entered By: Steve Bender A review of (100) medical records found (3)which had not been seen within the past (3) months. This information was provided to the assigned PRN for corrective action.	2

Corrective Action Plans for PerformanceMeasure: Mental Health (Q)

3 Are MH treatment plans updated every 90 days for each SMI inmate, and at least every 12 months for all other MH-3 and above inmates? [CC 2.20.2.10]
Level 1 Amber User: Steve Bender Date: 5/28/2013 10:56:41 AM

Corrective Plan: We will follow Mr. Bender's recommendation to have inmate treatment plans signed each time they are seen by the mental health staff.

Corrective Actions: See above.

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Grievances						
	Performance Measure (Description)	**Grn**	**Amb**	**Red**	**Notifications**	**Level**
1	Is a grievance tracking system in place and being utilized? [P-A-11; P-A-04]	X			5/31/2013 11:36 AM Entered By: Mark Haldane Grievances are tracked in an Excel spreadsheet. The system is being utilized.	1
2	Are grievance trends being tracked and addressed? [P-A-11; P-A-04]		X		5/31/2013 11:37 AM Entered By: Mark Haldane While the data is available, there was no evidence that trends were being identified and addressed.	1

Corrective Action Plans for PerformanceMeasure: Grievances
2 Are grievance trends being tracked and addressed? [P-A-11; P-A-04] **Level 1 Amber User: Mark Haldane Date: 5/31/2013 11:37:53 AM**
Corrective Plan: See October action plan as submitted by Corizon.
Corrective Actions: Reinforce the need for grievance trends to be tracked and addressed. Continue to monitor.

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Transfer Screening

	Performance Measure (Description)	Grn	Amb	Red	Notifications	Level
1	Are the inmate medical record being reviewed within 12 hours of Inmate arrival to unit by nursing staff? [NCCHC Standard P-E-03 and HSTM Chapter 5, Section 2.0, 5.0; DO 1104.05]		X		5/28/2013 7:45 AM Entered By: Mark Haldane Approximately 140 inmates were transferred to San Pedro Unit in early May. Several plastic bins of charts were in the medical records room for at least 2 days before they were reviewed. Nurse Nunn from San Carlos and Nurse Greenwalt from Lumley were summoned to San Pedro to complete the transfer summaries and did a fine job, but those summaries were not completed within the required timeframes. On other yards, the summaries reviewed were completed by the day after the charts' arrival. Medical records clerks are not on every yard each day, so charts do not travel on the same day as the inmate in several instances.	1
2	Is nursing staff ensuring inmate medication was transferred with inmate? [HSTM Chpt. 5, Sec. 6.1, 5.0, CC 2.7.2.3]		X		5/29/2013 9:10 AM Entered By: Mark Haldane In May there were at least two instances where medical staff sent records and medications to CDU when notified that an inmate had been moved, only to have security refuse to accept the sealed envelope. This problem was addressed with the Warden and seems to be resolved. Staff reports that PharmaCorr does not download inmate location from AIMS, and inmate locations on newly ordered or renewed medications are frequently incorrect. This delays the receipt of these medications from 2 to 7 days. Movement lists are sent to the medical records clerks daily, but the med nurses are not always aware of who is being moved, so MARs and meds are not always being transferred with the inmate. Again, delays are sometimes 2-5 days.	1
3	Is mental health staff reviewing inmate medical record with 24 hours of arrival (72 hours Friday / Weekend)? [CC 2.7.2.3, HSTM Chapter 5, Section 6.1,5.0]		X		5/31/2013 2:54 PM Entered By: Mark Haldane Although mental health staff sees inmates at intake in a timely manner, staff does not generally review charts within 24 hours when the movement is between units. Medical staff reviews the charts and mental health staff will review charts when referred by medical. Movement lists should be used to ensure that this review is completed. Some mental health staff has reported that with the loss of staff they need to prioritize functions based on need. These reviews have not been a high priority given other acute needs related to direct care. Nonetheless, mental health staff should receive daily meovement lists and review charts of inmates who move between units.	1

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4	Is dental staff reviewing inmate medical record with 24 hours of Inmate arrival (72 hours Friday / Weekend)?	X			5/29/2013 9:17 AM Entered By: Mark Haldane 5/29/2013 9:17 AM Entered By: Mark Haldane Dental staff is reviewing charts upon arrival at the Complex but does not review charts for intra-Complex movement. There is no dental unit at Santa Cruz, San Pedro or Lumley and Santa Maria's dental unit is open only one day per week. San Carlos dental is open 4 days per week, but charts are not reviewed for intra-Complex movements.	1

Corrective Action Plans for PerformanceMeasure: Transfer Screening
1 Are the inmate medical record being reviewed within 12 hours of Inmate arrival to unit by nursing staff? [NCCHC Standard P-E-03 and HSTM Chapter 5, Section 2.0, 5.0; DO 1104.05] **Level 1 Amber User: Mark Haldane Date: 5/28/2013 7:45:04 AM**
Corrective Plan: The Nurse Supervisors will be reminded that all charts must be reviewed within 12 hours of arrival to the unit. In accordance with the operational logistics of mass movement of inmates medical will plan to have enough staff present to meet this 12 hour obligation. See below.
Corrective Actions: Reinforce to staff the necessity that the medical records need to be reviewed within 12 hours of an Inmate's arrival to the unit by nursing staff. Responsible Parties = RN/LPN Target Date – 11/30/13
2 Is nursing staff ensuring inmate medication was transferred with inmate? [HSTM Chpt. 5, Sec. 6.1, 5.0, CC 2.7.2.3] **Level 1 Amber User: Mark Haldane Date: 5/29/2013 9:10:27 AM**
Corrective Plan: Once the nurses receive the movement sheet, they will pack up the MARS, meds and charts and it all is delivered to the unit with the inmate.
Corrective Actions: Nursing staff needs to ensure they receive the list of inmates being transferred and that there medication (DOT) are ready to be transferred when inmate is transferred. Responsible Parties = RN/LPN Target Date – 11/30/13
3 Is mental health staff reviewing inmate medical record with 24 hours of arrival (72 hours Friday / Weekend)? [CC 2.7.2.3, HSTM Chapter 5, Section 6.1,5.0] **Level 1 Amber User: Mark Haldane Date: 5/31/2013 2:54:21 PM**
Corrective Plan: See October action plan as submitted by Corizon.
Corrective Actions: Reinforce to staff the necessity that the medical records need to be reviewed within 12 hours of an Inmate's arrival to the unit by mental health staff. Responsible Parties = MH Staff Target Date – 11/30/13

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Medication Administration

	Performance Measure (Description)	Grn	Amb	Red	Notifications	Level
1	Is there a formal medication administration program? [NCCHC Standard P-C-05]	X			5/13/2013 10:26 AM Entered By: Vanessa Headstream	1
2	Is the documentation of completed training and testing kept on file for staff who administer or deliver medications? [NCCHC Standard P-C-05; HSTM Chapter 3, Section 4.1]		X		5/23/2013 9:34 AM Entered By: Vanessa Headstream Documentation of training/testing is not available for review, training presentation sent to HSA/DON	1
3	Is there a tracking system for KOP medications to determine if medications have been received by the inmate? [NCCHC Standard P-D-01]	X			5/10/2013 1:33 PM Entered By: Vanessa Headstream KOP medications are tracked via the KOP MARs on the units, officer delivery units (PU/SR) have inmate-signed rosters for tracking purposes	1
4	Are the Medication Administration Records (MAR) being completed in accordance with standard nursing practices? [HSTM Chapter 4, Section 1.1, Chapter 5, Section 6.4]		X		5/23/2013 9:33 AM Entered By: Vanessa Headstream IPC - [redacted], MAR does not have diagnosis, allergies, ADC #, DOB, start/stop dates, ordering provider, nursing signatures 5/21/2013 12:25 PM Entered By: Vanessa Headstream San Carlos - MARs reviewed demonstrate non compliance: Insulin MARs - missing dates of administration,[redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted]; nursing initials do not have corresponding signature Pill pass MARS - missing dates of administration, nursing initials do not have corresponding signature, no diagnosis, [redacted] has "NS" documented 8 days - 05/11/13 to 05/18/13; [redacted] has "NA" documented 9 days - 05/10/13 to 05/18/19, no documentation for 05/19/13 to today [redacted] has "NA" documented 8 days - 05/01/13 to 05/08/13, no documentation for 05/09/13 to today 5/6/2013 11:27 AM Entered By: Vanessa Headstream IPC - medications not documented as given (missing doses), "NA" documented, med circled (not administered) without reason given, nurse initials do not have corresponding signature - [redacted], [redacted], [redacted] 5/6/2013 8:17 AM Entered By: Vanessa Headstream Brent Lumley - 05/01/13 - The 1000 am med pass @ Lumley unit was not conducted in a timely manner today, the med deliveries started at around 1200 pm according to RN Lane and were completed about 1330. The MARs for 24, 26, and 28 yard have all been documented as being delivered at the scheduled 1000 am time, which is incorrect. The MARs for the same yards are also documented for the 1700 pm	1

					med pass today, the LPN on shift said she pulled the meds, so she documented them. That LPN will not be delivering the 1700 meds, the pre-poured meds will have to be destroyed and the nurse completing the evening med pass will have to prepare the meds himself.	
5	Are medication errors forwarded to the FHA to review corrective action plan?		X		5/23/2013 9:36 AM Entered By: Vanessa Headstream No medication errors reported though MAR documentation facility wide indicates occurrence of errors	2
6	Are there any unreasonable delays in inmate receiving prescribed medications?		X		5/23/2013 9:31 AM Entered By: Vanessa Headstream IPC - inmate , Insulin qhs not documented 05/07/13, 05/11/13, 05/13/13, Keflex qd not documented 05/18/13, protein supplement qd not documented 05/17,13, 05/18/13, 05/21/13, Mag Oxide qd not documented 05/18/13, 05/20/13, 05/22/13 inmate , Celexa qd not documented 05/21/13 inmate , Lorazepam TID not documented 05/19/13 am, 05/20/13 am & 1400, 05/21/13 am & 1400 5/21/2013 12:32 PM Entered By: Vanessa Headstream San Carlos - inmate , Methotrexate 2.5mg 3 po q Fri not documented as given 05/17/13; inmate , Zoloft 50mg po qhs not documented as given 05/02/13, 05/06/13 & 05/07/13; inmate , Cogentin 1mg 1 po BID not documented as given 05/18/13 am thru 05/21/13 am; inmate , meds d/c'd or changed to KOP 05/15/13 are documented as administered 05/17/13 5/6/2013 3:21 PM Entered By: Vanessa Headstream Santa Cruz - inmate Cephalexin 500mg 2 po BID x 7 days; dispensed 04/30/13, med card found in KOP bin for delivery, stop date 05/07/13 Santa Rosa - inmate Prednisone 5mg 2 tabs po qd x 7 days, then Prednisone 5mg 1 tab po qd x 14 days; ordered 04/25/13, not delivered until med taken from stock supply 05/06/13 Brent Lumley - inmate Loxapine 25mg 1 po qhs, started 01/23/13; MAR documentation "NA" 05/02/13 through 05/05/13 inmate Benztropine 2mg 1 po BID, started 01/09/13; MAR documentation "NA" 05/04/13 through 05/06/13; Excedrin Migraine 2 tabs po TID prn, started 01/21/13; MAR documentation "NA" 05/01/13 through 05/06/13 inmate Fluoxetine 20mg 1 cap po qam, started 02/22/13; MAR documentation "NA" 05/02/13 through 05/06/13	2

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7	Are inmates being required to show ID prior to being administered their medications?	X			5/10/2013 1:33 PM Entered By: Vanessa Headstream	2
8	Are chronic condition medication expiration dates being reviewed prior to expiration to ensure continuity of care? [NCCHC Standard P-D-01]		X		5/22/2013 11:46 AM Entered By: Vanessa Headstream Review of the stop date report for May 8-14, 2013 indicates - 87 i/m checked, 189 prescriptions; 103 were reordered on or prior to stop date, 86 expired; 26 prescriptions ran out of meds prior to reorder date based on "last fill date" information on stop date report. 5/10/2013 1:38 PM Entered By: Vanessa Headstream Review of the stop date report for May 1-7,2013 indicates - 85 i/m checked, 198 prescriptions; 126 were reordered on or prior to stop date, 72 expired; 3 i/m were out of meds prior to reorder date	2
9	Are non-formulary requests being reviewed for approval or disapproval within 24 to 48 hours?	X			5/21/2013 12:33 PM Entered By: Vanessa Headstream	2
10	Are providers being notified of non-formulary decisions within 24 to 48 hours?	X			5/21/2013 12:33 PM Entered By: Vanessa Headstream	2
11	Are medication error reports being completed and medication errors documented?		X		5/23/2013 9:37 AM Entered By: Vanessa Headstream No medication errors reported though MAR documentation facility wide indicates occurrence of errors	2

Corrective Action Plans for PerformanceMeasure: Medication Administration

2 Is the documentation of completed training and testing kept on file for staff who administer or deliver medications? [NCCHC Standard P-C-05; HSTM Chapter 3, Section 4.1]
Level 1 Amber User: Vanessa Headstream Date: 5/23/2013 9:34:43 AM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
1.Standardized process statewide to include, but not limited to :
a.Refusals/No Show - Policy titled “Appointment or Treatment Refusals” Chapter 5, Section 7.2 (Appendix VI.1.a.).
b.MAR documentation.
c.Administration of DOT/KOP.
d.Printing MARs (Pharmacy Appendix).
e.Medication error documentation/reporting (Pharmacy Appendix).
2.In-service staff on process and PharmaCorr policy.
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff.
3.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed.
b.Weekly site results discussed with RVP.
c.Audit results discussed a monthly CQI meeting.
d.Minutes and audit reported monthly to Regional office for tracking and trending.
Responsible Parties =FHA/DON/RDCQI/RVP/FHA
Target Date- 11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

4 Are the Medication Administration Records (MAR) being completed in accordance with standard nursing practices? [HSTM Chapter 4, Section 1.1, Chapter 5, Section 6.4]
Level 1 Amber User: Vanessa Headstream Date: 5/23/2013 9:33:14 AM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
1.Standardized process statewide to include, but not limited to :
a.Refusals/No Show - Policy titled “Appointment or Treatment Refusals” Chapter 5, Section 7.2 (Appendix VI.1.a.).
b.MAR documentation.
c.Administration of DOT/KOP.
d.Printing MARs (Pharmacy Appendix).
e.Medication error documentation/reporting (Pharmacy Appendix).
2.In-service staff on process and PharmaCorr policy.
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff.
3.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed.
b.Weekly site results discussed with RVP.
c.Audit results discussed a monthly CQI meeting.
d.Minutes and audit reported monthly to Regional office for tracking and trending.
Responsible Parties =FHA/DON/RDCQI/RVP/FHA
Target Date- 11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

4 Are the Medication Administration Records (MAR) being completed in accordance with standard nursing practices? [HSTM Chapter 4, Section 1.1, Chapter 5, Section 6.4]
Level 1 Amber User: Vanessa Headstream Date: 5/23/2013 9:33:14 AM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
1.Standardized process statewide to include, but not limited to :
a.Refusals/No Show - Policy titled “Appointment or Treatment Refusals” Chapter 5, Section 7.2 (Appendix VI.1.a.).
b.MAR documentation.

c.Administration of DOT/KOP.
d.Printing MARs (Pharmacy Appendix).
e.Medication error documentation/reporting (Pharmacy Appendix).
2.In-service staff on process and PharmaCorr policy.
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff.
3.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed.
b.Weekly site results discussed with RVP.
c.Audit results discussed a monthly CQI meeting.
d.Minutes and audit reported monthly to Regional office for tracking and trending.
Responsible Parties =FHA/DON/RDCQI/RVP/FHA
Target Date- 11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

5 Are medication errors forwarded to the FHA to review corrective action plan?
Level 2 Amber User: Vanessa Headstream Date: 5/23/2013 9:36:50 AM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
1.Standardized process statewide to include, but not limited to :
a.Medication error documentation/reporting (Pharmacy Appendix).
2.In-service staff on process and PharmaCorr policy.
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff.
3.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed.
b.Weekly site results discussed with RVP.
c.Audit results discussed a monthly CQI meeting.
d.Minutes and audit reported monthly to Regional office for tracking and trending.
Responsible Parties =FHA/DON/RDCQI/RVP/FHA
Target Date- 11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

6 Are there any unreasonable delays in inmate receiving prescribed medications?
Level 2 Amber User: Vanessa Headstream Date: 5/23/2013 9:31:02 AM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
Intakes-
1.Standardized process for meds to be available to inmate upon transfer (Pharmacy Appendix 1 & 2)
a.Intake Orders
b.Private Prisons
2.In-service staff on process per PharmaCorr policy,
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff
3.Custody educated regarding contract requirements regarding inmate transfer with meds.
4.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsibile Parties = FHA/DON/Custody/RDCQI/RVP
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results
1.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
2.Standardized process statewide to include, but not limited to (Appendix III.1.):
a.Internal

b.External
2.In-service staff on process and ADC policy titled “Continuity of Care Upon Transfer” Chapter 5, Section 5.0 (Appendices III.2.);
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff
3.Custody educated regarding contract requirements regarding inmate transfer with meds
4.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsible Parties = FHA/DON/Custody/RDCQI/RVP
Target Date - 11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

6 Are there any unreasonable delays in inmate receiving prescribed medications?
Level 2 Amber User: Vanessa Headstream Date: 5/23/2013 9:31:02 AM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
Intakes-
1.Standardized process for meds to be available to inmate upon transfer (Pharmacy Appendix 1 & 2)
a.Intake Orders
b.Private Prisons
2.In-service staff on process per PharmaCorr policy,
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff
3.Custody educated regarding contract requirements regarding inmate transfer with meds.
4.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsibile Parties = FHA/DON/Custody/RDCQI/RVP
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results
1.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
2.Standardized process statewide to include, but not limited to (Appendix III.1.):
a.Internal
b.External
2.In-service staff on process and ADC policy titled “Continuity of Care Upon Transfer” Chapter 5, Section 5.0 (Appendices III.2.);
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff
3.Custody educated regarding contract requirements regarding inmate transfer with meds
4.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsible Parties = FHA/DON/Custody/RDCQI/RVP
Target Date - 11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

6 Are there any unreasonable delays in inmate receiving prescribed medications?
Level 2 Amber User: Vanessa Headstream Date: 5/23/2013 9:31:02 AM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
Intakes-
1.Standardized process for meds to be available to inmate upon transfer (Pharmacy Appendix 1 & 2)
a.Intake Orders
b.Private Prisons
2.In-service staff on process per PharmaCorr policy,
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff
3.Custody educated regarding contract requirements regarding inmate transfer with meds.
4.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsibile Parties = FHA/DON/Custody/RDCQI/RVP
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results
1.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
2.Standardized process statewide to include, but not limited to (Appendix III.1.):
a.Internal
b.External
2.In-service staff on process and ADC policy titled “Continuity of Care Upon Transfer” Chapter 5, Section 5.0 (Appendices III.2.);
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff
3.Custody educated regarding contract requirements regarding inmate transfer with meds
4.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsible Parties = FHA/DON/Custody/RDCQI/RVP
Target Date - 11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

8 Are chronic condition medication expiration dates being reviewed prior to expiration to ensure continuity of care?
[NCCHC Standard P-D-01]
Level 2 Amber User: Vanessa Headstream Date: 5/22/2013 11:46:50 AM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
1.Standardized process for meds to be available to inmate upon transfer (Pharmacy Appendix 1 & 2)
2.In-service staff on process per PharmaCorr policy,
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff
3.Custody educated regarding contract requirements regarding inmate transfer with meds.
4.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsibile Parties = FHA/DON/Custody/RDCQI/RVP
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results
1.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting

d.Minutes and audit reported monthly to Regional office for tracking and trending
2.Standardized process statewide to include, but not limited to (Appendix III.1.):
a.Internal
b.External
2.In-service staff on process and ADC policy titled “Continuity of Care Upon Transfer” Chapter 5, Section 5.0 (Appendices III.2.);
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff
3.Custody educated regarding contract requirements regarding inmate transfer with meds
4.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed
b.Weekly site results discussed with RVP
c.Audit results discussed a monthly CQI meeting
d.Minutes and audit reported monthly to Regional office for tracking and trending
Responsible Parties = FHA/DON/Custody/RDCQI/RVP
Target Date - 11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

11 Are medication error reports being completed and medication errors documented?
Level 2 Amber User: Vanessa Headstream Date: 5/23/2013 9:37:30 AM

Corrective Plan: See October action plan as submitted by Corizon.

Corrective Actions: October Action plan submitted by Corizon-
1.Standardized process statewide to include, but not limited to :
a.Medication error documentation/reporting (Pharmacy Appendix).
2.In-service staff on process and PharmaCorr policy.
a.Agenda/sign off sheet to verify, inclusive of all pertinent staff.
3.Monitoring (Appendix I. - IV Monitoring Tools)
a.Audit tools developed.
b.Weekly site results discussed with RVP.
c.Audit results discussed a monthly CQI meeting.
d.Minutes and audit reported monthly to Regional office for tracking and trending.
Responsible Parties =FHA/DON/RDCQI/RVP/FHA
Target Date- 11/30/13
Continue to monitor weekly x 3 weeks, monthly until within compliance, then quarterly; monitoring frequency using audit tool per audit results.

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Infirmary Care

	Performance Measure (Description)	Grn	Amb	Red	Notifications	Level
1	Does policy or post order define the specific scope of medical, psychiatric, and nursing care provided in the infirmary setting?	X			5/20/2013 9:10 AM Entered By: Vanessa Headstream	1
2	Are patients always within sight or hearing of a qualified health care professional (do inmates have a method of calling the nurse?)		X		5/28/2013 9:52 AM Entered By: Vanessa Headstream The non existence of a patient call system has been brought to the attention of the HSA on multiple prior occasions with no resolution noted. NCCHC guideline P-G-03 #3 states "Patients are always within sight or hearing of a qualified health care professional." "The use of non medical staff to alert health staff in the event of a need does not constitute compliance." Patients housed in the isolation rooms may not have access to health care staff through visual or auditory signals. 5/6/2013 8:30 AM Entered By: Vanessa Headstream No call system in place, patients rely on officer or other staff person passing by roonms or calling loudly for nurse when needing assistance.	1
3	Is the number of appropriate and sufficient qualified health professionals in the infirmary determined by the number of patients, severity of illnesses and level of care required?	X			5/10/2013 1:28 PM Entered By: Vanessa Headstream Staffing plan is 1 RN and 1 CNA scheduled for 12 hour shift coverage at all times, posted scheduled indicates CNA coverage does not meet staffing plan.	1
4	Is a supervising registered nurse in the IPC 24 hours a day?	X			5/10/2013 1:28 PM Entered By: Vanessa Headstream	1
5	Is the manual of nursing care procedures consistent with the state's nurse practice act and licensing requirements?	X			5/6/2013 11:35 AM Entered By: Vanessa Headstream	1
6	Does admission to or discharge from infirmary care occur only on the order of physician or other provider where permitted by virtue of credentials and scope of practice?	X			5/13/2013 10:06 AM Entered By: Vanessa Headstream inmate - 05/11/13 @ 1459 nurse recv'd v.o. "send her to IPC", no admit order for diet/activity/etc. in medical file, no documentation that IPC nurse contacted a provider for orders 5/10/2013 1:28 PM Entered By: Vanessa Headstream	1
7	Is the frequency of physician and nursing rounds in the infirmary specified based on categories of care provided?	X			5/10/2013 1:29 PM Entered By: Vanessa Headstream	1

8	Is a complete inmate health record kept and include: -Admitted order (admitting diagnosis, medications, diet, activity restrictions, required diagnostic tests, frequency of monitoring and follow-up -Complete document of care and treatment given -Medication administration record -Discharge plan and discharge notes		X		5/21/2013 9:13 AM Entered By: Vanessa Headstream Review of IPC records demonstrates non compliance: inmate - 05/17/13 no documentation of care after beginning nurse assessment @ 1900 hours; 05/19/13 no beginning nurse assessment documented @ 1900 hours; SOAPE assessment with no time, date or vs documented; 05/20/13 no vs documented with beginning nurse assessment 5/13/2013 10:15 AM Entered By: Vanessa Headstream Review of IPC records demonstrates non compliance: inmate - no admit order noted in medical file, no d/c plan noted inmate, inmate, inmate - incomplete MAR documentation	1
9	If inpatient record is different than outpatient record, is a copy of the discharge summary from the infirmary care placed in the patient's outpatient chart?	X			5/10/2013 1 29 PM Entered By Vanessa Headstream IP and OP records are not differentiated.	1
10	If an observation patient is placed by a qualified health care professional for longer than 24 hours, is this order being done only by a physician?	X			5/10/2013 1:29 PM Entered By: Vanessa Headstream	1
11	Are vital signs done daily when required?	X			5/21/2013 9:14 AM Entered By: Vanessa Headstream completed vs are documented on CNA flow sheet, not consistently transferred to SOAPE note/assessment of nurse 5/10/2013 1:30 PM Entered By: Vanessa Headstream	1
12	Are there nursing care plans that are reviewed weekly and are signed and dated?		X		5/21/2013 8:59 AM Entered By: Vanessa Headstream Review of nursing care plans indicate continued non compliance, no signatures or dates of review are documented 5/10/2013 1:31 PM Entered By: Vanessa Headstream Review of nursing care plans indicate non comliance, no signatures or dates of review are present	1
13	Are medications and supplies checked regularly, and who is assigned to do it? [NCCHC Standard P-D-03]	X			5/10/2013 1:32 PM Entered By: Vanessa Headstream CNA is responsible for monitoring of supplies, the RN is responsible for monitoring of medications	1

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Corrective Action Plans for PerformanceMeasure: Infirmary Care
2 Are patients always within sight or hearing of a qualified health care professional (do inmates have a method of calling the nurse?) **Level 1 Amber User: Vanessa Headstream Date: 5/28/2013 9:52:08 AM**
Corrective Plan: See October action plan as submitted by Corizon.
Corrective Actions: Ensure that inmates have a method available to contact nursing staff.
8 Is a complete inmate health record kept and include: **-Admitted order (admitting diagnosis, medications, diet, activity restrictions, required diagnostic tests, frequency of monitoring and follow-up** **-Complete document of care and treatment given** **-Medication administration record** **-Discharge plan and discharge notes** **Level 1 Amber User: Vanessa Headstream Date: 5/21/2013 9:13:32 AM**
Corrective Plan: See October action plan as submitted by Corizon.
Corrective Actions: Reinforce to staff that a complete inmate health record is kept and must include: -Admitting orders (admitting diagnosis, medications, diet, activity restrictions, required diagnostic tests, frequency of monitoring and follow-up -Complete document of care and treatment given -Medication administration record -Discharge plan and discharge notes.
12 Are there nursing care plans that are reviewed weekly and are signed and dated? **Level 1 Amber User: Vanessa Headstream Date: 5/21/2013 8:59:01 AM**
Corrective Plan: See October action plan as submitted by Corizon.
Corrective Actions: Reinforce with staff to initiate a care plan upon admission and regularly update, making sure plan is signed and dated.

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Medical Tools

	Performance Measure (Description)	Grn	Amb	Red	Notifications	Level
1	Do nursing staff inventory and account for tools assigned to medical areas? D.O 702		X		5/31/2013 10:05 AM Entered By: Mark Haldane On Monday May 20, 2013, there was a discrepancy in the insulin syringe count on San Pedro. Staff reported that the nurse who had conducted the 0500 insulin line did not sign out the needles. The counts in both the "diabetic cabinet" and the back-up supply in the file cabinet were incorrect. According to staff, 30 syringes were unaccounted for. The missing syringes were not immediately reported to the shift commander as required by DO 712.02.1.8. Inventory was not taken at the beginning of the shift as required by DO 712.03.1.5. Information Reports and Tool Disposition forms were not completed in accordance with DO 712.02.1.8. The Health Services Summary Count Sheet was not completed in accordance with HSTM Chapter 2, Section 3.0.5.2. Inventory Control Logs were not completed in accordance with the DO 712 and HSTM Chapter 2, Section 3.0. On may 28, 2013, a syringe was reported missing and an ICS was called. At 0815, the syringe was reported being accounted for. Staff reported that a nurse had signed out the syringe on the wrong page, but the documentation on the log books does not indicate where,when or what the error was. At San Pedro there are two separate sharps books, one for the "diabetic cabinet" and another for all other sharps and tools. At San Carlos, there is a diabetic closet for insulin sharps, which are counted with the other sharps and tools. Santa Maria does not have insulin dependent diabetics and there is no separate diabetic cabinet. At Lumley and Santa Cruz, there is a separate diabetic cabinet. It was explained to me that the reason for a separate diabetic cabinet was so nurses could provide insulin shots without doing a complete inventory count on weekends when staffing was limited. However, sharps and tools are not locked with a numbered, locking tag, as they are stored in a 4-drawer file cabinet. In accordance with D.O. 712 and HSTM Chapter 2, Section 3.0, a daily inventory of all the instruments in the health area will be conducted to maintain control and accurate records. An inventory will be performed at the beginning of each shift that is staffed by Health Services personnel and at the end of each shift that is staffed by Health Services Personnel. Only Santa Maria is not staffed on weekends, so daily counts should be done on all other yards. Counts are not done on weekends on all staffed yards, as required.	1
2	Are missing / lost health tools or instruments reported immediately to the shift commander?		X		5/31/2013 10:07 AM Entered By: Mark Haldane On Monday May 20, 2013, there was a discrepancy in the insulin syringe count on San Pedro. Staff reported that the nurse who had conducted the 0500 insulin line did	2

					not sign out the needles. The counts in both the "diabetic cabinet" and the back-up supply in the file cabinet were incorrect. According to staff, 30 syringes were unaccounted for. The missing syringes were not immediately reported to the shift commander as required by DO 712.02.1.8. Inventory was not taken at the beginning of the shift as required by DO 712.03.1.5. Information Reports and Tool Disposition forms were not completed in accordance with DO 712.02.1.8. The Health Services Summary Count Sheet was not completed in accordance with HSTM Chapter 2, Section 3.0.5.2. Inventory Control Logs were not completed in accordance with the DO 712 and HSTM Chapter 2, Section 3.0. On may 28, 2013, a syringe was reported missing and an ICS was called. At 0815, the syringe was reported being accounted for. Staff reported that a nurse had signed out the syringe on the wrong page, but the documentation on the log books does not indicate where,when or what the error was. There were no other incidents of missing or lost tools during the review period.	
3	Does the Site Manager (FHA) maintain a Master Tool Inventory for all non-disposable surgical/dental tools, medical instruments/devices and hand-held medical/dental tools?		X		5/31/2013 11:16 AM Entered By: Mark Haldane D.O. 712.03 §1.2 requires the Facility Health Administrator to maintain a Master Tool Inventory for all non-disposable surgical and dental tools, medical instruments and devices and handheld tools used in providing medical and dental services to inmates. Assigned staff from each medical discipline shall maintain a master tool inventory for their area of responsibility. The Master Tool Inventory may be maintained by the FHA in a single binder or may be maintained by each Key Contact for their areas of responsibility. Where practical, any tool identified on the Master Tool Inventory shall be engraved, "HSD-PV" (ASPC- Perryville). Tools that cannot be engraved due to risk of alteration of clinical capability or decreased ability to sterilize will be identified by the Facility Health Administrator in accordance with Department Order 712. For example, the manufacturer's serial number shall be used to identify dental hand pieces, since these tools cannot be engraved. Each medical discipline shall provide a copy of the Master Tool Inventory for the previous month to the Facility Health Administrator on the third business day of each month. The Facility Health Administrator will on a monthly basis, review and collate the Master Tool Inventory and forward a copy to the Complex Chief of Security within the time frame of dates negotiated between the FHA and the complex Warden. The Complex Chief of Security will review and distribute the inventory to the Unit Chiefs of Security. Since the FHA maintains the Master Tool Inventory on a month by month basis, the units are not required to retain prior month inventories unless directed by the respective FHA.	1

					The Director of Nursing provided me with a file with Master Tool Inventories, however the folder did not include all units or disciplines. Santa Maria MAster Tool Inventoy was not completed until May 14th. The dental units at complex did have master tool inventories, but they are kept on forms that are not ADC approved or numbered. There is not a uniform understanding of what constitutes a medical tool or what is subject to daily inventory counts. Master Tool Inventories should be complete, accurate and timely.	
4	Are medical tools engraved, where practical, to identify the tools as health services items?	X			5/31/2013 11:21 AM Entered By: Mark Haldane Where practical, any tool identified on the Master Tool Inventory shall be engraved, "HSD-PV" (ASPC- Perryville). Tools that cannot be engraved due to risk of alteration of clinical capability or decreased ability to sterilize will be identified by the Facility Health Administrator in accordance with Department Order 712. For example, the manufacturer's serial number shall be used to identify dental hand pieces, since these tools cannot be engraved. As a result of the recent ADC audit, the tool control officers ingraved a number of previously unengraved items, such as stethescopes and pulse oxes. This standard has been met.	1
5	Where dental tools/hand pieces cannot be engraved, is the serial number used for identification?	X			5/31/2013 11:22 AM Entered By: Mark Haldane Although there are other itentifying numbers used as well, serial numbers on hand pieces are used.	1
6	Are sharps being inventority at the beginning and end of each shift?		X		5/31/2013 11:28 AM Entered By: Mark Haldane Sharps have not been consistently counted at the beginning and end of each shift as required by DO 712.03.1.5. In one example, a nurse's shift began at 0800. The Health Services Summary Count Sheet shows that tool count on 5/20/13 did not begin until 1110. There was an error in the count. This makes it more difficult to definitively say when the error occurred as the count was 3 hours into the shift when the error was discovered. As noted elsewhere, full counts are not done on weekends. At San Carlos, counts were done at 1630, rather than at the end of the nurse's shift (1900). Where weekend counts were conducted, they were only done once, rather than at the beginning and end of the shift.	2
7	If sharps count is off is nursing notifying the shift		X		5/31/2013 11:33 AM Entered By: Mark	2

	commander?				Haldane During the review period, there were two instances in which count was reported off. Both cases were at San Pedro. In one case the shift commander was not notified. In the other, the shift commander was notified and an ICS was called. In the former case, the nurse wrote a statement on an IR form, but it did not have a number and was not dated. It was not tuned in to security. Policy (DO 712.02 1.8) requires that any individual who discovers that a tool(s) is lost or missing shall immediately report the loss to the shift commander. The report shall include identification of the tool(s) lost or missing and the circumstances surrounding the disappearance, and all measures taken to investigate and search for the tool(s). The shift commander shall ensure all involved staff complete Information Reports and the appropriate Tool Disposition forms prior to the end of the shift. That process was not followed.	
8	Are officers present for sharps inventories with the nursing staff?	X			5/31/2013 11:34 AM Entered By: Mark Haldane With the exception of weekends when sharps counts are often not done, this standard is met.	2

Corrective Action Plans for PerformanceMeasure: Medical Tools
1 Do nursing staff inventory and account for tools assigned to medical areas? D.O 702 **Level 1 Amber User: Mark Haldane Date: 5/31/2013 10:05:33 AM**
Corrective Plan: See October action plan as submitted by Corizon.
Corrective Actions: Reinforce that nursing staff inventories and accounts for tools assigned to medical areas per policy.
2 Are missing / lost health tools or instruments reported immediately to the shift commander? **Level 2 Amber User: Mark Haldane Date: 5/31/2013 10:07:12 AM**
Corrective Plan: See October action plan as submitted by Corizon.
Corrective Actions: Reinforce with staff that missing tools or instruments are reporting to the shift commander. Continue to monitor.
3 Does the Site Manager (FHA) maintain a Master Tool Inventory for all non-disposable surgical/dental tools, medical instruments/devices and hand-held medical/dental tools? **Level 1 Amber User: Mark Haldane Date: 5/31/2013 11:16:49 AM**
Corrective Plan: See October action plan as submitted by Corizon.
Corrective Actions: Make sure Master Tool Inventory for all necessary instruments are maintained. Responsible Parties = FHA/AFHA Target Date= 11/30/13
6 Are sharps being inventority at the beginning and end of each shift? **Level 2 Amber User: Mark Haldane Date: 5/31/2013 11:28:57 AM**
Corrective Plan: See October action plan as submitted by Corizon.
Corrective Actions: Reinforce with staff that sharps inventories must be conducted at the beginning and end of every shift. Continue to monitor.

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7 If sharps count is off is nursing notifying the shift commander? **Level 2 Amber User: Mark Haldane Date: 5/31/2013 11:33:27 AM**
Corrective Plan: See October action plan as submitted by Corizon.
Corrective Actions: Reinforce with staff to notify the shift commander if counts are off. Continue to monitor.

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Medication Room

	Performance Measure (Description)	Grn	Amb	Red	Notifications	Level
1	Is the medical room kept locked when not occupied?	X			5/6/2013 2:49 PM Entered By: Vanessa Headstream 5/6/2013 11:29 AM Entered By: Vanessa Headstream IPC - nursing station door was open, staff was in the hallway with dr., cabinet containing syringes was unlocked and standing open -	1
2	Are quarterly audits of the unit (Floor Stock/RDSA)medicaton by a pharmacist being conducted and documented?	X			5/24/2013 8:03 AM Entered By: Vanessa Headstream will be conducted at the end of the current quarter	2
2	Are open medication vials being marked with the date they were opened?		X		5/21/2013 12:15 PM Entered By: Vanessa Headstream San Carlos - 4 insulin bottles open/not dated in the refrigerator; 1 flu vaccine open/dated 04/2013 expired 5/6/2013 2:44 PM Entered By: Vanessa Headstream Brent Lumley - 4 insulin bottles open/not dated Santa Cruz - 2 bottles TB solution open/not dated; 1 bottle insulin open/dated 03/2013 expired San Pedro - 1 insulin bottle open/not dated 5/6/2013 11:33 AM Entered By: Vanessa Headstream Complex - 3 insulin bottles open/dated 02/2013 & 03/2013 expired; 1 insulin bottle open/not dated; 2 bottles TB solution open/not dated	1
3	Is nursing staff checking for outdated (expiring)medications?		X		5/21/2013 12:14 PM Entered By: Vanessa Headstream San Carlos - 68 expired patient specific medications noted to be in current supply 5/14/2013 10:32 AM Entered By: Vanessa Headstream PU/SM/SR - 5 expired patient specific medications noted to be in current supply 5/6/2013 2:48 PM Entered By: Vanessa Headstream Brent Lumley - 14 expired patient specific medications noted to be in current supply Santa Cruz - 13 expired patient specific medications noted to be in current supply San Pedro - 1 expired patient specific medication noted to be in current supply 5/6/2013 11:34 AM Entered By: Vanessa Headstream Complex - 4 OTC/clinic stock medications	1

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Corrective Action Plans for PerformanceMeasure: Medication Room
2 Are open medication vials being marked with the date they were opened? **Level 1 Amber User: Vanessa Headstream Date: 5/21/2013 12:15:32 PM**
Corrective Plan: See October action plan as submitted by Corizon.
Corrective Actions: Reinforce to nursing staff to make sure vials are dated when they are opened. Responsible Parties = RN/LPN Target Date = 11/30/13
3 Is nursing staff checking for outdated (expiring)medications? **Level 1 Amber User: Vanessa Headstream Date: 5/21/2013 12:14:30 PM**
Corrective Plan: See October action plan as submitted by Corizon.
Corrective Actions: Reinforce to nursing staff to make sure clinic stock and DOT medications are not with expired dates. If they are expired, return to pharmacy per policy. Responsible Parties = RN/LPN Target Date = 11/30/13