

**California Department Of Corrections
and Rehabilitation**

Division of Juvenile Justice

NA Chaderjian Youth Correctional Facility
Health Care Audit
February 25-28, 2008¹

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Introduction

The Health Care Remedial Plan (HCRP) requires the Division of Juvenile Justice (DJJ) to make a number of specific changes in the medical, mental health, and dental care programs. To measure DJJ compliance with the requirements of the Health Care Remedial Plan, the Medical Experts developed this audit instrument with clearly defined standards and criteria, and thresholds of compliance. The audit instrument is comprised of indicators selected from:

- The Health Care Remedial Plan
- DJJ policies and procedures developed in consultation with the Medical Experts
- National Commission on Correctional Health Care (NCCCHC) Standards for Health Services in Juvenile Detention and Confinement Facilities, 2004 Edition
- The American Medical Association's Guidelines for Adolescent Preventive Services (GAPS)
- US Preventive Services Task Force (USPSTF)
- Guidelines for the evaluation and treatment of other disease such as those published by the Centers for Disease Control and Prevention (CDC)

Regarding those areas related to nursing and medical care practice, the Medical Experts will use their professional judgment to assess compliance.

This audit instrument does not address mental health or dental services. The Mental Health and Dental Experts will develop the Mental Health and Dental Audit Instruments.

The Medical Experts have developed a companion document to the audit instrument entitled *Health Care Audit Instrument Instructions*. Its purpose is to clarify interpretations and scoring of the audit instrument. This document is available on request.

Audit Instrument and Compliance Thresholds

The audit instrument will be used by the Medical Experts to evaluate compliance with the HCRP. It is also intended for use by the DJJ Office of Health Services Quality Management Team and by the local facility Quality Management Team to evaluate progress consistent with the HCRP. The audit instrument includes indicators from sources cited above, which the Medical Experts judge to be critical in establishing an adequate health care system. Some indicators allow for partial compliance if the facility is close to, but has not yet achieved substantial compliance.

A facility is in substantial compliance when all of the following conditions are satisfied:

- a. The facility receives a score of 85% or higher during an audit conducted by the Court experts. When determining overall compliance, areas that are determined to be in partial compliance will be considered non-compliant. The experts shall have the discretion to find a facility providing adequate medical care in compliance if it achieves a score of no less than 75%.

- b. Medical assessments and treatment plans provided to youth comply with the policies and procedures, as determined by the medical experts. The medical assessment and treatment plans provided to the youth shall be deemed adequate and appropriate under these policies and procedures, only under any one of the following conditions:
 - (1) The assessment or treatment plan is consistent with guidelines specifically adopted in the policies and procedures; or
 - (2) The practitioner documents in the medical notes that he/she is deviating from adopted policies and procedures, and that such deviation is consistent with the community standard; or
 - (3) Where no treatment guidelines are specifically adopted in these policies and procedures, the assessment or plan is consistent with the community standard.
- c. The facility is conducting minimally adequate death reviews and quality management proceedings.
- d. The facility has tracking, scheduling, and medication administration systems adequately in place.
- e. Both experts have concluded that there is not a pattern or practice that is likely to result in serious violations of wards' rights that is not being adequately addressed.

NA Chaderjian (Chad) Youth Correctional Facility

Executive Summary

Overall, the facility scored 61% (453 of 744 indicators).

The facility population at the time of our visit was 210 youths. Staff reported that there are plans to increase the population to 330 youth when departmental program moves are completed. Currently they have 11 housing units open and ultimately plan to have 12 units. In addition to the main outpatient clinic, there is a clinic in the Intensive Treatment Program (ITP).

With respect to contracts and personnel, staff reported continued problems with both processes. The CMO advised us that the contracts for the local hospital (San Joaquin) and for Alpine orthopedic services have not been completed for the current fiscal year. In July 2007, they applied for an extension of the other specialty contracts for 60-90 days, which was approved, but it expired and was not renewed. Despite the lack of a contract, they are using the services but the respective vendors have not been paid. Staff believed the process worked more efficiently when DJJ had the ability to develop and implement local contracts.

The statewide nursing registry contracts for July 2007 to July 2008 were only recently approved and sent to them in January. Prior to this they were not able to use registry nurses because they did not have a contract. Moreover, these registries are statewide, and they are required to call registries that may not be in their geographical area (e.g., West Covina for psych and pharmacy techs). Even after the registry recruits people, they have to go through the personnel approval process, which takes 2-3 months. The primary delay in hiring is in the Livescan fingerprinting process. Apparently, the Livescan machine at the facility does not work properly resulting in some prospective employees having to come back five times for repeat fingerprint scans. Staff said they often are not even notified that there is a problem until a significant amount of time has elapsed. A request has been made to replace the machine but it has not been approved for reasons that were not made clear to us. They have lost a number of prospective employees due to the lengthy approval process.

Summary of Health Care Areas Reviewed

Clinic Space and Sanitation

This area was not independently scored. We noted that significant improvements in sanitation had occurred in the OHU where they have a full time janitor. In the Chad outpatient clinic there have been physical plant improvements. The walls in most rooms were painted and the hallway, office, and clinical examination room floors were recently stripped and waxed. The main clinic treatment room is somewhat cluttered and not as clean as other areas. This is undoubtedly due to its frequent use, which should result in more, not less frequent cleaning and disinfection activities. There was no posted schedule of cleaning and disinfection activities in any of the clinical areas.

There are no dedicated or consistent janitorial services in the Chad outpatient clinic. The ITP

clinic is cluttered and the floors are dirty. Some of the furniture is old and in disrepair, and equipment is broken (e.g., copier). We understand that the youth are currently being housed in Mohave while Merced is under renovation, and strongly recommend that the medical clinic be renovated as well.

Facility Leadership, Budget, Staffing, Orientation, and Training scored 55%

Key health care leadership positions are filled. The Chief Medical Officer, Dr. Gabriel Tanson, is board-certified in family practice. Although it was reported to us that the Chief Medical Officer was provided a health care budget, it is unclear to the medical experts that this is a functional budget. Staff reported that they have been given budget figures, but that the facility does not actually have the dedicated funds; health care invoices are paid from a general fund. Although there has been improved cooperation between medical and custody staff, health care staff reported that youth are not being consistently escorted to the medical unit for medical appointments. Contributing to this is the fact that the medical waiting area is used for youth awaiting parole hearings, which often prevents other youth from being brought up for medical appointments. There was no posted security staff assigned to the Chad outpatient medical unit, other than in the control unit outside the clinic. There was also no security post in the control unit after 5 pm. When nurses give out medications, there is no dedicated correctional officer to facilitate the process. We recommend that the facility establish a correctional officer post for the medical clinic and control station for 16 hours per day, 7 days per week.

Although we did not conduct a formal staffing assessment during this visit, we noted that staff continues to be added to the complex despite the decreasing population. The Northern California Youth Correctional Complex (NCYCC), currently consists of NA Chaderjian (population 210), OH Close (population 184), and Dewitt Nelson (population 183). Dewitt Nelson is scheduled to close by 7/31/08. NCYCC is budgeted for a Chief Medical Officer, three physicians, and a 0.7 FTE nurse practitioner for approximately 580 youth. Even with the projected increase in population at Chad, the overall population of the complex will decrease by 63 youth with the closure of DeWitt Nelson. The 0.7 nurse practitioner was only recently hired and had not yet started at the time of our visit. In addition, physician permanent intermittent employees (PIEs) are used to fill in when physicians are on vacation. As previously recommended, in the face of the current state budget crisis, we recommend that DJJ re-evaluate staffing needs at these facilities.

Medical reception scored 42%

Youth who are parole revocators are receiving timely medical reception evaluations. The clinician who conducts these evaluations appears to be very conscientious. However, there are some system and clinical issues that affect the quality of the evaluations. One issue is that both the receiving medical screening and the history and physical examination are being performed the day the youth arrives, yet staff reported that the health record was available only about 50% of the time. This has resulted in the clinician not having access to, and not addressing important historical information.

Moreover, the clinician does not adequately explore historical information that is provided at the time of the physical such as a history of asthma, TB infection, etc. One youth reported a history of hypertension and a 'mild stroke' for which no further information was obtained. The history

and physical examination form contributes to the lack of a complete history. It contains a review of symptoms but the form does not require a yes or no response to each symptom, and it is unclear whether each question is asked. This should be done. The lack of access to the health record also results in the Problem List not being updated when the physical examination is performed. We noted that both routine and specifically ordered lab tests are not consistently being implemented. Because DJJ policy does not require clinicians to write orders for 'routine' admission labs (RPR, Chlamydia and Gonorrhea urine screening, voluntary HIV antibody, and tuberculin skin tests), there is no system of transcription and accountability for carrying out the orders. We also noted that laboratory results are not being reviewed until approximately three weeks after results are available, which is an undue delay.

Nurses are conducting post test counseling in the housing units. This was reportedly due to escort problems. Post test counseling requires a confidential setting in which to answer questions and provide risk reduction counseling. Nurses are not measuring visual acuity for newly arriving youth.

Finally, the clinician does not consistently identify each active medical problem, document a plan, and monitor the patient until the plan is implemented and the desired clinical result achieved.

In summary, we recommend that the health care leadership develop a medical reception process, in which the clinician does not perform the history and physical examination until the health record has been obtained and lab results are available. Clinicians should address all pertinent historical information and explore current symptoms more fully. Nurses should measure visual acuity of all newly arriving youth and notify patients of their test results in a medical setting that provides confidentiality. We recommend that clinicians write orders for any lab test, diagnostic procedure, and treatment the patient is to receive and that completion of these tests be documented in the health record. DJJ may wish to develop a standardized physician order sheet for newly arriving or returning youth to save time for clinicians writing orders (sample is attached).

Finally, the clinician should update the Problem List with all current medical problems (including health risks such as obesity, tobacco, alcohol and drug use, etc.) and develop a treatment plan for each problem.

Intrasystem Transfer Scored 56%

The intrasystem transfer review process is occurring in a timely manner. However, in three of nine applicable records, the sending facility did not complete the top portion of the form. Nurses need to complete all portions of the form, including disposition of the patient. In four of ten records a clinician did not review and sign the form in a timely manner, or at all. Three of seven patients did not receive medications or have them renewed in a timely manner. Most significantly, five of seven youth did not receive appropriate and timely follow-up for chronic disease management, previously ordered consultations, and clinical monitoring. We recommend that clinicians perform a more thorough review of the youth's previous medical history and treatment plan, and ensure appropriate follow-up and clinical monitoring.

Nursing Sick Call was not Evaluated

We did not evaluate nursing sick call during this visit because health care leadership reported that all patients were being referred directly to a clinician. We will evaluate this area during our next site visit.

Medical Care scored 65%

Areas requiring improvement included the history and plan, and ensuring that the plan is implemented in a timely manner.

Chronic Disease Management scored 60%

Chad does not have a reliable chronic disease tracking system. The main clinic and ITP maintain independent tracking systems. When we requested the chronic disease tracking log, we were provided only the main clinic log, not the ITP. It was only after we inadvertently found a youth with HIV infection who was not on the list (who was housed in the ITP) that we realized there were two lists. Moreover, neither list contained the names of all chronic disease patients. This was not unexpected given that we found that newly arriving youth were not consistently enrolled in the program. In addition to the development of a reliable tracking system, other areas requiring improvement included the initial history, frequency of chronic care visits, the assessment, the treatment plan, education, and vaccinations.

Infection Control scored 38%.

There are no local policies regarding the implementation of the infection control program. There is a nurse who is assigned infection control responsibilities. She is relatively new to her job duties and appears to be very conscientious. She has not received any formal training. Infection control meetings have been recently implemented but do not address all required areas. We discussed this with the infection control nurse and made some recommendations regarding meeting content and the need to address trends.

Pharmacy Services scored 100%

Congratulations!

Medication Administration Process scored 60%

Areas requiring improvement include sanitation of both the main clinic room and the Intensive Treatment Program clinic area. There is an accountability system for narcotics and syringes; however, during our review, we found narcotics in an unlocked bag and not double locked. It was reported that each evening narcotics are transported for the Chad clinic to the OHU to ensure that two nurses count and document accountability for the medication; this was reportedly why the nurse kept the narcotics in the bag for transport later that evening. However, this is a serious breach of security practices regarding narcotics. The DJJ Director of Nurses was present at the time of our observation, and addressed the situation with the nurse immediately and with the SRN the following day.

Medication Administration Health Record Review scored 80%

This area is doing generally well. However, nurses do not currently transcribe the physician order onto the MAR prior to the pharmacy filling the order. This should be done since there are no other checks and balances (aside from checking the original order) to assure that the dispensed medication is what the physician ordered or that the ordered medication was actually dispensed by the pharmacy (i.e., if nothing is on the MAR, how does the nurse know that a medication should have been delivered from the pharmacy?). Other areas of improvement include nursing documentation of administration status (e.g., administered, refused, etc.) for every scheduled dose onto the MAR. Nurses should also discontinue medication orders according to policy and standard nursing procedures. Nurses should refrain from crossing out the original order on the MAR as a mechanism to signal that the order is discontinued.

Urgent/Emergent Care scored 60%

The evaluation of urgent care involved inspection of emergency equipment and supplies in the main clinic and ITP. In both areas, the emergency response bag did not contain a list of standardized equipment and supplies. Thus, when the nurse checks the bag each day, the nurse has nothing to compare it against for completeness. In the ITP the bag was disorganized. There was no peak flow meter. Ace bandages were old and stuck together. No emergency drills have been conducted. Our record review included both a sample of charts from the Chad emergency log and also the OHU log, which included youth from Chad. Our review showed concerns regarding nursing and clinical assessments, and clinical follow-up after patient visits to the emergency room.

Outpatient Housing Unit scored 73%

Areas requiring improvement include physicians writing complete admission orders and nurses documenting complete and appropriate assessments.

Health Records scored 0%

At Chad, we learned that if the person responsible for health records is on vacation, no one is assigned to complete her responsibilities. The health records are not consistently organized. The Problem List was not consistently visible upon opening the record. In some records there was a tab for physician orders and in other records there was not. The Receiving Screening form and History and Physical Examination form were filed in the progress notes rather than the database. Physician orders were found in both the progress notes and physician order forms. In fact, we found primarily medication orders on the physician order forms. This was reportedly because the pharmacy requested only pharmacy orders on the physician order sheet; however, we were later told that this was not policy. There was no tracking system for laboratory and consultation reports, or a reliable health record filing system.

We recommend that the facility: develop local policies to ensure compliance with the statewide policies; organize health records consistent with statewide policies; develop a laboratory and consultation report tracking system; and assign responsibility for health record duties when the assigned person is on vacation.

Preventive Services scored 79%

Areas requiring improvement included clinician identification and development of a treatment plan for youth who are obese, and follow-up of abnormal blood pressures.

Consultations scored 38%

Areas requiring improvement included timeliness of consults and follow-up after the consultation.

Peer Review scored 60%

Areas requiring improvement included development and implementation of local peer review policy and review of sentinel events.

Credentialing scored 88%

Areas requiring improvement included the development and implementation of statewide and local credentialing policies.

Quality Management scored 50%

Areas requiring improvement included ongoing quality management meetings and studies, physician review of nursing sick call, SRN review of nursing sick call, and annual Quality Management Report to the Statewide Medical Director.

Recognizing that there are areas requiring improvement, we wish to congratulate staff on their progress to date.

Facility Leadership, Budget, Staffing, Orientation and Training

Interview facility leadership. Review staffing and vacancy reports, facility health care budget, staff credentials and licensure, and orientation and training documentation. Key: SC =Substantial Compliance, PC=Partial Compliance, NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Key facility health care leadership positions (Chief Medical Officer [CMO], Supervising Registered Nurse [SRN], Pharmacist, etc.) are filled or are being effectively recruited. Pay parity exists with CDCR.	1 ²			
Question #2	Each facility has a full-time CMO who is board-certified or eligible in a primary care field. The NCYCC shall have one full-time CMO responsible for all complex facilities. The CMO's duties are consistent with the HCSR (see page 14).	1 ³			
Question #3	In both policy and actual practice, the facility is assigned a health care budget that is under the control of the CMO.		0 ⁴		
Question #4	Budgeted and actual physician staffing hours are sufficient to meet policy and procedures requirements, and to provide quality medical services.	1			
Question #5	Budgeted and actual registered nurse staffing hours are sufficient to meet policy and procedures requirements and to provide quality nursing services.				N/E
Question #6	Medical Technical Assistant's (MTA) primary responsibilities will be the performance of health care duties.	1			
Question# 7	Escort staffing and cooperation are sufficient to assure that youth attend on-site health care appointments		0 ⁵		
Question #8	The CMO ensures that an accurate and complete system exists for tracking professional and DEA licensure; and that CPR certification is in place. All licensed staff has a current and valid license.	1 ⁶			
Question #9	Newly hired staff receives a structured orientation program within 30 days of arrival. Documentation of orientation is kept in personnel files.		0 ⁷		
Question #10	Existing staff is trained regarding changes in new policies and procedure within 60 days of distribution.		0 ⁸		
	Totals:	5	4		1

Compliance = 55% (5 of 9 Applicable Questions)

Medical Reception

Select 10 to 20 health records of youth completing medical reception within the past 60-90 days. Include youth with known Latent TB infection and other health problems. Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	The medical reception process is conducted in a confidential and private manner. Signage (in English and Spanish) regarding confidentiality is in the medical area.				N/E
Question #2	There is a comprehensive verbal and written orientation program (minimum English and Spanish) for youth in a language they understand.				N/E
	For calculating score, only give credit for applicable questions in substantial compliance.	Totals:			

Write the youth's ID number in top row:

State ID# →	1 ⁹	2 ¹⁰	3 ¹¹	4 ¹²	5 ¹³	6 ¹⁴	7 ¹⁵	8 ¹⁶	9 ¹⁷	10 ¹⁸
Screen # 1	1	1 ¹⁹	1 ²⁰	1	1	1	1	1 ²¹	1	1
Screen # 2	N/A	N/A	1	N/A	N/A	N/A	1	0 ²²	1	N/A
Screen # 3	0 ²³	0 ²⁴	0 ²⁵	0 ²⁶	0 ²⁷	0 ²⁸	0 ²⁹	0 ³⁰	0 ³¹	0 ³²
Screen # 4	0 ³³	1	1 ³⁴	0 ³⁵	0 ³⁶	1	0 ³⁷	0 ³⁸	N/A ³⁹	0 ⁴⁰
Screen # 5	0 ⁴¹	1 ⁴²	N/A	0 ⁴³	N/A	0 ⁴⁴	1	N/A	N/A	0 ⁴⁵
Screen # 6	1 ⁴⁶	0 ⁴⁷	0 ⁴⁸	0 ⁴⁹	0 ⁵⁰	0 ⁵¹	0 ⁵²	0 ⁵³	0 ⁵⁴	0 ⁵⁵
Screen # 7	N/A	N/A	1 ⁵⁶	0 ⁵⁷	0 ⁵⁸	1	0 ⁵⁹	1	0 ⁶⁰	1 ⁶¹
Screen # 8	N/A	0 ⁶²	0 ⁶³	0 ⁶⁴	0 ⁶⁵	0 ⁶⁶	1 ⁶⁷	0 ⁶⁸	1	N/A
Screen # 9	N/A	N/A	N/A	N/A	0 ⁶⁹	1	1	0 ⁷⁰	1 ⁷¹	N/A
Screen # 10	N/A	0 ⁷²	1	N/A	1	N/A	1	0 ⁷³	1 ⁷⁴	0 ⁷⁵

- Screen # 1 A nurse completed the Receiving Health Screening form on the day of arrival. The nurse referred to, or contacted a clinician for all youth with acute medical, mental health, or dental conditions; with symptoms of TB; or on essential medications.
- Screen # 2 A clinician ordered essential medications (e.g., chronic disease, mental health) on the day of arrival. Medications were administered within 24 hours. No insulin, TB, or HIV doses were missed.
- Screen # 3 A nurse measured the youth's height and weight, vital signs, visual acuity, initiated the immunization history, and planted a PPD (unless previously positive) within 24 hours of arrival. The TB test was read and documented within 72 hours.
- Screen # 4 A nurse obtained routine laboratory tests (RPR, GC, and Chlamydia, voluntary HIV antibody test, pregnancy screen, disease specific tests) within 72 hours and results were communicated to youth either at the time the physical exam was performed or when the youth was brought back for counseling. The clinician appropriately addressed abnormal laboratory findings, including counseling the youth as appropriate.
- Screen # 5 A nurse or clinician documented HIV Post-Test notification and counseling.
- Screen # 6 A clinician performed a history and physical including a testicular exam for males and pelvic examination for females (if clinically indicated) within seven calendar days of arrival. The clinician integrated information from the health screening examination, laboratory tests, and medical history into the physical exam process.
- Screen # 7 A clinician (MD, NP, or PA) initiated a Problem List noting all significant medical, dental, and mental health diagnoses.
- Screen # 8 A clinician documented an appropriate treatment plan on the History and Physical Exam Form or in the Progress Notes. The plan included appropriate diagnostic, therapeutic measures, patient education, and clinical monitoring (if indicated).
- Screen # 9 The UHR reflects that all medical reception physician orders were implemented as ordered.

Screen # 10

Youth with chronic diseases (e.g., asthma, diabetes) were enrolled in the chronic disease management program and clinically evaluated by a clinician for their chronic disease within 30 days of arrival.

Medical Reception Summary:

Screen #	# Records Reviewed	#N/A	Final # of Records	# of Compliant Records	COMMENTS
1	10	0	10	10	In two of ten cases the health record was not present when screening was performed.
2	10	6	4	3	One MAR could not be located to show continuity of medications
3	10	0	10	0	Visual acuity measurements not performed for any patients. Staff reported there is a Snellen eye chart in Dr. Lai's office. Recommend additional chart.
4	10	1	9	3	Either documentation of notification and counseling not present or nurse is conducting notification of test results in the housing units that does not provide adequate privacy for counseling and patient questions. Staff does not write orders for admission labs. There is no tracking system as to whether they are completed or not.
5	10	4	6	2	
6	10	0	10	1	The clinician does not explore relevant medical histories and conduct pertinent examinations. Genital examinations 'declined' in all cases. UHR documented as not being present in some cases.
7	10	2	8	4	
8	10	2	8	2	
9	10	5	5	3	
10	10	3	7	4	Three of four youth eligible for chronic disease management were either not enrolled, or not seen in a timely manner
Total	100	23	77	32	Plus N/E of 2 Questions

Compliance = 42% (32 of 77 Applicable Questions + Screens)

Intrasystem Transfer

Select 10 to 20 health records from the Intrasystem Transfer Log and corresponding Medical Administration Records (MARs) of youth transferred to the facility in the previous 120 days. Review pertinent scheduling logs (consultation, chronic illness clinic, etc.).

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy and procedure. The statewide Transfer Form is in use.			0 ⁷⁶	
Question #2	There is a process whereby health care staff is notified of pending transfers from the facility one business day in advance of transfer.	1			
For calculating score, only give credit for applicable questions in substantial compliance.					
Totals:					

Write the youth's ID number in top row.

State ID# →	1 ⁷⁷	2 ⁷⁸	3 ⁷⁹	4 ⁸⁰	5 ⁸¹	6 ⁸²	7 ⁸³	8 ⁸⁴	9 ⁸⁵	10 ⁸⁶
Date of arrival	10/9/07	7/3/07	10/31/07	11/19/07	1/9/08	12/10/07	12/19/07	1/3/08	11/2/07	12/13/07
Screen # 1	1	0 ⁸⁷	1	1	N/A ⁸⁸	1	0 ⁸⁹	1	0 ⁹⁰	1
Screen # 2	1	0 ⁹¹	1 ⁹²	1	1 ⁹³	0 ⁹⁴	1	1	1	1
Screen # 3	N/A	0 ⁹⁵	1	N/A	0 ⁹⁶	1	N/A	N/A	N/A	N/A
Screen # 4	1	0 ⁹⁷	0 ⁹⁸	0 ⁹⁹	0 ¹⁰⁰	1	1	1	1	1
Screen # 5	N/A	0 ¹⁰¹	0 ¹⁰²	N/A	0 ¹⁰³	N/A	N/A	N/A	N/A	N/A
Screen # 6	1	0 ¹⁰⁴	1	N/A	0 ¹⁰⁵	N/A	N/A	0 ¹⁰⁶	1	1
Screen # 7	0 ¹⁰⁷	0 ¹⁰⁸	1	N/A	0 ¹⁰⁹	0 ¹¹⁰	1 ¹¹¹	N/A	N/A	0 ¹¹²

- Screen # 1 A sending facility nurse reviewed the youth's record prior to transfer and documented required health information on the statewide transfer form. If the sending facility nurse did not complete the transfer form, the receiving nurse documented that she notified the facility of this (minimum information is the sending facility and who the nurse spoke to).
- Screen # 2 Upon arrival, a nurse interviewed the youth and reviewed the UHR. The nurse completed the form noting any additional information related to acute and chronic medical or mental health conditions, current medications, pending or recently completed consultations, and any other health condition requiring follow-up or special housing on the transfer form.
- Screen # 3 The receiving nurse referred youth with acute medical, dental, or mental health conditions on the day of arrival.
- Screen # 4 The receiving physician reviewed the health record of each youth within one business day of arrival and legibly signed and dated the Intrasystem form. The clinician addressed any significant medical problems.
- Screen # 5 A clinician evaluated youth with chronic diseases within 3 business days and enrolled the youth into the chronic disease program.
- Screen # 6 The MAR showed that continuity of essential medications (e.g., chronic disease, mental health, antibiotics, etc.) was provided.
- Screen # 7 The UHR shows that medical care ordered at the previous facility (e.g., vaccinations, consultations, laboratory tests) was carried out following arrival, or a clinical progress note provided an appropriate rationale for doing otherwise.

Intrasystem Transfer Summary:

Screen #	# Records Reviewed	# N/A	Final # of Records	# of Compliant Records	COMMENTS
1	10	1	9	6	
2	10	0	10	8	
3	10	6	4	2	
4	10	0	10	6	Physician/NP did not document review of the form in a timely manner or at all.
5	10	7	3	0	
6	10	3	7	4	
7	10	3	7	2	5 of 7 youth did not receive appropriate follow-up with respect to chronic disease management, consultations, and previously recommended monitoring.
Total	70	20	50	28	1 of 2 Questions

Compliance = 56% (29 of 52 Questions + Screens)

Medical Care

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Did the clinician sign all medical encounters? If the signature was illegible, was a stamp with the clinician's name and credentials used?	1			

Select 10 to 20 records of youth seen by an MD, NP, or PA for medical encounters (return from hospitalization, infirmary, sick call referral, etc.) in the past 180 days.

State ID# →	1	2	3	4	5	6	7	8	9	10
Visit date:	1/6/08	1/15/08	1/23/08	1/23/08	1/25/08	1/14/08	2/26/08	1/24/08	1/16/08	1/4/08
Clinician name:	A	B	B	B	B	B	A	A	A	A
Nature of visit:	Facial infection	Viral syndrome	Knee pain	Headache and stomachache	Vomiting	Finger infection	Chest pain	infection	headache	Back pain
Screen # 1	0 ¹¹³	1	0 ¹¹⁴	0 ¹¹⁵	1	0 ¹¹⁶	0 ¹¹⁷	1	0 ¹¹⁸	0 ¹¹⁹
Screen # 2	1	1	1	1	1	1	1	0	0	1
Screen # 3	1	1	1	0 ¹²⁰	1	0 ¹²¹	1	1	0 ¹²²	0 ¹²³
Screen # 4	1	1	1	N/A	1	1	1	1	N/A	N/A
Screen # 5	1	1	1	N/A	1	0 ¹²⁴	1	1	N/A	N/A
Screen # 6	0 ¹²⁵	1	1	0	1	0 ¹²⁶	1	1	0	1
Screen # 7	1	1	0 ¹²⁷	N/A	N/A	N/A	0 ¹²⁸	0 ¹²⁹	N/A	N/A

- Screen # 1 The clinician addressed the patient's current complaint by obtaining a history of the present illness and appropriate review of systems.
- Screen # 2 The nurse or clinician measured a full set of vital signs when clinically appropriate (including weight, if clinically indicated).
- Screen # 3 The clinician documented all pertinent physical findings, laboratory, and diagnostic results or other related objective data.
- Screen # 4 The clinician made an appropriate assessment based upon the patient's medical history, laboratory, and physical findings.
- Screen # 5 The clinician documented an appropriate treatment plan that included diagnostic and therapeutic measures, clinical monitoring, and follow-up.
- Screen # 6 The clinician documented appropriate patient education related to the diagnosis and treatment plan.
- Screen # 7 All aspects of the treatment plan occurred as ordered within a clinically appropriate time.

Medical Care Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	3	
Screen #2	10	0	10	8	
Screen #3	10	0	10	6	
Screen #4	10	3	7	7	
Screen #5	10	3	7	6	
Screen #6	10	0	10	6	
Screen #7	10	5	5	2	
Total	70	11	59	38	Plus 1 of 1 Question

Compliance = 65% (39 of 60 Questions + Screens)

Chronic Disease Management

Number of patients enrolled in clinic- 26¹³⁰

Percent of clinic health records reviewed 65 %

Select 10 to 20 health records or 10% of this clinic population. Avoid records of youth arriving within the past 90 days. Write the youth's ID number in top row below:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	0 ¹³¹	1	1	1	1	1	1	1	1	1
Screen # 2	0 ¹³²	0 ¹³³	0 ¹³⁴	0 ¹³⁵	0 ¹³⁶	1	0 ¹³⁷	0 ¹³⁸	0 ¹³⁹	0 ¹⁴⁰
Screen # 3	1	N/A	N/A	0 ¹⁴¹	N/A	1	N/A	N/A	0 ¹⁴²	1
Screen # 4	1	0 ¹⁴³	N/A	1	N/A	1	1	1	1	1
Screen # 5	1	0 ¹⁴⁴	N/A	0 ¹⁴⁵	N/A	1	1	0 ¹⁴⁶	1	0 ¹⁴⁷
Screen # 6	0 ¹⁴⁸	N/A	1	1	1	1	1	1	1	1
Screen # 7	0 ¹⁴⁹	N/A	N/A	1	1	1	1	0 ¹⁵⁰	0 ¹⁵¹	0 ¹⁵²
Screen # 8	1	1	1	1	1	1	1	1	1	1
Screen # 9	1	0 ¹⁵³	N/A	1	N/A	1	1	1	1	1
Screen # 10	1	1	1	N/A	0 ¹⁵⁴	N/A	1	N/A	N/A	N/A

State ID# →	11	12	13	14	15	16	17	18	19	20
Screen # 1	1	1	1	1	1	1 ¹⁵⁵	1			
Screen # 2	0 ¹⁵⁶	0 ¹⁵⁷	0 ¹⁵⁸	0 ¹⁵⁹	0 ¹⁶⁰	0 ¹⁶¹	0 ¹⁶²			
Screen # 3	0 ¹⁶³	N/A	N/A	N/A	0 ¹⁶⁴	0 ¹⁶⁵	N/A			
Screen # 4	1	0	N/A	0 ¹⁶⁶	0	1	0 ¹⁶⁷			
Screen # 5	1	N/A	N/A	1	N/A	0 ¹⁶⁸	N/A			
Screen # 6	1	N/A	0	1	N/A	0	N/A			
Screen # 7	0 ¹⁶⁹	N/A	N/A	0 ¹⁷⁰	0 ¹⁷¹	0 ¹⁷²	N/A			
Screen # 8	1	0	0	0	1	1	0			
Screen # 9	1	1	1	1	1	1	1			
Screen # 10	N/A	0 ¹⁷³	0 ¹⁷⁴	0 ¹⁷⁵	N/A	0 ¹⁷⁶	1			

Screen # 1 All chronic diseases are listed on the Problem List.

- Screen # 2 For the initial chronic care visit the clinician performed an appropriate medical history, physical examination pertinent to the management of the chronic disease.
- Screen # 3 Baseline and ongoing follow up laboratory/diagnostic data (HbA_{1c}, serum drug levels, if ordered, etc.) were completed prior to the scheduled clinic visit and the clinician addressed results during the clinic visit.
- Screen # 4 The clinician saw the patient quarterly or more frequently as clinically indicated (i.e., based on degree of disease control). Appropriate exceptions are documented in the UHR.
- Screen # 5 The clinician's evaluation of the youth was clinically appropriate (interval history, physical examination, laboratory tests, etc.).
- Screen # 6 The clinician accurately assessed degree of disease control (i.e., good, fair, poor).
- Screen # 7 The clinician's treatment plan documented appropriate diagnostic & therapeutic measures based upon disease control and indicates when the patient is to be seen for the next clinic follow up visit.
- Screen # 8 The clinician's or nurse's notes document appropriate patient education regarding disease process, diagnostic tests, treatment goals, medication purpose, and side effects, etc.
- Screen # 9 There were no lapses in medication continuity. The clinician's assessment of medication adherence is consistent with the MAR. If the patient was non-adherent, counseling is documented in the health record.
- Screen # 10 The clinician offered/ordered Pneumococcal and annual influenza immunizations as recommended. If accepted, the nurse documented the date of administration and initials on the Immunization and Communicable Disease Record. If refused, the clinician or nurse obtained refusal of treatment.

Chronic Disease Management Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	17	0	17	16	
Screen #2	17	0	17	1	
Screen #3	17	9	8	3	
Screen #4	17	3	14	9	
Screen #5	17	6	11	6	
Screen #6	17	4	13	10	
Screen #7	17	5	12	4	
Screen #8	17	0	17	13	
Screen #9	17	2	15	14	
Screen #10	17	7	10	5	
Total	170	36	134	81	

Compliance = 60% (81 of 134 Screens)

Infection Control

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question # 1	There is a Local Operating Procedure (LOP) describing the facility's infection control program that is consistent with statewide policy.			0 ¹⁷⁷	
Question # 2	There is a licensed health care provider who is designated as having public health/infection control duties and who has received appropriate orientation and training.		0 ¹⁷⁸		
Question # 3	There is a functional system for reporting diseases and laboratory test results, which are required by State and Federal Law (e.g., AIDS cases, positive HIV results, Hepatitis A, B, or C, syphilis, etc.).	1			
Question # 4	There are exposure control plans in place for airborne and blood borne pathogens that include: a) Documentation of new hire and annual training regarding exposure control plans. Not new hire training. b) A policy describing use of standard precautions to prevent contact with blood or other potentially infectious materials (OPIM). Yes c) A policy describing engineering (sharps disposal, specimen handling) and work practice controls intended to eliminate or minimize employee exposure. Yes. d) A policy describing housekeeping procedures used to maintain a clean and sanitary environment, including a written schedule for cleaning and methods of decontamination. No		0 ¹⁷⁹		
Question # 5	Engineering Controls: a) Sharps containers are secure and easily accessible in areas where sharps are used. Yes b) Hand wash facilities are in or near all work areas and antiseptic hand cleaner are available when needed. Yes c) An eyewash station is present and tested quarterly for functionality. The eyewash station functions properly. No eyewash station. d) Specimen containers are used for transport of biological specimens (e.g., blood, urine). Yes. e) Biohazard storage bins are available. Yes. f) Blood and body fluid spills are cleaned appropriately per policy. Not evaluated.	1			
Question # 6	Compliance with work practice controls: a) Food and drink are not kept in refrigerators, freezers, shelves, cabinets, or counter tops where blood, laboratory specimens, or other potentially infectious materials are kept. Yes. b) Staff observes Standard Precautions. Not evaluated. c) Refrigerators are labeled appropriately (biohazard for specimens, food only, or medication only). Yes. d) Personal Protective Equipment is immediately available in health care delivery areas. Yes e) Staff performs hand-washing as required. Not evaluated.	1			

Infection Control Continued:

						SC	PC	NC	NA
Question 7	Are Infection Control Meetings held quarterly (minimum 4 meetings per year)?						0 ¹⁸⁰		
Question 8	If Question 7 is SC or PC , do the minutes address the following areas? (Put Y if topics are present or N if topic is missing, for each quarter in space provided):					QTR 1 ¹⁸¹	QTR 2	QTR 3	QTR 4 ¹⁸²
	a) TB skin testing programs for staff and youth					1			0
	b) Exposure control plans and training regarding airborne and blood borne pathogens					1			0
	c) Hepatitis B training and vaccination programs (e.g., number of employees trained, number accepting vaccine, and number completing vaccination series)					1			0
	d) Staff compliance with work practice controls					0 ¹⁸³			0
	e) Reporting communicable diseases for the previous quarter, noting any trends present					1			1
	f) Sanitation reports (institutional and infection control) and any follow-up action taken					1			0
Question 9	If respiratory isolation rooms are used for the purposes of respiratory isolation they are functional as evidenced by routine testing (at least monthly when not in use and daily when in use). Is staff fit-tested for N-95 respirators?								N/A
For calculating score, only give credit for applicable questions in substantial compliance. Totals:						3	4	1	1

Compliance = 38% (3 of 8 Applicable Questions)

Pharmacy Services

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Is the pharmacy currently licensed?	1			
Question #2	Are the pharmacy and medication rooms adequately lit, organized, clean, and provide sufficient space to prepare medications?	1			
Question #3	Does the facility pharmacist or pharmacy tech conduct monthly inspections of the pharmacy, medications rooms, and all areas of the facility where medications are stored? Does the facility pharmacist or designee develop and implement a plan to correct identified deficiencies?	1			
Question #4	Does the pharmacy have computers and software programs to track medication usage, inventory, cost, drug-drug interactions, and clinical prescribing patterns?	1			
Question #5	Does the pharmacist dispense all prescriptions into appropriate containers labeled with the youth's name, ID number, and medication information as required by state law?	1			
Question #6	Is there strict accountability for all medications dispensed from the pharmacy, including medications administered from a night locker?	1			
Question #7	Is there a pharmacy system for monitoring patient adverse drug reactions?	1			
Question #8	Does the facility have a 24-hour prescription service or other mechanism to provide essential medications 24 hours per day (e.g., night locker)?	1			
Question #9	Are stock bottles of legend medications kept inside the pharmacy (except for biological agents such as insulin and vaccines under proper storage conditions)?	1			
Question #10	Is there a facility Pharmacy and Therapeutics Committee that meets quarterly? Do P & T meeting minutes reflect meaningful content and initiatives to improve pharmacy services?	1			
Question #11	Are youth with asthma permitted to keep inhalers in their possession (except for cause documented in the health record)? Are youth permitted to keep other medications in their possession as determined by the CMO?	1			
Question #12	The pharmacist provides a monthly report detailing pharmacy utilization costs, drug stop lists, monthly lists of drugs used by class, and physician prescribing lists.	1			
Question #13	When a youth paroled, is medication continuity provided in accordance with the policy?	1			
	For calculating score, only give credit for applicable questions in substantial compliance. Totals:	13			

Compliance = 100% (13 of 13 Questions)

Medication Administration Process

Observe all areas where medications are stored and administered. Observe the medication administration process.

Key: SC =Substantial Compliance, PC=Partial Compliance, NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Are medications administered from centralized medication rooms, except in specialized mental health units, SMP, TD, or BTP?	1			
Question #2	Is there a local policy for medication administration that is in compliance with the statewide policy and procedure?			0 ¹⁸⁴	
Question #3	Are the medication storage and administration rooms secure, clean, organized, and have adequate space, storage, lighting, and a sink or alcohol-based hand sanitizer?		0 ¹⁸⁵		
Question #4	Are all medications in the Documented or night locker current and accounted for (from a sample of 5 medications)?				N/E
Question #5	Are all narcotics and other controlled substances double-locked, counted at every shift, and all accounted for (from a sample of 5 medications)?		0 ¹⁸⁶		
Question #6	Are all needles and syringes securely stored, counted at every shift, and all accounted for?		0 ¹⁸⁷		
Question #7	The medication room contains no medications that are discontinued or expired. (There is a 3-day window period to return these medications to the pharmacy.)	1			
Question #8	Are external medications stored separately from internal medications?				N/E
Question #9	Does the nurse administer all legend medication from properly labeled containers and not from stock bottles?	1			
Question #10	Does custody staff provide continuous security during medication administration?				N/E
Question #11	Medications that are to be administered at the hour of sleep are not administered before 2100 hours (one hour window permitted).	1			
Question #12	Is the medication refrigerator clean and used only to store medications (no food or specimens)? Does staff check and log the temperature daily?	1			
Question #13	Medications are not crushed except upon a physician order and for a valid reason (e.g., patient is known to hoard medication). Time-released medications are not crushed.	1			
Question #14	Observe the nurse administering medications to 5 to 10 youth, and answer the following elements.				N/E
					Y or N
a.	The medication administration record (MAR) was available to the nurse during medication administration.				
b.	The nurse confirmed the identity of the youth per policy.				
c.	The nurse compared the medication container label to the MAR.				
d.	The nurse placed the medications into a cup prior to administration.				
e.	The nurse performed visual oral cavity checks for medications in accordance with medication administration policies.				
f.	The nurse documented on the MAR at the time the medication is administered.				
g.	If a medication was not available after hours, the nurse obtained the medication from the Documented or night locker and signed it out prior to administration.				

Compliance = 60% (6 of 10 Applicable Questions)

Medication Administration Health Record Review

Select 10 to 20 health records and corresponding MARs of patients receiving medications in the preceding 180 days to review.

Write the youth's ID number in top row below:

State ID# →	1 ¹⁸⁸	2 ¹⁸⁹	3 ¹⁹⁰	4 ¹⁹¹	5 ¹⁹²	6 ¹⁹³	7 ¹⁹⁴	8 ¹⁹⁵	9 ¹⁹⁶	10 ¹⁹⁷
Screen # 1	1	1	1	1	1	1	1	0 ¹⁹⁸	0 ¹⁹⁹	1
Screen # 2	1	1	1	1	1	1	0 ²⁰⁰	1	1	0 ²⁰¹
Screen # 3	1	1	1	1	1	1	0 ²⁰²	1	1	1
Screen # 4	1	1	1	1	1	1 ²⁰³	0 ²⁰⁴	1	1	0 ²⁰⁵
Screen # 5	1	1	1	1	1	1	0 ²⁰⁶	1	1	0 ²⁰⁷
Screen # 6	1	1	1	1	1	1	1	1	1	0 ²⁰⁸
Screen # 7	0 ²⁰⁹	0 ²¹⁰	0 ²¹¹	1	1	1	1	1	0 ²¹²	0 ²¹³
Screen # 8	1	1	0 ²¹⁴	N/A	N/A	N/A	0 ²¹⁵	N/A	N/A	N/A
Screen # 9	1 ²¹⁶	1 ²¹⁷	1 ²¹⁸	1	1 ²¹⁹	1	1 ²²⁰	1	1	1

- Screen #1 The medication orders were complete (name of medication, strength, route of administration, frequency, duration, and number of refills).
- Screen #2 The clinician order was dated, timed, and legibly signed (if the signature is not legible, a signature stamp must also be used).
- Screen #3 The clinician documented an appropriate clinical note that corresponds with the initial medication order.
- Screen #4 The nurse dated and timed the medication order transcription (routine orders within 4 hours, urgent orders within 2 hours, and stat orders within 1 hour).
- Screen #5 The nurse and/or pharmacy accurately transcribed the physician order onto the MAR.
- Screen #6 The MAR reflected that all medications were initiated within 24 hours of the order being written or on the start date ordered.
- Screen #7 There is documentation of medication administration status (e.g., administered, refused, etc.) for every dose ordered for the youth.
- Screen #8 For discontinued medications, the nurse discontinued medications according to policy.
- Screen #9 The MAR is neat and legible, and contains legible initials, signatures, and credentials of nursing staff who have administered medications to youth.

MAR Review Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	8	
Screen #2	10	0	10	8	
Screen #3	10	0	10	9	
Screen #4	10	0	10	8	
Screen #5	10	0	10	8	
Screen #6	10	0	10	9	
Screen #7	10	0	10	5	
Screen #8	10	6	4	2	
Screen #9	10	0	10	10	
Total	90	6	84	67	

Compliance =80% (67 of 84 Applicable Screens)

Urgent/Emergent Care Services

Select 10 to 20 health records from the Urgent/Emergent Care Tracking Log in the previous 180 days. Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question # 1	There is an Urgent/Emergent Tracking Log that records all unscheduled health care encounters.	1			
Question # 2	Emergency equipment and supplies at the facility are consistent with the statewide policy and procedure. The facility has at least one automated external defibrillator (AED).		0 ²²¹		
Question # 3	The emergency equipment, medications, and supplies are in proper working order. An equipment checklist log shows that health care staff inspects equipment and supplies each shift.	1 ²²²			
Question # 4	There is documentation that health care providers have been trained regarding emergency response. There is documentation of the last three emergency drills and one disaster drill, which delineates the events of the drill and identifies strengths and weaknesses.			0 ²²³	
Question # 5	Interview nurses, physicians, nurse practitioners, physicians assistants, and dentists to ensure that all know how to properly operate the emergency equipment (O ₂ , Ambu bag, cardiac monitor, AED, etc.).				N/E
For calculating score, only give credit for applicable questions in substantial compliance.					
Totals:		2	1	1	1

Write the youth's ID number in the top row:

State ID# →	1 1/23/08	2 1/28/08	3 1/18	4 1/14/08	5 2/14/08	6 2/12/08	7 1/23/08	8 1/19/08	9 2/8/08	10 2/21/08
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	0 ²²⁴	0 ²²⁵	1	0 ²²⁶	1	0 ²²⁷	1	1	1	1
Screen # 3	N/A	1	0 ²²⁸	0 ²²⁹	1	1	0 ²³⁰	1	1	0 ²³¹
Screen # 4	N/A	1	N/A	N/A	1	1	1	1	1	0 ²³²
Screen # 5	1	N/A	N/A	N/A	N/A	N/A	0 ²³³	0 ²³⁴	N/A	N/A
Screen # 6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Screen # 7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

State ID# →	11 ²³⁵	12 ²³⁶	13 ²³⁷	14 ²³⁸	15 ²³⁹	6	7	8	9	10
Screen # 1	1	1	1	1	1					
Screen # 2	0 ²⁴⁰	N/A	1	1	0 ²⁴¹					
Screen # 3	0 ²⁴²	N/A	0 ²⁴³	1	0					
Screen # 4	0 ²⁴⁴	N/A	0 ²⁴⁵	1 ²⁴⁶	0					
Screen # 5	0 ²⁴⁷	0 ²⁴⁸	1 ²⁴⁹	0 ²⁵⁰	0					
Screen # 6	N/A	0 ²⁵¹	0 ²⁵²	1	0					

Screen # 7	N/A	0 ²⁵³	1 ²⁵⁴	0 ²⁵⁵	0					
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- Screen # 1 The entry in the Urgent/Emergent Log is complete, legible, and there is a corresponding progress note in the health care record.
- Screen # 2 The nurse documented the date and time of the encounter and documented an assessment in SOAP format.
- Screen # 3 The nurse's subjective and objective evaluation was appropriate given the nature of the complaint (e.g., vital signs, SOB = peak flow meter, abdominal pain =abdominal assessment)
- Screen # 4 The nurse's assessment and plan were appropriate, including notification or referral to the clinician when clinically indicated.
- Screen # 5 If the nurse referred the youth to a clinician, the follow-up visit was timely and clinically appropriate.
- Screen # 6 For patients returning from the emergency room, nursing staff contacted the physician on-call to obtain follow-up orders.
- Screen # 7 If the youth was sent to an outside facility, the physician saw the youth the following business day.

Urgent/Emergent Care Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	15	0	15	15	
Screen # 2	15	1	14	8	
Screen # 3	15	2	13	6	
Screen # 4	15	4	11	7	
Screen # 5	15	7	8	2	
Screen # 6	15	11	4	1	
Screen # 7	15	11	4	1	
Total	105	37	68	41	Plus 2 of 4 Applicable Questions

Compliance = 57% (42 of 73 Applicable Questions + Screens)

Outpatient Housing Unit

Select 10 to 20 health records of patients currently admitted or discharged from the OHU within the last 180 days.

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy and procedure.			0	
Question #2	There is an Outpatient Housing Unit (OHU) log that lists all youth placed in the OHU in the past 180 days. The log contains youth name, I.D. number, reason for admission and admission and discharge dates.		0 ²⁵⁶		
Question #3	There is a current, standardized nursing procedure manual in the OHU at all times.			0	
Question #4	There is in policy and actual practice a physician on call 24 hours per day, 7 days a week.	1			
Question #5	All youth placed in an OHU are within sight or sound of licensed health care staff at all times in accordance with policy	1			
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	2	1	2	

Write the youth's ID number in the top row:

State ID# →	1	2	3	4	5	6	7	8
Placement date: →	2/4/08	12/23/07	12/26/08	11/30/07	2/15/08	1/12/07	1/23/08	1/28/07
Discharge date: →	2/7/08	12/25/07	12/27/08	12/10/07	2/21/08	1/21/07	1/24/08	2/7/07
Screen # 1	1	1	1	1	1	1	1	1
Screen # 2	0 ²⁵⁷	0 ²⁵⁸	0 ²⁵⁹	0 ²⁶⁰	0 ²⁶¹	0 ²⁶²	0 ²⁶³	0 ²⁶⁴
Screen # 3	1	1	1	1	1	1	1	1
Screen # 4	0 ²⁶⁵	0 ²⁶⁶	0 ²⁶⁷	0 ²⁶⁸	0 ²⁶⁹	1	0 ²⁷⁰	0 ²⁷¹
Screen # 5	1	1	1	1	1	1	1	1
Screen # 6	1	1	1	1	1	1	1	1
Screen # 7	0 ²⁷²	1	1	1	0 ²⁷³	1	1	1
Screen # 8	1	1	1	1	1	1	1	1
Screen # 9	1	1	1	1	1	1	0 ²⁷⁴	1

- Screen #1 The clinician (MD, NP, PA, or psychologist) wrote or gave a verbal order to place the youth in the OHU.
- Screen #2 The clinician orders include the initial impression: diagnostic and therapeutic measures, the frequency of vital signs, and other monitoring (e.g., peak flow meter and capillary glucose measurements, etc.), and clinical criteria for notifying the physician (change in clinical status).
- Screen #3 The youth's clinical condition/reason for admission did not exceed the criteria for placement in the OHU.
- Screen #4 A nurse documented an appropriate initial assessment, plan of care, and patient education (including orientation to the OHU).
- Screen #5 The clinician performed and documented a clinical assessment on the next business day or sooner, if clinically indicated.

- Screen #6 Nursing assessments are documented at least once every shift, or more often if clinically indicated, and are pertinent to the admitting diagnosis (es).
- Screen #7 A clinician conducts clinically appropriate rounds that are documented in the UHR daily, Monday through Friday.
- Screen #8 The UHR reflects that the clinical and nursing plan of care was implemented (e.g., vital signs recorded, lab tests performed, medications administered, etc.).
- Screen #9 A physician and nursing discharge note was completed at the time of release from the OHU.

Outpatient Housing Unit Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	8	0	8	8	
Screen # 2	8	0	8	0	
Screen # 3	8	0	8	8	
Screen # 4	8	0	8	1	
Screen # 5	8	0	8	8	
Screen # 6	8	0	8	8	
Screen # 7	8	0	8	6	
Screen # 8	8	0	8	8	
Screen # 9	8	0	8	7	
Total	72	0	72	54	Plus 2 of 5 Applicable Questions

Compliance = 73% (56 of 77 Applicable Questions + Screens)

Health Records

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question # 1	Local policies are consistent with statewide policies and procedures, and address all aspects of health record management. (See Audit Tool Instructions.)			0 ²⁷⁵	
Question # 2	The Movement and Problem List is visible upon opening the UHR.		0 ²⁷⁶		
Question # 3	There is a functional tracking system for laboratory, diagnostic, and consultation reports.		0 ²⁷⁷		
Question # 4	The facility has a functional system for UHR accountability, filing, and retrieval.		0 ²⁷⁸		
	For calculating score, only give credit for questions in substantial compliance.				
	Totals:	0	3	1	

Compliance = 0% (0 of 4 Applicable Questions)

Preventive Services

Select 10 to 20 health records of youth who have been in DJJ over one year.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a policy and procedure regarding preventive services that is consistent with the US Preventive Services Task Force (USPSTF) and American Medical Association Guidelines for Adolescent Preventive Services (GAPS) in areas that are applicable to DJJ youth.	1			

Write the youth's ID number in the top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Screen # 3	1	0 ²⁷⁹	1	1	1	1	1	0 ²⁸⁰	1	1
Screen # 4	1	0 ²⁸¹	0 ²⁸²	0 ²⁸³	1	0 ²⁸⁴	1	0 ²⁸⁵	0 ²⁸⁶	0 ²⁸⁷
Screen # 5	1	1	1	1	1	1	1	1	0 ²⁸⁸	1
Screen # 6	1	N/A	N/A	1	N/A	1	1	1	1	N/A

- Screen # 1 TB skin testing was performed annually. If previously positive, a nurse conducted a TB symptom screen.
- Screen # 2 Annual pap smears were performed (at a minimum) beginning 3 years after initiation of sexual intercourse and 2 consecutive years thereafter. If there are 3 consecutive normal annual pap smears, then they are performed every 3 years thereafter. Management of abnormal pap smears was appropriate, including referral.
- Screen # 3 A nurse measures the youth's blood pressure annually. The nurse refers youth with abnormal blood pressure to a clinician.
- Screen # 4 A nurse measures the youth weight annually. Obesity is addressed if clinically indicated (BMI >24 %).
- Screen # 5 Hepatitis A and B vaccinations are current, as applicable.
- Screen # 6 Youth are offered Tetanus-Diphtheria Booster if not received within ten years.

Preventive Services Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	10	
Screen # 2	10	10	0	0	
Screen # 3	10	0	10	8	
Screen # 4	10	0	10	3	
Screen # 5	10	0	10	9	
Screen # 6	10	4	6	6	
Total	60	14	46	36	Plus 1 of 1 Question

Compliance = 79% (37 of 47 of Questions + Screens)

Consultation and Specialty Services

Interview staff responsible for specialty service contracts and consultation tracking. Review the Consultation Tracking log. Select 10 health records from the facility of youth who received consultation services in the last 180 days.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local consultation policy and procedure that is consistent with the statewide policy.			0	
Question #2	The facility has implemented the outside specialty care log to include receipt of reports. Staff maintains it accurately and contemporaneously.			0 ²⁸⁹	
Question #3	There is sufficient custody staffing and cooperation to transport youths to outside medical appointments.	1			
	For calculating score, only give credit for questions in substantial compliance.				
	Totals:	1		2	

Write the youth's ID number in top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	0	0	0	1	0	1	1	0	1	1
Screen # 2	N/A	N/A	N/A	1	N/A	1	1	0	1	1
Screen # 3	0	0	1	1	0	1	0	1	1	N/A
Screen # 4	1	0	N/A ²⁹⁰	1	1	1	1	0 ²⁹¹	1	1
Screen # 5	0	0	0	N/A	0	0	0	0	0	0
Screen # 6	0	0	N/A ²⁹²	0 ²⁹³	0 ²⁹⁴	1	0	N/A	0	0
Screen # 7	1	0	1	0	0 ²⁹⁵	0 ²⁹⁶	0	0	0	0
Screen # 8	N/A	0 ²⁹⁷	1	N/A	0 ²⁹⁸	0 ²⁹⁹	N/A	N/A	N/A	N/A
Screen # 9	N/A	0	N/A	0 ³⁰⁰	0 ³⁰¹	N/A	N/A	0 ³⁰²	N/A	N/A

- Screen # 1 The health record contained a Consultation Request Form. The clinician legibly documented the service requested, urgency (routine or urgent), and dated and signed the form.
- Screen # 2 The clinician legibly documented the history of the present illness, physical findings, and lab data that supports the rationale for the service on the Consultation Request Form.
- Screen # 3 The clinician legibly documented the medical history, physical and laboratory findings, and an assessment that supports the need for the consult in the Progress Notes.
- Screen # 4 The record reflects that the youth was seen by the consultant within the required time frames (90 days for routine, 10 ten days for urgent unless indicated sooner).
- Screen # 5 Upon the patient's return from the consultation appointment, the nurse reviewed the consultant's recommendations and addressed any urgent recommendations.
- Screen # 6 The clinician reviewed, dated, and initialed the consultation report within 3 business days of the youth's return to the facility or receipt of the report.
- Screen # 7 The UHR shows that the clinician met with the youth 5 business days (sooner if clinically indicated) to review results of the consult with the youth and develop a treatment plan.
- Screen # 8 The health record reflected that the consultant's recommendations were ordered and implemented, or a valid reason for **not** implementing the recommendations was documented (i.e., patient is out to court, refused, etc.). If the physician disagrees with the consultant's recommendations, an appropriate alternate plan of care was ordered and implemented.
- Screen # 9 The health record reflected that the clinician monitored the youth to ensure that the treatment plan was implemented and the desired clinical outcome was achieved, or the treatment plan was amended.

Consultation and Specialty Services Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	5	
Screen # 2	10	4	6	5	
Screen # 3	10	1	9	5	
Screen # 4	10	1	9	7	
Screen # 5	10	1	9	0	
Screen # 6	10	2	8	1	
Screen # 7	10	0	10	2	
Screen # 8	10	6	4	1	
Screen # 9	10	6	4	0	
Total	90	21	69	26	Plus 1 of 3 Questions

Compliance =38% (27 of 72 of Questions + Screens)

Peer Review

Review the local and statewide peer review policies and procedures, interview staff, inspect peer review file storage locations.

Review peer review files to ensure compliance with policy and the Health Care Remedial Plan.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question # 1	The local peer review policy and procedure, and actual practice are consistent with the statewide policy and procedure, NCCHC standards, and the Health Care Remedial Plan.			0	
Question # 2	The Statewide DJJ Medical Director, Health Care Director, or clinical service chief monitors the peer review process, which includes regular reporting from the facilities on peer review activities and regular quality management meetings at least annually.	1			
Question # 3	The CMO reviews sentinel events (unexpected hospitalizations, medical errors) and the Statewide Medical Director/Chief Psychiatrist reviews the reports of these investigations. The Statewide Medical Director/Chief Psychiatrist reviews all deaths.			0	
Question # 4	There is biannual peer review for MDs, PAs, and NPs at each facility. These files are marked "Peer Review" and kept in a secure location. There is documentation that findings have been shared with applicable staff	1			
Question # 5	The peer review process includes a meaningful corrective and adverse action process up to, and including, suspending privileges for inappropriate care or unprofessional behavior.	1			
	For calculating score, only give credit for questions in substantial compliance. Totals:	3		2	

Compliance = 60% (3 of 5 Questions)

Credentialing

Review the local and statewide credentialing policies and procedures, interview staff, and inspect storage locations of credential files.

Review credentials files to ensure compliance with policy and the Remedial Plan.

Key: SC =Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	N/A
Question # 1	The local credential policies and procedures, and actual practice are consistent with statewide policies and procedures, NCCHC standards, and the Health Care Remedial Plan.			0	
Question # 2	Credential files are stored in a locked cabinet with access limited to those with a legitimate need to know.	1			
Question # 3	Specific staff is assigned to maintain the credential files. Inspection shows that the files are current and well-maintained.	1			
Question # 4	Review all credential files. They contain the required elements of the Health Care Remedial Plan: a) Curriculum Vitae that includes relevant personal information; undergraduate, graduate, and postgraduate education b) Employment history and hospital appointments (including disciplinary action and loss of privileges) c) Academic appointments and society memberships, if applicable d) Copies of all current licenses, registrations, board certifications, and Drug Enforcement Agency (DEA) licenses e) Statement of physical and mental health f) Drug and alcohol dependence history, if any g) Results of National Practitioner Data Bank Inquiry h) Prior and current malpractice claims and judgments i) Prior professional liability coverage and current coverage for contractors, if not covered by State of California j) ECFMG certificate, if applicable k) Authorization for release of information for any information required to complete the application process, including confidential material l) Three references	1			
Question # 5	Review of credentialing process listed in question #4 reveals no substantial problems or concerns regarding the clinician's mental fitness, clinical competence, or moral character.	1			
Question # 6	Recredentialing occurs bi-annually. All files are current.	1			
Question # 7	Physicians, nurse practitioners, and physician assistants do not begin work until the credentialing process is completed. Under extenuating circumstances, temporary privileges may be granted until the credentialing process is completed, not to exceed 3 months.	1			
Question # 8	Physicians or nurse practitioners treating chronically ill youth are board certified or eligible in a primary care-related field.	1			
Question # 9	Physicians treating HIV infected youth are board certified in infectious diseases (ID) or have completed a primary care residency with additional HIV related training, and are experienced in the treatment of HIV patients. If no facility clinician meets this requirement, ID consultants are used.	1			
	For calculating score, only give credit for applicable questions in substantial compliance. Totals:	8		1	

Compliance = 88% (8 of 9 of Questions)

Quality Management

Review the local and statewide Quality Management Program policy and procedure. Review the composition of the QM Committee and meeting minutes. Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question # 1	There is a local policy and procedure that is consistent with the statewide policy and procedure.	1			
Question # 2	The facility has a Quality Management (QM) Committee that meets quarterly or more often as needed, as determined by Statewide policy.	1 ³⁰³			
Question # 3	The composition of the institutional QM Committee meetings meets policy requirements.	1			
Question # 4	Minutes of the QM Committee are available for review.	1			
Question # 5	QM studies for the previous 2 quarters from the date of the last audit are available for review.		0 ³⁰⁴		
Question # 6	The reasons for the QM studies performed by the facility are specified on the tools or in meeting minutes, and are related to suspected problems identified by staff, Health Care Service audits, Superintendents, and youth, etc. (high risk, high volume, problem prone aspects of care).		0		
Question # 7	The most recent Corrective Action Plan (CAP) developed as part of a QM study is reviewed for the following: Enter date of CAP reviewed: _____	Y	N	NA	0
	a) The CAP identified specific improvements needed.				
	b) The CAP identified specific staff members responsible for improvements.				
	c) The CAP had a targeted completion date.				
	d) There was documentation to indicate any recommended training was held.				
	e) Follow-up studies were done to determine whether or not corrective actions solved the problem or issue.				
Question # 8	Physician Chart Reviews: a) There will be quarterly review of nursing sick call records based upon criteria developed by the QM Committee (a minimum of 5 records per nurse performing sick call) b) Outpatient Housing Unit: 10% or 10 records/ quarter. Findings are addressed at QM meetings.			0 ³⁰⁵	
Question # 9	The Supervising Nurse reviews 10 records monthly of each nurse who conducts nursing sick call, urgent care, or outpatient housing unit care. There is documentation that findings from chart reviews have been discussed with the applicable staff members. As performance improves, reviews may be performed quarterly.	1			
Question # 10	On at least an annual basis, the Chief Medical Officer develops a Quality Management report for the Statewide Medical Director that focuses on high risk, problem prone aspects of patient care; identifies deficiencies; makes recommendations for improvements; and provides direction for quality improvement activities.			0	
For calculating score, only give credit for applicable questions in substantial compliance.					
Totals:		5	3	2	

Compliance = 50% (5 of 10 of Questions)

Total Number of Questions and Screens Evaluated	= 744
Total Number of Questions and Screens in Substantial Compliance	= 453
Total Score	= 61%

Endnotes:

¹ This report was revised on 4/14/08 following comments from Doug Ugarkovich.

² The SRN is unsure that nurses have pay parity with CDCR Nurses. This will be further explored by the experts with headquarters staff.

³ Dr. Tanson is board-certified in family practice.

⁴ The CMO states that funds have been allocated but funds have not been deposited to the respective account. Staff report that they are still required to obtain 3 bids for everything over \$100, even if only there is only one manufacturer. They are required to fill out extensive justifications for standard equipment (e.g. shredders, copiers, and file cabinets) including requirements to draw dimensions of the room and where the equipment will be placed, specify what documents are going to be filed or shredded). This is time consuming and excessive.

⁵ Staff reported issues with youth being escorted to the clinics.

⁶ There is a system however there is one staff member whose license expired in January 2008. It was later determined that the nurse no longer works at the facility, however this should be noted on the tracking log. Credit given.

⁷ The facility does not provide a standard security or health care orientation for staff. According to staff, the facility conducts basic orientation for all new employees infrequently. The last one was reported to have occurred six months previously, even though new employees have been brought on board.

⁸ Staff has not received formal training for all new policies and procedures.

⁹ [] Identity removed. Parole Violator. Arrived on 12/4/07.

¹⁰ [] Identity removed. Parole Violator arrived on 1/30/08.

¹¹ [] Identity removed. Parole violator arrived on 1/22/08.

¹² [] Identity removed. Parole violator arrived on 12/4/07.

¹³ [] Identity removed. Parole violator arrived on 1/16/08.

¹⁴ [] Identity removed. Parole violator arrived on 10/31/07.

¹⁵ [] Identity removed. Parole violator arrived on 1/16/08.

¹⁶ [] Identity removed. Parole violator arrived on 1/9/08.

¹⁷ [] Identity removed. Parole violator arrived on 2/20/08.

¹⁸ [] Identity removed. Arrived on 12/6/2007.

¹⁹ The nurse documented that the UHR was not available at the time of the encounter.

²⁰ The nurse documented that the UHR was not available at the time of the encounter.

²¹ NP did not document a response to question “Have you been treated for a medical problem in the last six months?”

²² No January 2008 MAR showing that the patient received Albuterol Inhaler.

²³ Visual acuity not measured.

²⁴ Visual acuity not measured.

²⁵ Visual acuity not measured.

²⁶ Visual acuity not measured.

²⁷ Visual acuity not measured. TB skin test planted but results filed in the diagnostic reports section.

²⁸ Visual acuity not measured.

²⁹ Visual acuity not measured.

³⁰ Visual acuity not measured.

³¹ Visual acuity not measured.

³² Visual acuity not measured.

³³ Lab report available on 12/9/07 but not initialed as reviewed until 12/27/07. No documentation in the progress notes that youth was notified and counseled regarding laboratory test results (RPR, HIV, Chlamydia, and GC). A nurse wrote a physician order that the youth was notified of test results. Upon interview, we learned that the nurse goes out to the housing units with the lab test results and notifies the patients in the housing units. This does not provide a confidential setting for the youth to ask questions or provide risk-reduction counseling.

³⁴ On 1/23/08 the patient refused an RPR and HIV antibody test. The refusal was obtained by a nurse. The form used does not document the consequences of refusal of this testing by a clinician.

³⁵ Lab report available on 12/9/07 but not initialed as reviewed until 12/27/07. A nurse wrote a physician order that the youth was notified of test results. Upon interview, we learned that the nurse goes out to the housing units with the lab test results and notifies the patients in the housing units. This does not provide a confidential setting for the youth to ask questions or provide risk-reduction counseling.

³⁶ Routine labs ordered but results not found in the record.

³⁷ Routine labs reported on 1/17/08 initialed by NP on 1/23/08. NP wrote an order to notify youth. A nurse wrote a physician order that the youth was notified of test results. Upon interview, we learned that the nurse goes out to the housing units with the lab test results and notifies the patients in the housing units. This does not provide a confidential setting for the youth to ask questions or provide risk-reduction counseling.

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- ³⁸ Urine Chlamydia and Gonorrhea test obtained (Chlamydia screen was positive), but there are no orders or results for an RPR or HIV antibody test. No refusal documented.
- ³⁹ This youth who has a history of hypertension and ‘mild stroke’ refused all lab testing. This was noted in the progress notes not on a refusal form. A physician should counsel the youth regarding the need for cholesterol and kidney function tests given his medical history.
- ⁴⁰ There is no documentation in the progress notes that the patient was notified, counseled and had the opportunity to ask questions.
- ⁴¹ There is no documentation in the progress notes that the patient was notified and counseled in person and had the opportunity to ask questions.
- ⁴² See previous comment.
- ⁴³ There is no documentation in the progress notes that the patient was notified and counseled in person and had the opportunity to ask questions.
- ⁴⁴ No documentation of HIV post-test counseling.
- ⁴⁵ No documentation of HIV post-test counseling.
- ⁴⁶ Genital examination not performed. “Declined.”
- ⁴⁷ The youth had a history of moderate asthma listed on the Problem List from a previous admission in 2004. This was not addressed in the nurse’s or clinician’s history. Apparently the history and physical was performed on the day of arrival without the medical record present. No genital examination performed. ‘Declined’.
- ⁴⁸ The patient has a history of asthma. The clinician did not obtain an adequate history (onset, frequency of symptoms and inhaler use). No genital examination performed. “Declined.”
- ⁴⁹ The clinician documented that the patient had a history of penicillin allergy and positive TB skin test but did not describe the type of reaction to penicillin or explore the history of the positive TB skin test or perform a symptom review (e.g. fever, night sweats, weight loss, etc). Chart review show that in September 2005 the patient’s TB skin test was 15 mm. at Preston Youth Correctional Facility. The patient was asymptomatic and had a normal chest x-ray. He was treated with INH 900 mg biweekly for 9 months. MARs showed the patient was compliant and received the full 9 month course of therapy. This information should be included in the current medical history. Genital examination not performed. “Declined.”
- ⁵⁰ The patient has a Body Mass Index of 36% but this was not addressed. Clinician documented some of the patient’s asthma history on the physical examination form, and some in the progress notes. It would be best if the medical history form facilitated clinicians documenting the information in one location. Genital examination not performed. “Declined.”
- ⁵¹ The clinician performed a history and physical examination however it is unclear whether questions related to sexually transmitted infections were asked. The clinician did not perform a genital examination because the patient “declined.” The patient was subsequently diagnosed with Chlamydia and gonorrhea and reported dysuria. Thus, raises a concern that each question on the medical history questions on the form was not asked.
- ⁵² The patient gave a history of asthma on no current medications but the clinician did not obtain a further history including most recent symptoms, whether the patient has nighttime awakening, or was ever prescribed medication, etc. The patient also gave a history of chronic back pain due to a

herniated disc being struck by a car as a pedestrian. No questions were asked regarding bowel or bladder function. The only examination of the back indicated that the patient had no scoliosis and “no obvious herniation with ROM.” Medical record review shows that the patient had an MRI on 6/20/05 showing L4-5 central spinal stenosis, a combination of congenital and acquired factors. This should have been described. The clinician also did not perform a genital examination, documenting patient “declined.” The patient gave a history of unprotected sexual activity and was diagnosed two weeks later with genital condyloma.

⁵³ The patient has a history of asthma treated with Albuterol inhaler but the clinician did not describe the patient’s history or frequency of symptoms. The patient also gave a history of Chlamydia treatment five months prior, however the clinician did not perform a genital examination, documenting “Declined.” Patient reported right ear pain secondary to injury and clinician identified perforation of the right tympanic membrane.

⁵⁴ This 23 year old obese patient presented a history hypertension and mild stroke. The clinician did not document any further history. In addition, during a previous admission he was identified as being allergic to Penicillin and right hand and ankle fractures. The clinician did not perform a genital examination documenting “Declined.”

⁵⁵ On 12/6/07 the clinician performed the history and physical examination. Although previous medical records show that the patient had a history of asthma with Albuterol inhaler use, latent TB infection, and depression there is no documentation of this history on the current history and physical form suggesting that the UHR was not available when the examination was performed. A genital examination was not performed because the patient “declined.” The clinician documented that the patient had no medical issues at this time. However the discharge summary documented on 12/14/07 documents that the patient has asthma.

⁵⁶ Stage of asthma not initially assessed or updated.

⁵⁷ The clinician did not document the patient’s allergy to penicillin or TB infection with previous treatment on the Problem List.

⁵⁸ The clinician did not document the patient’s asthma or obesity on the Problem List.

⁵⁹ Sexually transmitted infection condyloma acuminata, not listed.

⁶⁰ The patient’s obesity, hypertension and “mild stroke” were not listed on the Problem List. In addition, during previous admissions the patient was identified as being allergic to Penicillin, and right ankle fracture with ORIF, and right hand metacarpal fracture, both in 2006.

⁶¹ Problem List is current from previous admission entries.

⁶² The NP did not note the patient’s history of moderate asthma sufficiently explore the significance of this history and write an appropriate plan (which may have included a reclassification of the patients asthma).

⁶³ No medical plan was documented for the patients’ asthma. Only ‘cleared for all activity.’

⁶⁴ At the conclusion of the history and physical examination, the clinician did not document a treatment plan.

⁶⁵ There is no documented plan for the patients’ obesity.

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- ⁶⁶ The patient gave a history of sexual activity without protection and was diagnosed with Chlamydia and Gonorrhea. No plan documented regarding risk of STD's or partner notification.
- ⁶⁷ The NP did enroll the patient in the chronic disease clinic.
- ⁶⁸ No documentation of follow-up for partner notification for Chlamydia infection. Staff unable to locate January 2008 MAR showing that the patient received treatment for Chlamydia. The clinician did not document patient enrollment into the asthma clinic as part of the plan, but did write an order for it.
- ⁶⁹ Ordered labs not obtained.
- ⁷⁰ Follow-up February 7, 2008 HIV test ordered. Not documented as being performed and no results in the record as of 2/26/08. Dr Lai said the test was not done. Nursing staff later reported that the patient refused the test but this is not documented in the record. ENT consult for perforated right TM occurred on 2/11/08.
- ⁷¹ The clinician should have requested previous medical records for history of a mild stroke.
- ⁷² This patient had a documented history of moderate asthma and should have been enrolled into the chronic disease program for an initial evaluation.
- ⁷³ NP wrote an order on 1/9/08 for follow-up in chronic disease program in two weeks. This has not occurred.
- ⁷⁴ Youth was enrolled but has not yet been seen. However only 7 days have elapsed since his arrival.
- ⁷⁵ Not enrolled into the chronic disease management program for asthma.
- ⁷⁶ The facility has no local policies and procedures.
- ⁷⁷ 92198. This 19 year old arrived at Preston on 9/20/07. His initial history and physical process were completed at PYCF. The youth has a congenital history of left eye blindness. He had a medical restriction for safety glasses.
- ⁷⁸ Identity removed. Transferred 7/3/07.
- ⁷⁹ Identity removed. Transferred on 10/31/07.
- ⁸⁰ Identity removed. Transferred on 11/19/07.
- ⁸¹ Identity removed. This patient was listed on the Intrasystem Transfer log. It does not specify the facility he was transferred from.
- ⁸² Identity removed. Transferred 12/10/07.
- ⁸³ Identity removed. Transferred from ?Pine Grove on 12/19/07.
- ⁸⁴ Identity removed. Transferred to ITP on 1/3/08.
- ⁸⁵ Identity removed. Transferred to ITP on 11/2/07. Incidental No Problem List.

⁸⁶ [] Identity removed. Transferred to ITP on 12/13/07.

⁸⁷ DeWitt Nelson the sending facility did not fill out the top portion of the form

⁸⁸ Youth was transferred from a County Jail. Unclear as to when he left Chad. Last progress note was 11/28/07.

⁸⁹ No form completed. Patient transferred from “fire camp.”

⁹⁰ SYCRCC did not complete the intrasystem transfer form.

⁹¹ The nurse did not obtain vital signs, document a nursing assessment or disposition.

⁹² The nurse noted that the patient was concerned regarding an approximate 10 lbs weight loss and history of positive TB skin test.

⁹³ Neither Receiving Screening nor Intrasystem Transfer Form completed, only progress note.

⁹⁴ The nurse did not document a disposition.

⁹⁵ Upon arrival the patient complained of having a hard time breathing and wheezing. The nurse measured respiratory rate and oxygen saturation did not measure complete vital signs or a PEFr. The nurse did not contact a physician but referred the patient to sick call the following day. A note the following day documented a request for the patient’s inhaler from Dewitt Nelson.

⁹⁶ Patient had a history of asthma. The nurse did not refer the patient.

⁹⁷ No documented physician review.

⁹⁸ No documented physician review.

⁹⁹ The physician documented review 2 business days after arrival.

¹⁰⁰ No documented physician review.

¹⁰¹ The clinician noted the patient’s asthma but did not initially the patient’s history of cerebellar astrocytoma with both chemo- and radiation therapy. This history of cerebellar astrocytoma was not noted for almost 3 months following arrival at Chad. On 9/25/07 a clinician did note this history and that a neurology consultation was pending.

¹⁰² Although the clinician saw the patient on the day of arrival, he did not adequately address the patients’ reported history of recent weight loss (documented weight loss is approximately 6.5 lbs). The patient’s history was significant for TB infection and Lithium treatment which is known to cause thyroid disorders (hypo and hyperthyroidism). The patient has never had baseline thyroid test.

¹⁰³ A clinician did not see the patient at all.

¹⁰⁴ The patient had a history of asthma and was prescribed an inhaler that was not transferred with the patient from Dewitt Nelson. The order for the Albuterol inhaler was not written for two days after the patients transfer to Chad. There is no MAR in the record for July 2007 documenting receipt of the Albuterol Inhaler.

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- ¹⁰⁵ The patient had his inhaler with him upon arrival, however the order for it has not been renewed and he has not been seen by a physician or enrolled in the chronic disease management program.
- ¹⁰⁶ Patient arrived on 1/3/08 and the physician ordered Risperdal, Wellbutrin, and Depakote. MAR shows that medication was not administered.
- ¹⁰⁷ Patient is due for hepatitis B vaccine #3 and hepatitis A vaccine by 3/20/08. Varicella #2 due 10/07 not done. These vaccinations were not ordered upon his arrival at Chad. An ophthalmology consultation was requested at Preston to evaluate the patient's history of congenital blindness in the left eye. This was not done at Preston and when the youth transferred to Chad on 9/20/07, although it was noted on the sending portion of the consultation form, it was not noted or addressed by the nurses or physician at Chad. On 1/25/08 a nurse practitioner wrote an optometry request to evaluate the patient's vision. As of 2/25/08 this had not been completed. An appointment is scheduled on 2/28/08.
- ¹⁰⁸ This patient is not receiving consistent monitoring for his asthma or history of cerebellar astrocytoma in the chronic disease program. The youth has not been seen for chronic care since 9/25/07. At that time the clinician noted his history of brain cancer and that a neurology consultation was pending. An MRI was completed in October 2007. A December 2007 clinician note documents that the neurology consultation did occur and the neurologist recommended annual MRIs and clinical follow-up. However, we do not find a neurology report in the record.
- ¹⁰⁹ Patient was not re-enrolled in the chronic disease clinic visit nor had his order for Albuterol inhaler renewed.
- ¹¹⁰ The patient was to have a cardiology consultation in December however there is no documentation that the consultation occurred.
- ¹¹¹ Follow-up orthopedic consultation for right thumb injury.
- ¹¹² Incidental observation. This youth had a CBC with differential on 11/29/07 that shows a low lymphocytopenia and mild anemia Hgb 13.8/Hct 41.3%. The psychiatrist noted these results but simply requested a repeat test in six months. The psychiatrist also requested that the patient's weight, BMI, FBS and lipid panel be checked every six months, however this was not scheduled on any logs in the clinic. The patient was not interviewed for an STD risk history and he has not been offered HIV antibody testing. This should be done and was discussed with the clinic nurse.
- ¹¹³ No history documented. Subjective section has objective information. No history of pain, fever, chills, etc
- ¹¹⁴ Inadequate history related to knee pain
- ¹¹⁵ Did not see patient. Only ordered medications.
- ¹¹⁶ No HX of pain, movement, fever, chills
- ¹¹⁷ No history related to intensity of pain, quality, difficulty breathing, exacerbating factors
- ¹¹⁸ Note stated that patient was requesting meds for headache. No prior nursing note. MD ordered meds without seeing patient.
- ¹¹⁹ No history related to intensity, exacerbating factors, duration, radiation, neuro symptoms
- ¹²⁰ Did not see patient. Only ordered medications.
- ¹²¹ No documentation of tenderness, range of motion,

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- ¹²² Note stated that patient was requesting meds for headache. No prior nursing note. MD ordered meds without seeing patient.
- ¹²³ “neuro – grossly intact” is not adequate neuro exam in patient with back pain
- ¹²⁴ No follow-up ordered. Patient with hand infection should be followed closely.
- ¹²⁵ Did not advise patient of what complications to look for, i.e. spreading infection, increasing pain, fever
- ¹²⁶ No education related to signs/symptoms that would prompt notification of staff
- ¹²⁷ X-ray done 1/24 (normal) but NP did not sign off results and inform youth until 2/4
- ¹²⁸ No documentation that clinician reviewed results of x-ray or that patient was informed of results
- ¹²⁹ Follow-up ordered on 1/2. Did not occur.
- ¹³⁰ There were 20 patients on the chronic care list for CHAD and an additional 2 patients on a list at the ITP (one of whom had a chronic hearing problem). We found an additional 4 patients with chronic illnesses who were not on the chronic disease list – [] Identity removed (asthma), [] Identity removed (asthma), [] Identity removed (hypertension), 91929 (asthma).
- ¹³¹ Youth with asthma and hypertension. Hypertension not on Problem List.
- ¹³² No documentation of appropriate intake visit
- ¹³³ No documentation of appropriate intake visit
- ¹³⁴ No history related to ER visits or hospitalizations
- ¹³⁵ No initial history documented, no family history
- ¹³⁶ No history of ER visits or prior use of inhaled steroids
- ¹³⁷ No documentation of appropriate intake visit
- ¹³⁸ No documentation of appropriate intake visit
- ¹³⁹ No documentation of appropriate intake visit. Patient had been on treatment for hypertension in the past. Meds were discontinued at his request in 7/07. Saw NP 10/11/07 and requested that meds be restarted. Blood pressure was 135/84. Med was restarted. Should have re-checked blood pressure before restarting meds.
- ¹⁴⁰ No documentation of appropriate intake visit
- ¹⁴¹ No urinalysis since 2003
- ¹⁴² No urinalysis in chart
- ¹⁴³ Seen 3/21/07 and then not until 10/21/07 when seen for an exacerbation

-
- ¹⁴⁴ No history related to exacerbations or nighttime symptoms
- ¹⁴⁵ No urinalysis, lipid studies
- ¹⁴⁶ No urinalysis since 2005.
- ¹⁴⁷ No urinalysis since 2006 or lipid studies since 2005
- ¹⁴⁸ Did not document degree of control for hypertension
- ¹⁴⁹ Ordered follow-up in 3 months but should be sooner since increased medication. 18-year-old with new diagnosis of hypertension. Should evaluate for secondary hypertension.
- ¹⁵⁰ Cholesterol was 273 in 1/07. No follow-up.
- ¹⁵¹ Lipids were elevated in 0/07. Noted would repeat in 3 months. Not done.
- ¹⁵² Did not order urinalysis or lipid studies.
- ¹⁵³ Ran out of inhaler 10/21/07. Seen for exacerbation and re-ordered.
- ¹⁵⁴ No influenza vaccine
- ¹⁵⁵ Patient with HIV disease. Problem list states “medical condition” and refers to date of entry which is in Volume 1 of 2. HIV disease should be in Problem List.
- ¹⁵⁶ No documentation of appropriate intake visit
- ¹⁵⁷ No documentation of appropriate intake visit
- ¹⁵⁸ No documentation of appropriate intake visit
- ¹⁵⁹ No documentation of appropriate intake visit
- ¹⁶⁰ No documentation of appropriate intake visit
- ¹⁶¹ No documentation of appropriate intake visit
- ¹⁶² No documentation of appropriate intake visit
- ¹⁶³ No urinalysis or lipids since 2004
- ¹⁶⁴ No urinalysis
- ¹⁶⁵ No recent CD4 or viral loads.
- ¹⁶⁶ Youth with HX of asthma arrived 6/13/07. Albuterol MDI and Singulair prescribed. Not seen in chronic care program until 10/1.

-
- ¹⁶⁷ Not seen in chronic care since 9/07.
- ¹⁶⁸ Inadequate history
- ¹⁶⁹ Dosage of blood pressure medication was reduced. Follow-up ordered in 3 months. Should be sooner.
- ¹⁷⁰ Patient seen in chronic care on 12/10. NP noted that he had not needed inhaler x 3 months. Continued meds and D/C'd patient from chronic care program. Patient should still be in chronic care and ? Use of Singulair. This case was discussed with Dr. Lai.
- ¹⁷¹ No lipids since 2005
- ¹⁷² Did not order labs
- ¹⁷³ Patient with asthma. No flu vaccine.
- ¹⁷⁴ Patient with asthma. No flu vaccine.
- ¹⁷⁵ Patient with asthma. No flu vaccine.
- ¹⁷⁶ No flu vaccine
- ¹⁷⁷ There are no local operating procedures.
- ¹⁷⁸ The infection control nurse appears very conscientious. She has not received any training.
- ¹⁷⁹ No documentation of new hire training regarding exposure control plans or sanitation schedules.
- ¹⁸⁰ Program is in early stages of development. Some meetings have begun but do not cover all areas.
- ¹⁸¹ 2/8/08 Infection Control Meeting.
- ¹⁸² 10/25/07 Infection Control Meeting.
- ¹⁸³ This section should comment on the actual practices to include availability and use of personal protective equipment, observational studies of hand-washing practices, availability of soap and water in clinical areas and bathrooms, etc.
- ¹⁸⁴ There are no local operating procedures.
- ¹⁸⁵ The medication rooms in the main clinic and ITP were not clean. Especially the ITP. In both areas, the floors were dirty. There was no porter assigned to this area.
- ¹⁸⁶ The narcotics were being kept in an unsecured black bag and were not double locked.
- ¹⁸⁷ There is a system for counting needles and syringes. However on the day of the site visit, the nurses did not cosign for the day to night shift, or the day to evening shift.
- ¹⁸⁸ [] Identity removed. Order written on 12/28/07 to begin 1/8/08.

-
- 189 Identity removed. Order written on 2/8/08.
- 190 Identity removed. Order written on 1/28/08.
- 191 Identity removed. Order written on 11/6/07.
- 192 Identity removed. Order written on 2/8/08.
- 193 Identity removed. Order written on 9/7/07.
- 194 Identity removed. Order written on 12/3/07.
- 195 Identity removed. Order written on 12/13/07.
- 196 Identity removed. Order written 1/23/08. There was disruption of medications from 1/20 and 1/21/08.
- 197 Identity removed. Order written 1/25/08.
- 198 The order did not contain route of administration.
- 199 The order did not contain the route of administration.
- 200 The order was dated but not timed.
- 201 The order was dated but not timed.
- 202 No clinical note was documented.
- 203 The order was written at 9/7/07 at 1040 and transcribed on the same date at 1030.
- 204 The order was written on 12/3/07 and transcribed on 12/4/07 at 0900.
- 205 The order was not timed, and could not be assessed with regard to transcription.
- 206 The 12/3/07 order for continuation of Fluoxetine was not transcribed on the MAR until 12/6/07. No interruption of therapy.
- 207 The order had a 1/25/08 start date, but the order was started on 1/26/08 and not given that day. The patient was a No show for 1/27/08 and 1/28/08.
- 208 See above.
- 209 No documentation of medication administration status for 1/9 and 1/14/08.
- 210 No documentation of administration status for 2/20/08.
- 211 No documentation of administration status for 2/5/08.
- 212 No documentation of administration status for 1/25/08 and 1/29/08.

-
- ²¹³ No documentation status of 1/25/08 and 1/26/08.
- ²¹⁴ Nurses did not date and sign discontinued order.
- ²¹⁵ The nurse did not initiate the new order on 12/3/07 but marked the old order as expired on 12/6/07.
- ²¹⁶ The nurses cross out the medication order to indicate that the order is no longer in effect.
- ²¹⁷ The nurses cross out the medication order to indicate that the order is no longer in effect.
- ²¹⁸ The nurses cross out the medication order to indicate that the order is no longer in effect.
- ²¹⁹ The nurses cross out the medication order to indicate that the order is no longer in effect.
- ²²⁰ The nurses cross out the medication order to indicate that the order is no longer in effect.
- ²²¹ The emergency bag does not contain a standardized checklist that staff checks against the bag. There is no peak flow meter in the emergency bag. Elastic bandages in the ITP emergency bag are old and stuck together.
- ²²² Checklist is too generic for all items.
- ²²³ No drills have been conducted.
- ²²⁴ Seen in ITP and sent to Chad clinic to be seen by MD. No nursing note from ITP
- ²²⁵ Nursing note not in SOAP format. Subjective information in objective section.
- ²²⁶ Nursing note not in SOAP format. Subjective information in objective section.
- ²²⁷ No SOAP format.
- ²²⁸ Did not obtain adequate history for abdominal pain. Did not obtain vital signs or perform physical exam.
- ²²⁹ Did not obtain adequate history for chest pain, i.e., quality, radiation, HX of trauma. Did not examine chest or lungs.
- ²³⁰ Inadequate history for abdominal pain and headache.
- ²³¹ Nurse did not obtain adequate history, i.e. History of trauma, range of motion; unable to read objective findings
- ²³² Advised youth to submit sick call request. Should have referred for follow-up. Seen by MD 2/21 – ordered x-rays and referred to orthopedist.
- ²³³ Patient was referred to NP. NP performed chart review and ordered medications. Did not see patient.
- ²³⁴ Patient was referred to OHU for further evaluation. Not seen by NP by 1/22 after he had been seen by another nurse for same complaint. NP diagnosed otitis externa and ordered antibiotic drops.
- ²³⁵ [] Identity removed. On 2/1/08 the patient complained of a painful, swollen, and tender right foot.

²³⁶ [] Identity removed. Urgent event on 2/7/08. This 19 year old had a history of left nephrectomy at age 1 (1990) secondary to cancer. On 2/7/08 he complained of left testicular pain.

²³⁷ [] Identity removed. On 2/13/08 at 0300 the patient complained of abdominal pain.

²³⁸ [] Identity removed. On 10/31/07 the patient complained of severe abdominal pain.

²³⁹ [] Identity removed. On 9/16/07 he complained of a migraine headache. This 23-year-old has bipolar disorder, is obese, and has a strong family history of diabetes. He is on Risperdal which can cause diabetes. On 1/8/08 his triglycerides were >300, Hgb A1C is 5.9% in July 2007. He should have a FBS and his lipids routinely monitored.

²⁴⁰ The nurse documented the date and time but did not document the note in SOAP format.

²⁴¹ There is no progress note in the health record for the 9/16/07 entry on the log.

²⁴² The nurse did not document onset or duration of symptoms.

²⁴³ On 2/13 at 1335 the patient complained of abdominal pain. The nurse did not obtain a history of associated symptoms such as nausea, vomiting, diarrhea, etc. The nurse did not examine the patient's abdomen.

²⁴⁴ This patient had signs and symptoms of cellulitis. The nurse should have spoken directly to a physician to describe the patient's symptoms and clinical findings. Instead the system at NCYCC is for the nurse to call the OHU, speak to another nurse, who calls the physician and then relays the information back to the facility nurse. This adds an unnecessary layer and barrier to the physician obtaining complete clinical information. In this case, the nurse was given an order for Tylenol, observe the area, and if the toe was still bleeding in the morning to call Dr. T or schedule the patient for sick call on Monday. On 2/2/08 at 1030 the patient complained of increased pain and now had developed a visible abscess. The patient was sent to the OHU where Dr. T diagnosed the patient with cellulitis, performed a surgical procedure (incision and drainage), and ordered an antibiotic (Bactrim DS). He ordered twice daily dressing changes to the foot, that the patient be permitted to wear sandals, and discharged him back to his facility. Given that this patient had an infected and painful foot and would have been required to walk across the yard for his dressing changes and to receive antibiotics he should have been admitted to the OHU. The nurse obtained 8 doses of antibiotic from the Documed.

²⁴⁵ The nurse did not document an appropriate assessment it was as follows: "talking with staff, slow response but alert and oriented x 3. The nurse appropriately referred the patient to the OHU for evaluation.

²⁴⁶ The nurse did not document an assessment but transferred the youth to the OHU for observation and subsequent transfer to the local hospital.

²⁴⁷ This patient was admitted to the OHU on 2/4/08. Staff were unable to locate a medication administration record that showed that patient received the antibiotic from 2/2/08 until 2/11/08. There is a MAR that documented the transcription of the order beginning on 2/9/08. It shows that the patient was a no show for all his morning doses and only received 3 afternoon doses from 2/9-2/11/08. We find no documentation of dressing changes. This patient did not receive a timely initial evaluation and ordered medical care was not implemented.

²⁴⁸ On 2/7/08 at 1030 am a physician saw the patient for complaints of a painless swollen left testicle for 2 months. The physician documented a 5 x 4 cm testicular mass and phimosis. His diagnosis was rule out testicular mass and he ordered an ultrasound of the scrotum ASAP and urology clinic.

There is no further information or follow-up documented in the record. Upon further investigation, the patient was sent to the emergency room the same day where he underwent ultrasound and was diagnosed with left testicle hydrocele. Upon his return from the emergency department, the patient was not seen by a nurse or doctor and he has had no further follow-up. The urology appointment is pending and has not been made.

²⁴⁹ On 2/13 at 1430 the physician saw the patient and performed an evaluation. His diagnosis was acute abdominal pain, rule out acute abdomen. He made the patient NPO and documented that he planned to send the patient to the emergency department. At the ED, the patient was diagnosed with nonspecific acute abdominal pain, treated with a GI cocktail, and returned to the facility the same day. Upon his return he was not seen by a nurse or physician. We note that labs showed that his white blood cell count was low (WBC 3.5 and neutrophils 31.3 absolute count 1.10 (normal 1.9 -8.00) and that he was anemic (Hgb 12.6/hct 37%). A clinician has not reviewed either the ED or lab reports. Initialed as reviewed. He was discharged. Upon return to the facility, he was not seen.

²⁵⁰ On 10/31/07 at 0900 a nurse saw the patient following his return from the ED and performed an assessment. The nurse notified Dr Lai but the patient was not seen by a physician.

²⁵¹ This patient had no follow-up upon his return to the facility and does not yet have a urology appointment.

²⁵² The patient was not seen upon his return and ED and lab reports have not initialed as reviewed.

²⁵³ The patient has had no further follow-up.

²⁵⁴ On 2/14/08 the patient returned with continued abdominal pain. The nurse referred the patient to Dr Wong who noted the patient's ED labs. He ordered H. Pylori test and repeat CBC. On 2/20/08 the CBC showed the patient had a WBC of 2.4 and anemia (Hgb 12.9/Hct 38.4%) and positive H. Pylori IGG. On 2/22/08 the physician saw the patient and noted the lab results and treated the patient for H. pylori infection with plans to repeat the CBC in one month.

²⁵⁵ Dr A did not see the patient until 11/2/07 and noted that the patient had a 3 mm left renal calculus per abdominal CT (The original report is unsigned and shows mild left hydronephrosis). He ordered a follow-up KUB for 11/5/07. We find no KUB report in the record. On 11/6/07 Dr. A saw him again but did not address his previous order for a KUB. Clinically the patient was doing better. On 12/3/07 the patient returned with follow-up flank pain. Dr A ordered a CT of the abdomen, increased fluid intake and Motrin. This took place on 12/11/07 and was largely normal without hydronephrosis. The physician saw the patient on 12/21/07 and noted that the patient reported that the stone had passed. There is no notation in the chart of when the patient was sent out and returned from the abdominal CT or that he was seen by a nurse or clinician following his return.

²⁵⁶ There is a daily log. The log does not contain the discharge date.

²⁵⁷ Orders did not include frequency of vital signs or criteria for notification

²⁵⁸ Orders did not include frequency of vital signs or criteria for notification

²⁵⁹ No admission orders

²⁶⁰ No admission orders

-
- 261 Orders did not include frequency of vital signs or criteria for notification
- 262 No admission orders in chart
- 263 No admission orders
- 264 Orders did not include frequency of vital signs or criteria for notification
- 265 No documentation of education
- 266 No initial nursing assessment
- 267 No documentation of education
- 268 No documentation of education
- 269 No initial nursing assessment
- 270 No documentation of education
- 271 No documentation of education
- 272 Not seen by MD on 2/5
- 273 The nursing note noted that the physician saw the patient. There was no progress note from the physician.
- 274 No nursing note
- 275 There is no local policy
- 276 This is not occurring consistently
- 277 There is no tracking system for consultation or x-ray reports. There is tracking for lab results.
- 278 Facility uses a out card system but staff reported that it does not work well d/t lack of health records staff. Other staff often take charts w/o filling out cards.
- 279 Blood pressure 137/91. No follow-up. Discussed with Dr. Lai
- 280 Blood pressure 146/96. No follow-up. Discussed with Dr. Lai
- 281 BMI 25.6. Weight not addressed
- 282 BMI 25.1. Weight not addressed
- 283 BMI 30.8. Weight not addressed
- 284 BMI 26.3. Weight not addressed

285 BMI 27.1. Weight not addressed
286 BMI 38.7. Weight not addressed
287 BMI 25.8. Weight not addressed
288 No documentation of hepatitis A.
289 Receipt of reports is not being tracked
290 Not clear when it was ordered.
291 There was no consultation report in the medical record. Medical staff stated that youth went to appointment on 12/29.
292 Consultant's report was not in medical record. (It was faxed from consultant's office when experts requested it).
293 CT scan done on 12/13/07. Not reviewed until 1/11/08.
294 Patient seen in endocrine clinic on 1/9/08. Not reviewed until 1/29/08.
295 Not seen until 2/15/08.
296 No progress note.
297 Ortho consult recommended x-ray on 1/8. Not ordered or done
298 Inappropriate delay in implementation of recommendation. Medication not increased until 5 weeks after seen by consultant.
299 Consultant recommended follow-up in 6 months. No documentation that it was ordered.
300 No follow-up of headaches.
301 On chronic care for endocrine problem. Not being seen regularly.
302 No recent CD4 count or viral load.
303 Meetings started 11/07. Have had 2 meetings and have schedule for rest of year.
304 The facility has recently begun doing studies. There are no corrective action plans.
305 Review of OHU records is not occurring. (Nursing sick call does not take place).

**CALIFORNIA DEPARTMENT OF
CORRECTIONS
AND REHABILITATION
DIVISION OF JUVENILE JUSTICE**

**OH Close Youth Correctional Facility
Health Care Audit
June 2-4, 2008**

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Introduction

The Health Care Remedial Plan (HCRP) requires the Division of Juvenile Justice (DJJ) to make a number of specific changes in the medical, mental health, and dental care programs. To measure DJJ compliance with the requirements of the Health Care Remedial Plan, the Medical Experts developed this audit instrument with clearly defined standards and criteria, and thresholds of compliance. The audit instrument is comprised of indicators selected from:

- The Health Care Remedial Plan
- DJJ policies and procedures developed in consultation with the Medical Experts
- National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Juvenile Detention and Confinement Facilities, 2004 Edition
- The American Medical Association's Guidelines for Adolescent Preventive Services (GAPS)
- US Preventive Services Task Force (USPSTF)
- Guidelines for the evaluation and treatment of other disease such as those published by the Centers for Disease Control and Prevention (CDC)

Regarding those areas related to nursing and medical care practice, the Medical Experts will use their professional judgment to assess compliance.

NOTE: This audit instrument does not address mental health. The Mental Health Experts will develop the Mental Health Audit Instrument.

Audit Instrument and Compliance Thresholds

The audit instrument will be used by the Medical Experts to evaluate compliance with the HCRP. It is also intended for use by the DJJ Office of Health Services Quality Management Team and by the local facility Quality Management Team to evaluate progress consistent with the HCRP. The audit instrument includes indicators from sources cited above, which the Medical Experts judge to be critical in establishing an adequate health care system. Some indicators allow for partial compliance if the facility is close to, but has not yet achieved substantial compliance.

A facility is in substantial compliance when all of the following conditions are satisfied:

- a. The facility receives a score of 85% or higher during an audit conducted by the Court experts. When determining overall compliance, areas that are determined to be in partial compliance will be considered non-compliant. The experts shall have the discretion to find a facility providing adequate medical care in compliance if it achieves a score of no less than 75%.

- b. Medical assessments and treatment plans provided to youth comply with the policies and procedures, as determined by the medical experts. The medical assessment and treatment plans provided to the youth shall be deemed adequate and appropriate under these policies and procedures, only under any one of the following conditions:

(1) The assessment or treatment plan is consistent with guidelines specifically adopted in the policies and procedures; or

(2) The practitioner documents in the medical notes that he/she is deviating from adopted policies and procedures, and that such deviation is consistent with the community standard; or

(3) Where no treatment guidelines are specifically adopted in these policies and procedures, the assessment or plan is consistent with the community standard.

- c. The facility is conducting minimally adequate death reviews and quality management proceedings.
- d. The facility has tracking, scheduling, and medication administration systems adequately in place.
- e. Both experts have concluded that there is not a pattern or practice that is likely to result in serious violations of wards' rights that is not being adequately addressed.

The medical experts have developed audit instrument instruction to clarify interpretations and scoring of the audit instrument. We are available to answer questions as well as provide training to staff regarding the audit instrument.

Executive Summary

The facility scored 81% (444 of 550 Screens/Questions).

We would like to thank Superintendent Yvette Marc-Aurele and her staff for their assistance and cooperation during the audit. We were impressed by the staff's desire to provide the youth quality health services. This was the first formal audit for the facility and there are a number of health care services that are doing well including medical care and chronic disease management, and the medication administration process. There did not appear to be any contract issues affecting health care delivery as there were at our last visit to the Northern California Youth Correctional Complex (NCYCC) in February 2008.

There are however, some fundamental structural aspects of health care services that are not in place. This includes a complete and current set of policies and procedures to which staff have been trained and a timely and comprehensive orientation program.¹ DJJ also has not developed nursing protocols and guidelines for the treatment of common conditions among adolescents and young adults that are required by the remedial plan.² Although there is a health care budget now under the control of the Chief Medical Officer (CMO), the budget was not available to the CMO until more than half the fiscal year had passed.

The facility population at the time of our visit was 198 youths. Currently there are 1.6 primary care providers (physician and nurse practitioner) at the facility which is a clinician to youth ratio of 1:124³. This appears to be more clinical coverage than is necessary to meet youth needs. There is only one exam room so on the days that both clinicians are at the facility they alternate seeing patients in the same room. Moreover, our review of clinician patient encounter logs for the months of March-May 2008 showed that for the 3 month period each provider saw an average of patients per 9.8 patients per day. The majority of these encounters were for minor conditions such as previously diagnosed acne that could be managed by nurses if nursing protocols in place and staff properly trained.

Recognizing that there are areas needing improvement, we wish to congratulate staff on their progress to date.

Summary of Health Care Areas Reviewed

Facility Leadership, Budget, Staffing, Orientation and Training scored 67%

Positively, all key leadership positions are filled. The Chief Medical Officer (CMO) is board-certified in a primary care field. The budget is now under the control of the CMO however this did not occur until more than half the fiscal year had passed. The facility does not have a complete set of local policies and procedures and staff has not been systematically trained regarding the policies. The medical space consists of an examination room and a small office adjacent to the exam room. The examination room is cramped and often 2 clinicians, a nurse and Medical Technical Assistant (MTA) occupy this area. There is no schedule of sanitation activities and it does not appear that the room has been thoroughly cleaned in some time.

Staff expressed concern that there is no officer posted in the immediate medical area. The communication center is the closest correctional officer to the medical clinic. However if a

disturbance were to occur these officers cannot leave their post and would have to call for assistance. Staff is concerned whether the response would be timely. This concern should be discussed and resolved among medical staff and facility management. There are only two correctional officers designated as youth escorts which staff report at times delays youth movement and appointments.

Medical Reception was not evaluated

Medical reception was not evaluated because the facility is not a reception center and does not receive parole revocators.

Intrasystem Transfer scored 80%

We found that not all transferred youth were listed on the log, but a review of those records showed that the intrasystem transfer review process did occur. Of concern is that in only 1 of 5 records of youth who were taking prescription medication did the record show that continuity of medication was provided. In two cases, the findings may possibly be attributed to documentation issues (an MAR was missing and in another record the nurse did not date when the youth was given his asthma inhaler). Also, in 4 of 10 cases clinical follow-up was indicated and did not take place. In two cases youths with previously abnormal labs that warranted repeating were not noted and did not take place; one was enrolled in an obesity program for which follow-up did not occur; and one saw a psychiatrist who wanted follow-up in six weeks but this did not occur.

Nursing Sick Call Scored 55%

Only the structural aspects of this area were reviewed because nurses are not conducting sick call. We found that there is no policy and procedure for nursing sick call at OH Close. Nurses have not been trained regarding health assessment and use of nursing protocols as they have not been developed by Headquarters staff. Consequently youth requesting sick call services are referred directly to a clinician. We note that many youth are being seen repeatedly for minor conditions that in the community they would not go to a physician for and could be handled by a nurse (acne, colds, athlete's foot) with proper training and protocols. On the other hand, we know that DJJ is reconsidering nursing sick call and the use of nursing protocols. It is possible that primary reliance on clinicians will be most efficient and effective. We also note that there is no policy with respect to making rounds in detention areas and rounds are not documented daily.

Medical Care Scored 97%

While the facility met the goal of 85%, an area that could be improved is ensuring that all aspects of the treatment plan occur as ordered. The facility should be proud of its achievement in this area.

Chronic Disease Management Scored 87%

While the facility met the goal of 85%, areas that could be improved included the initial history and the treatment plan.

Infection Control Scored 50%

This area was subject to a limited review⁴. Areas needing attention include updating the 2005 infection control manual, ensuring that exposure control and engineering controls are in place to prevent transmission of communicable diseases, and the development and implementation of sanitation schedules.

Pharmacy Services

Pharmacy services were not reviewed during this visit since they were reviewed during our recent visit to N.A. Chaderjian.

Medication Administration Process Scored 92%

Congratulations! The only area that required attention was to ensure that when youth are transferred back to the facility from the OHU, that their record (including the medication administration record) and medications are transferred with the youth.

Medication Administration Health Record Review Scored 75%

Although the medication administration process is going well, documentation in the record requires improvement. With respect to physician orders, in 3 of 10 records the physician did not document the route of administration. In 3 of 10 orders the clinician dated but did not time the order. A concern is that when the nurses document medication orders as being transcribed, they do not actually transcribe the order at that time, but wait until the medication arrives and then place the label onto the MAR. Thus when subsequent nurses view the MAR they do not know there is a new order for a medication. This presents a risk that the medication will not be administered to the youth in a timely manner or at all.

For example, in the case of one youth taking TB preventive therapy the nurse did not transcribe the order and the pharmacy apparently did not receive the order. The patient's MAR that was automatically printed by the pharmacy showed the old January order and not the one written in March. In 6 of 10 records the patient received the medication within 24 hours of the medication being ordered. In only 5 of 9 records did the nurse document the administration status (e.g. administered, refused, etc) on the MAR for each dose of medication.

Urgent/Emergent Care Scored 54%

Areas requiring improvement included the accuracy of the log, nursing documentation and nursing evaluations.

Outpatient Housing Unit was not scored.

The Medical experts evaluated this area during our recent visit to the complex in February 2008.

Health Records Scored 25%

Areas requiring improvement included development of a local policy, a functional tracking system for laboratory and diagnostic studies, and a functional system for UHR accountability, filing, and retrieval.

Preventive Services Scored 76%

An area that required improvement is clinician identification and development of a treatment plan for youth who are obese. In some cases, the calculated BMI's may have been higher than the current BMI since the patients' heights were based on heights that had been obtained at intake into the system. This issue was discussed with Dr. Morris.

Specialty Services Scored 80%

Areas requiring improvement included the ordering clinician's documentation and follow-up after the consultation.

Peer Review

Peer Review was not reviewed during this visit as it was reviewed during our recent visit to the NCYCC Outpatient Housing Unit and N.A. Chaderjian YCF.

Credentialing

Credentialing was not reviewed during this visit as it was reviewed during our recent visit to NCYCC Outpatient Housing Unit and N.A. Chaderjian YCF.

Quality Management

Quality Management was not reviewed during this visit as it was reviewed during our recent visit to NCYCC Outpatient Housing Unit and N.A. Chaderjian YCF.

Facility Leadership, Budget, Staffing, Orientation and Training

Interview facility leadership. Review staffing and vacancy reports, facility health care budget, staff credentials and licensure, and orientation and training documentation. Key: SC =Substantial Compliance, PC=Partial Compliance, NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Key facility health care leadership positions (Chief Medical Officer [CMO], Supervising Registered Nurse [SRN], Pharmacist, etc.) are filled or are being effectively recruited. Pay parity exists with CDCR.	1			
Question #2	Each facility has a full-time CMO who is board-certified or eligible in a primary care field. The NCYCC shall have one full-time CMO responsible for all complex facilities. The CMO's duties are consistent with the HCSR (see page 14).	1			
Question #3	In both policy and actual practice, the facility is assigned a health care budget that is under the control of the CMO.	1 ⁵			
Question #4	Budgeted and actual physician staffing hours are sufficient to meet policy and procedures requirements, and to provide quality medical services.	1			
Question #5	Budgeted and actual registered nurse staffing hours are sufficient to meet policy and procedures requirements and to provide quality nursing services.	1 ⁶			
Question #6	Medical Technical Assistant's (MTA) primary responsibilities will be the performance of health care duties.	1			
Question #7	Escort staffing and cooperation are sufficient to assure that youth attend on-site health care appointments		0 ⁷		
Question #8	The CMO ensures that an accurate and complete system exists for tracking professional and DEA licensure; and that CPR certification is in place. All licensed staff has a current and valid license.				N/E
Question #9	Newly hired staff receives a structured orientation program within 30 days of arrival. Documentation of orientation is kept in personnel files.		0 ⁸		
Question #10	Existing staff is trained regarding changes in new policies and procedure within 60 days of distribution.		0 ⁹		
	Totals:				

Compliance = 67% (6 of 9 applicable Questions)

Intrasystem Transfer

Select 10 to 20 health records from the Intrasystem Transfer Log and corresponding Medical Administration Records (MARs) of youth transferred to the facility in the previous 120 days. Review pertinent scheduling logs (consultation, chronic illness clinic, etc.).

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy and procedure. The statewide Transfer Form is in use.	1			
Question #2	There is a process whereby health care staff is notified of pending transfers from the facility one business day in advance of transfer.	1			
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	2			

Write the youth's ID number in top row.

State ID# →	1 ¹⁰	2	3	4	5	6	7	8	9 ¹¹	10
Date of arrival	5/7/08	5/12/08	5/9/08	4/29/08	4/23/08	3/25/08	3/24/08	1/29/08	1/16/08	1/9/08
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	1	1	0 ¹²	1	1
Screen # 3	n/a	n/a	n/a	n/a	n/a	0 ¹³	n/a	n/a	n/a	n/a
Screen # 4	0 ¹⁴	1	1	1	1	1	1	1	1	1
Screen # 5	n/a	n/a	1	1	n/a	1	n/a	1	1	1
Screen # 6	n/a	n/a	1 ¹⁵	1	n/a	0 ¹⁶	n/a	0 ¹⁷	n/a	0 ¹⁸
Screen # 7	0 ¹⁹	1	0 ²⁰	1	0 ²¹	1	n/a	n/a	n/a	0 ²²

- Screen # 1 A sending facility nurse reviewed the youth's record prior to transfer and documented required health information on the statewide transfer form. If the sending facility nurse did not complete the transfer form, the receiving nurse documented that she notified the facility of this (minimum information is the sending facility and who the nurse spoke to).
- Screen # 2 Upon arrival, a nurse interviewed the youth and reviewed the UHR. The nurse completed the form noting any additional information related to acute and chronic medical or mental health conditions, current medications, pending or recently completed consultations, and any other health condition requiring follow-up or special housing on the transfer form.
- Screen # 3 The receiving nurse referred youth with acute medical, dental, or mental health conditions on the day of arrival.
- Screen # 4 The receiving physician reviewed the health record of each youth within one business day of arrival and legibly signed and dated the Intrasystem form. The clinician addressed any significant medical problems.
- Screen # 5 A clinician evaluated youth with chronic diseases within 3 business days and enrolled the youth into the chronic disease program.
- Screen # 6 The MAR showed that continuity of essential medications (e.g., chronic disease, mental health, antibiotics, etc.) was provided.
- Screen # 7 The UHR shows that medical care ordered at the previous facility (e.g., vaccinations, consultations, laboratory tests) was carried out following arrival, or a clinical progress note provided an appropriate rationale for doing otherwise.

Intrasystem Transfer Summary:

Screen #	# Records Reviewed	# N/A	Final # of Records	# of Compliant Records	COMMENTS
1	10	0	10	10	
2	10	0	10	9	
3	10	9	1	0	
4	10	0	10	9	
5	10	4	6	6	
6	10	5	5	2	
7	10	3	7	3	
Total	70	21	49	39	2 of 2 Questions

Compliance = 80% (41 of 51 Questions + Screens)

Nursing Sick Call

Select 10 to 20 health records from general population nursing sick call encounters during the last 120 days. Key: SC =Substantial Compliance, PC=Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy. The statewide health services request form is in use.			0 ²³	
Question #2	Youth can confidentially submit Health Services Request forms (HSRF) daily into a locked box accessed only by health care staff. Health care staff collects and triages the forms daily.	1 ²⁴			
Question #3	Upon youth request, custody or health care staff assists youth with completion of the HSRFs. Sign language and translation services are available.	1			
Question #4	Nursing sick call is conducted in clean, adequately equipped, and supplied rooms with access to a sink for hand-washing or alcohol-based sanitizer with a sink nearby.		0 ²⁵		
Question #5	Nursing sick call is conducted 5 days a week for each housing unit, excluding weekends and holidays.			0 ²⁶	
Question #6	All registered nurses conducting sick call have been trained and demonstrate competency in health assessment and use of nursing protocols.			0 ²⁷	
Question #7	The UHR is available and present for sick call encounters including in specialized housing units and during lockdowns.	1			
Question #8	Nurses conduct sick call with, at a minimum, auditory privacy, and also with visual privacy if a physical examination is performed.	1			
Question #9	There is signage in all health care delivery areas stating that staff shall maintain the confidentiality of medical information.	1			
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:				

Compliance = 55% (5 of 9 Questions)²⁸

Medical Care

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Did the clinician sign all medical encounters? If the signature was illegible, was a stamp with the clinician's name and credentials used?	1			

Select 10 to 20 records of youth seen by an MD, NP, or PA for medical encounters (return from hospitalization, infirmary, sick call referral, etc.) in the past 180 days.

State ID# →	1	2	3	4	5	6	7	8	9	10
Visit date:	4/3	4/9	3/11	3/26	5/12	94/15	4/9	4/22	4/21	5/7
Clinician name:	A	B	B	A	B	B	B	A	A	B
Nature of visit:	Arm pain	diarrhea	Back pain	Allergies	Foot pain	Chest pain	Abdominal pain	Abdominal pain	Hand pain	Insect bite
Screen # 1	1	1	1	1	1	1	1	0 ²⁹	1	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	1	1	1	1	1	1	1	1	1
Screen # 4	1	1	1	1	1	1	1	1	1	1
Screen # 5	1	1	1	1	1	1	1	1	1	1
Screen # 6	1	1	1	1	1	1	1	1	1	1
Screen # 7	n/a ³⁰	n/a ³¹	1	n/a ³²	n/a ³³	n/a ³⁴	n/a ³⁵	n/a ³⁶	n/a ³⁷	n/a ³⁸

State ID# →	11	12	13	14	15	16	17	18	19	20
Visit date:	5/21	4/18	5/27	5/27	3/26	5/7	4/14	5/13	3/11	4/30
Clinician name:	A	A	A	B	B	A	B	B	B	A
Nature of visit:	Back pain	Hand/wrist pain	Ankle pain	Wrist pain	URI	Chest pain	URI	Insect bite	Shortness of breath	Wrist injury
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	1	1	1	1	1	1	1	1	1

State ID# →	11	12	13	14	15	16	17	18	19	20
Screen # 4	1	1	1	1	1	1	1	1	1	1
Screen # 5	1	1	1	1	1	1	1	1	1	1
Screen # 6	1	1	1	1	1	1	1	1	1	1
Screen # 7	n/a ³⁹	0 ⁴⁰	0 ⁴¹	n/a ⁴²	n/a ⁴³	n/a ⁴⁴	n/a ⁴⁵	n/a ⁴⁶	1	0 ⁴⁷

- Screen # 1 The clinician addressed the patient's current complaint by obtaining a history of the present illness and appropriate review of systems.
- Screen # 2 The nurse or clinician measured a full set of vital signs when clinically appropriate (including weight, if clinically indicated).
- Screen # 3 The clinician documented all pertinent physical findings, laboratory, and diagnostic results or other related objective data.
- Screen # 4 The clinician made an appropriate assessment based upon the patient's medical history, laboratory, and physical findings.
- Screen # 5 The clinician documented an appropriate treatment plan that included diagnostic and therapeutic measures, clinical monitoring, and follow-up.
- Screen # 6 The clinician documented appropriate patient education related to the diagnosis and treatment plan.
- Screen # 7 All aspects of the treatment plan occurred as ordered within a clinically appropriate time.

Medical Care Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	20	0	20	19	
Screen #2	20	0	20	20	
Screen #3	20	0	20	20	
Screen #4	20	0	20	20	
Screen #5	20	0	20	20	
Screen #6	20	0	20	20	
Screen #7	20	15	5	2	
Total	140	15	125	121	Plus 1 of 1 Question

Compliance = 97% (122 of 126 Questions + Screens)

Chronic Disease Management

Number of patients enrolled in clinic 33

Percent of clinic health records reviewed 30 %

Select 10 to 20 health records or 10% of this clinic population. Avoid records of youth arriving within the past 90 days. Write the youth's ID number in top row below:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	0 ⁴⁸	1	0 ⁴⁹	0 ⁵⁰	0 ⁵¹	1	0 ⁵²	1	0 ⁵³
Screen # 3	n/a	n/a	n/a	n/a	1	n/a	n/a	0 ⁵⁴	n/a	n/a
Screen # 4	1	0 ⁵⁵	1	1	1	n/a ⁵⁶	1	1	1	n/a ⁵⁷
Screen # 5	1	1	1	1	1	1	1	1	1	1
Screen # 6	1	1	1	1	1	1	1	1	1	1
Screen # 7	1	1	1	1	0 ⁵⁸	1	1	0 ⁵⁹	1	1
Screen # 8	1	1	1	1	1	1	1	1	1	1
Screen # 9	1	1	1	n/a	1	1	1	1	1	1
Screen # 10	1	0 ⁶⁰	1	1	1	n/a ⁶¹	1	n/a	n/a	n/a ⁶²

- Screen # 1 All chronic diseases are listed on the Problem List.
- Screen # 2 For the initial chronic care visit the clinician performed an appropriate medical history, physical examination pertinent to the management of the chronic disease.
- Screen # 3 Baseline and ongoing follow up laboratory/diagnostic data (HbA_{1c}, serum drug levels, if ordered, etc.) were completed prior to the scheduled clinic visit and the clinician addressed results during the clinic visit.
- Screen # 4 The clinician saw the patient quarterly or more frequently as clinically indicated (i.e., based on degree of disease control). Appropriate exceptions are documented in the UHR.
- Screen # 5 The clinician's evaluation of the youth was clinically appropriate (interval history, physical examination, laboratory tests, etc.).
- Screen # 6 The clinician accurately assessed degree of disease control (i.e., good, fair, poor).
- Screen # 7 The clinician's treatment plan documented appropriate diagnostic & therapeutic measures based upon disease control and indicates when the patient is to be seen for the next clinic follow up visit.
- Screen # 8 The clinician's or nurse's notes document appropriate patient education regarding disease process, diagnostic tests, treatment goals, medication purpose, and side effects, etc.
- Screen # 9 There were no lapses in medication continuity. The clinician's assessment of medication adherence is consistent with the MAR. If the patient was non-adherent, counseling is documented in the health record.
- Screen # 10 The clinician offered/ordered Pneumococcal and annual influenza immunizations as recommended. If accepted, the nurse documented the date of administration and initials on the Immunization and Communicable Disease Record. If refused, the clinician or nurse obtained refusal of treatment.

Chronic Disease Management Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	10	
Screen #2	10	0	10	4	
Screen #3	10	8	2	1	
Screen #4	10	2	8	7	
Screen #5	10	0	10	10	
Screen #6	10	0	10	10	
Screen #7	10	0	10	8	
Screen #8	10	0	10	10	
Screen #9	10	1	9	9	
Screen #10	10	4	6	5	
Total	100	15	85	74	

Compliance = 87% (74 of 85 Screens)

Infection Control

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question # 1	There is a Local Operating Procedure (LOP) describing the facility's infection control program that is consistent with statewide policy.	1			
Question # 2	There is a licensed health care provider who is designated as having public health/infection control duties and who has received appropriate orientation and training.				n/e ⁶³
Question # 3	There is a functional system for reporting diseases and laboratory test results, which are required by State and Federal Law (e.g., AIDS cases, positive HIV results, Hepatitis A, B, or C, syphilis, etc.).				n/e ⁶⁴
Question # 4	<p>There are exposure control plans in place for airborne and blood borne pathogens that include:</p> <ul style="list-style-type: none"> a) Documentation of new hire and annual training regarding exposure control plans. Not evaluated. b) A policy describing use of standard precautions to prevent contact with blood or other potentially infectious materials (OPIM) Yes, however the infection control manual is dated 2005. c) A policy describing engineering (sharps disposal, specimen handling) and work practice controls intended to eliminate or minimize employee exposure. Yes. however the infection control manual is dated 2005. d) A policy describing housekeeping procedures used to maintain a clean and sanitary environment, including a written schedule for cleaning and methods of decontamination No. 		0 ⁶⁵		
Question # 5	<p>Engineering Controls:</p> <ul style="list-style-type: none"> a) Sharps containers are secure and easily accessible in areas where sharps are used. Yes. b) Hand wash facilities are in or near all work areas and antiseptic hand cleaner are available when needed. Yes. c) An eyewash station is present and tested quarterly for functionality. The eyewash station functions properly. No. d) Specimen containers are used for transport of biological specimens (e.g., blood, urine). No. e) Biohazard storage bins are available. Yes f) Blood and body fluid spills are cleaned appropriately per policy. Not observed. 		0		
Question # 6	<p>Compliance with work practice controls:</p> <ul style="list-style-type: none"> a) Food and drink are not kept in refrigerators, freezers, shelves, cabinets, or counter tops where blood, laboratory specimens, or other potentially infectious materials are kept. Yes. b) Staff observes Standard Precautions. Not observed. c) Refrigerators are labeled appropriately (biohazard for specimens, food only, or medication only). Yes. d) Personal Protective Equipment is immediately available in health care delivery areas. Yes. e) Staff performs hand-washing as required. Yes 	1			

Infection Control Continued:

						SC	PC	NC	NA
Question 7	Are Infection Control Meetings held quarterly (minimum 4 meetings per year)?								n/e ⁶⁶
Question 8	If Question 7 is SC or PC , do the minutes address the following areas? (Put Y if topics are present or N if topic is missing, for each quarter in space provided):				QTR 1	QTR 2	QTR 3	QTR 4	
	a) TB skin testing programs for staff and youth								
	b) Exposure control plans and training regarding airborne and blood borne pathogens								
	c) Hepatitis B training and vaccination programs (e.g., number of employees trained, number accepting vaccine, and number completing vaccination series)								
	d) Staff compliance with work practice controls								
	e) Reporting communicable diseases for the previous quarter, noting any trends present								
	f) Sanitation reports (institutional and infection control) and any follow-up action taken								
Question 9	If respiratory isolation rooms are used for the purposes of respiratory isolation they are functional as evidenced by routine testing (at least monthly when not in use and daily when in use). Is staff fit-tested for N-95 respirators?								n/a
For calculating score, only give credit for applicable questions in substantial compliance. Totals:						2	2		4

Compliance = 50% (2 of 4 Applicable Questions)

Medication Administration Process

Observe all areas where medications are stored and administered. Observe the medication administration process.

Key: SC =Substantial Compliance, PC=Partial Compliance, NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Are medications administered from centralized medication rooms, except in specialized mental health units, SMP, TD, or BTP?	1			
Question #2	Is there a local policy for medication administration that is in compliance with the statewide policy and procedure?	1			
Question #3	Are the medication storage and administration rooms secure, clean, organized, and have adequate space, storage, lighting, and a sink or alcohol-based hand sanitizer?				n/a
Question #4	Are all medications in the Documed or night locker current and accounted for (from a sample of 5 medications)?				n/a
Question #5	Are all narcotics and other controlled substances double-locked, counted at every shift, and all accounted for (from a sample of 5 medications)?	1			
Question #6	Are all needles and syringes securely stored, counted at every shift, and all accounted for?	1			
Question #7	The medication room contains no medications that are discontinued or expired. (There is a 3-day window period to return these medications to the pharmacy.)	1			
Question #8	Are external medications stored separately from internal medications?	1			
Question #9	Does the nurse administer all legend medication from properly labeled containers and not from stock bottles?	1			
Question #10	Does custody staff provide continuous security during medication administration?	1			
Question #11	Medications that are to be administered at the hour of sleep are not administered before 2100 hours (one hour window permitted).	1			
Question #12	Is the medication refrigerator clean and used only to store medications (no food or specimens)? Does staff check and log the temperature daily?	1			
Question #13	Medications are not crushed except upon a physician order and for a valid reason (e.g., patient is known to hoard medication). Time-released medications are not crushed.	1			
Question #14	Observe the nurse administering medications to 5 to 10 youth, and answer the following elements.		0		
					Y or N
a.	The medication administration record (MAR) was available to the nurse during medication administration.				No ⁶⁷
b.	The nurse confirmed the identity of the youth per policy.				Yes
c.	The nurse compared the medication container label to the MAR.				Yes
d.	The nurse placed the medications into a cup prior to administration.				Yes
e.	The nurse performed visual oral cavity checks for medications in accordance with medication administration policies.				Yes
f.	The nurse documented on the MAR at the time the medication is administered.				Yes
g.	If a medication was not available after hours, the nurse obtained the medication from the Documed or night locker and signed it out prior to administration.				No ⁶⁸

Compliance = 92% (11 of 12 Questions)

Medication Administration Health Record Review

Select 10 to 20 health records and corresponding MARs of patients receiving medications in the preceding 180 days to review. Write the youth's ID number in top row below:

State ID# →	1 ⁶⁹	2 ⁷⁰	3 ⁷¹	4 ⁷²	5 ⁷³	6 ⁷⁴	7 ⁷⁵	8 ⁷⁶	9 ⁷⁷	10 ⁷⁸
Screen # 1	1	1	1	1	1	0 ⁷⁹	0 ⁸⁰	1	1	0 ⁸¹
Screen # 2	0 ⁸²	0 ⁸³	0 ⁸⁴	1	0 ⁸⁵	1	1	1	0 ⁸⁶	1
Screen # 3	1	1	1	1	1	1	1	1	1	1
Screen # 4	0 ⁸⁷	1	1	0 ⁸⁸	1	1	1	1	1	1
Screen # 5	1 ⁸⁹	1 ⁹⁰	1	1 ⁹¹	1 ⁹²	1 ⁹³	0 ⁹⁴	1	1 ⁹⁵	1 ⁹⁶
Screen # 6	1	1	1 ⁹⁷	0 ⁹⁸	0 ⁹⁹	1	1	1	0 ¹⁰⁰	0 ¹⁰¹
Screen # 7	1	1	0 ¹⁰²	n/a	0 ¹⁰³	0 ¹⁰⁴	1	1	0 ¹⁰⁵	1
Screen # 8	n/a	n/a	0 ¹⁰⁶	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Screen # 9	1	1	1	1	1	1	1 ¹⁰⁷	1	1	1

- Screen #1 The medication orders were complete (name of medication, strength, route of administration, frequency, duration, and number of refills).
- Screen #2 The clinician order was dated, timed, and legibly signed (if the signature is not legible, a signature stamp must also be used).
- Screen #3 The clinician documented an appropriate clinical note that corresponds with the initial medication order.
- Screen #4 The nurse dated and timed the medication order transcription (routine orders within 4 hours, urgent orders within 2 hours, and stat orders within 1 hour).
- Screen #5 The nurse and/or pharmacy accurately transcribed the physician order onto the MAR.
- Screen #6 The MAR reflected that all medications were initiated within 24 hours of the order being written or on the start date ordered.
- Screen #7 There is documentation of medication administration status (e.g., administered, refused, etc.) for every dose ordered for the youth.
- Screen #8 For discontinued medications, the nurse discontinued medications according to policy.
- Screen #9 The MAR is neat and legible, and contains legible initials, signatures, and credentials of nursing staff who have administered medications to youth.

MAR Review Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	7	In 3 records, route of administration not documented
Screen #2	10	0	10	5	In 5 records, the order was dated but not timed.
Screen #3	10	0	10	10	
Screen #4	10	0	10	8	In 2 of 10 records the nurse documented the date but not the time
Screen #5	10	0	10	9	However, the nurses did not transcribe the orders in 7 of 10 records
Screen #6	10	0	10	6	Documentation did not reflect that patient's received their medication within 24 hours
Screen #7	10	1	9	5	
Screen #8	10	9	1	0	
Screen #9	10	0	10	10	
Total	90	10	80	60	

Compliance = 75% (60 of 80 Screens)

Urgent/Emergent Care Services

Select 10 to 20 health records from the Urgent/Emergent Care Tracking Log in the previous 180 days. Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question # 1	There is an Urgent/Emergent Tracking Log that records all unscheduled health care encounters.		0 ¹⁰⁸		
Question # 2	Emergency equipment and supplies at the facility are consistent with the statewide policy and procedure. The facility has at least one automated external defibrillator (AED).	1			
Question # 3	The emergency equipment, medications, and supplies are in proper working order. An equipment checklist log shows that health care staff inspects equipment and supplies each shift.	1			
Question # 4	There is documentation that health care providers have been trained regarding emergency response. There is documentation of the last three emergency drills and one disaster drill, which delineates the events of the drill and identifies strengths and weaknesses.			0 ¹⁰⁹	
Question # 5	Interview nurses, physicians, nurse practitioners, physicians assistants, and dentists to ensure that all know how to properly operate the emergency equipment (O ₂ , Ambu bag, cardiac monitor, AED, etc.).				N/E
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	2	1	1	

Write the youth's ID number in the top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	0 ¹¹⁰	0 ¹¹¹	0 ¹¹²	0 ¹¹³	1	1	1	1	1
Screen # 2	0 ¹¹⁴	0 ¹¹⁵	0 ¹¹⁶	1	n/a ¹¹⁷	n/a ¹¹⁸	0 ¹¹⁹	1	0 ¹²⁰	0 ¹²¹
Screen # 3	1	0 ¹²²	0 ¹²³	1	n/a	n/a	0 ¹²⁴	0 ¹²⁵	1	0 ¹²⁶
Screen # 4	1	1	0 ¹²⁷	1	n/a	n/a	1	n/a ¹²⁸	0 ¹²⁹	0 ¹³⁰
Screen # 5	1	n/a	n/a	1	1	n/a	n/a	n/a	n/a	n/a
Screen # 6	n/a	n/a	1	0 ¹³¹	1	1	n/a	n/a	n/a	n/a
Screen # 7	n/a	n/a	1	1	1	0 ¹³²	n/a	n/a	n/a	n/a

- Screen # 1 The entry in the Urgent/Emergent Log is complete, legible, and there is a corresponding progress note in the health care record.
- Screen # 2 The nurse documented the date and time of the encounter and documented an assessment in SOAP format.
- Screen # 3 The nurse's subjective and objective evaluation was appropriate given the nature of the complaint (e.g., vital signs, SOB = peak flow meter, abdominal pain =abdominal assessment)
- Screen # 4 The nurse's assessment and plan were appropriate, including notification or referral to the clinician when clinically indicated.
- Screen # 5 If the nurse referred the youth to a clinician, the follow-up visit was timely and clinically appropriate.
- Screen # 6 For patients returning from the emergency room, nursing staff contacted the physician on-call to obtain follow-up orders.
- Screen # 7 If the youth was sent to an outside facility, the physician saw the youth the following business day.

Urgent/Emergent Care Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	6	
Screen # 2	10	2	8	2	
Screen # 3	10	2	8	3	
Screen # 4	10	3	7	4	
Screen # 5	10	7	3	3	
Screen # 6	10	6	4	3	
Screen # 7	10	6	4	3	
Total	70	26	44	24	Plus 2 of 4 questions

Compliance = 54% (26 of 48 Questions + Screens)

Health Records

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question # 1	Local policies are consistent with statewide policies and procedures, and address all aspects of health record management. (See Audit Tool Instructions.)			0	
Question # 2	The Movement and Problem List is visible upon opening the UHR.	1			
Question # 3	There is a functional tracking system for laboratory, diagnostic, and consultation reports.			0	
Question # 4	The facility has a functional system for UHR accountability, filing, and retrieval.		0 ¹³³		
	For calculating score, only give credit for questions in substantial compliance.				
	Totals:	1	1	2	

Compliance = 25% (1 of 4 Questions)

Preventive Services

Select 10 to 20 health records of youth who have been in DJJ over one year.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a policy and procedure regarding preventive services that is consistent with the US Preventive Services Task Force (USPSTF) and American Medical Association Guidelines for Adolescent Preventive Services (GAPS) in areas that are applicable to DJJ youth.				

Write the youth's ID number in the top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Screen # 3	1	1	1	1	1	1	1	1	1	1
Screen # 4	0 ¹³⁴	0 ¹³⁵	0 ¹³⁶	0 ¹³⁷	0 ¹³⁸	0 ¹³⁹	0 ¹⁴⁰	1	0 ¹⁴¹	0 ¹⁴²
Screen # 5	1	1	1	1	1	1	1	1	1	1
Screen # 6	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

- Screen # 1 TB skin testing was performed annually. If previously positive, a nurse conducted a TB symptom screen.
- Screen # 2 Annual pap smears were performed (at a minimum) beginning 3 years after initiation of sexual intercourse and 2 consecutive years thereafter. If there are 3 consecutive normal annual pap smears, then they are performed every 3 years thereafter. Management of abnormal pap smears was appropriate, including referral.
- Screen # 3 A nurse measures the youth's blood pressure annually. The nurse refers youth with abnormal blood pressure to a clinician.
- Screen # 4 A nurse measures the youth weight annually. Obesity is addressed if clinically indicated (BMI >24 %).
- Screen # 5 Hepatitis A and B vaccinations are current, as applicable.
- Screen # 6 Youth are offered Tetanus-Diphtheria Booster if not received within ten years.

Preventive Services Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	10	
Screen # 2	10	10	0	0	
Screen # 3	10	0	10	10	
Screen # 4	10	0	10	1	Weights are current but heights are from intake. Heights may have changed so BMI may be less than calculated value.
Screen # 5	10	0	10	10	
Screen # 6	10	10	0	0	
Total	60	20	40	31	

Compliance = 76% (31 of 41 Questions + Screens)

Consultation and Specialty Services

Interview staff responsible for specialty service contracts and consultation tracking. Review the Consultation Tracking log. Select 10 health records from the facility of youth who received consultation services in the last 180 days.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local consultation policy and procedure that is consistent with the statewide policy.	1			
Question #2	The facility has implemented the outside specialty care log to include receipt of reports. Staff maintains it accurately and contemporaneously.	1			
Question #3	There is sufficient custody staffing and cooperation to transport youths to outside medical appointments.	1			
	For calculating score, only give credit for questions in substantial compliance.				
	Totals:	3			

Write the youth's ID number in top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	0 ¹⁴³	1	1	0 ¹⁴⁴
Screen # 2	0 ¹⁴⁵	0 ¹⁴⁶	0 ¹⁴⁷	0 ¹⁴⁸	0 ¹⁴⁹	1	1	0 ¹⁵⁰	1	n/a
Screen # 3	0	1	1	1	1	0	1	1	1	1
Screen # 4	1	1	1	1	1	1	n/a	1	1	1
Screen # 5	n/a ¹⁵¹	n/a ¹⁵²	n/a ¹⁵³	n/a ¹⁵⁴	n/a ¹⁵⁵	n/a ¹⁵⁶	n/a ¹⁵⁷	n/a ¹⁵⁸	n/a ¹⁵⁹	1
Screen # 6	0 ¹⁶⁰	1	1	1	1	1	1	1	1	1
Screen # 7	0 ¹⁶¹	0	1	1	1	0 ¹⁶²	1	1	1	1
Screen # 8	1	0 ¹⁶³	1	1	1	1	1	1	1	1
Screen # 9	1	0	1	1	1	1	1	1	n/a	1

- Screen # 1 The health record contained a Consultation Request Form. The clinician legibly documented the service requested, urgency (routine or urgent), and dated and signed the form.
- Screen # 2 The clinician legibly documented the history of the present illness, physical findings, and lab data that supports the rationale for the service on the Consultation Request Form.
- Screen # 3 The clinician legibly documented the medical history, physical and laboratory findings, and an assessment that supports the need for the consult in the Progress Notes.
- Screen # 4 The record reflects that the youth was seen by the consultant within the required time frames (90 days for routine, 10 ten days for urgent unless indicated sooner).
- Screen # 5 Upon the patient's return from the consultation appointment, the nurse reviewed the consultant's recommendations and addressed any urgent recommendations.
- Screen # 6 The clinician reviewed, dated, and initialed the consultation report within 3 business days of the youth's return to the facility or receipt of the report.
- Screen # 7 The UHR shows that the clinician met with the youth 5 business days (sooner if clinically indicated) to review results of the consult with the youth and develop a treatment plan.
- Screen # 8 The health record reflected that the consultant's recommendations were ordered and implemented, or a valid reason for **not** implementing the recommendations was documented (i.e., patient is out to court, refused, etc.). If the physician disagrees with the consultant's recommendations, an appropriate alternate plan of care was ordered and implemented.
- Screen # 9 The health record reflected that the clinician monitored the youth to ensure that the treatment plan was implemented and the desired clinical outcome was achieved, or the treatment plan was amended.

Consultation and Specialty Services Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	8	The consultation forms do not ask for the urgency of the referral.
Screen # 2	10	1	9	3	
Screen # 3	10	0	10	8	
Screen # 4	10	1	9	9	
Screen # 5	10	9	1	1	
Screen # 6	10	0	10	9	
Screen # 7	10	0	10	7	
Screen # 8	10	0	10	9	
Screen # 9	10	1	9	8	
Total	90	12	78	62	Plus 3 of 3 Questions

Compliance =80% (65 of 81 Questions + Screens)

Total Number of Questions and Screens Evaluated	= 550
Total Number of Questions and Screens in Substantial Compliance	= 444
Total Score	= 81%

Endnotes

¹ Basic facility orientation for new employees is not provided on a routine basis. We were informed that the most recent orientation occurred six months prior to our visit.

² DJJ has requested that the experts re-evaluate the value of nursing sick call. The experts are willing to consider replacing nursing sick call with clinician sick call. At this time, the plan requires nursing sick call. DJJ has placed the development of these protocols on hold pending the resolution of this issue with the experts.

³ When the Farrell Medical Experts published their original report in 2003 the overall clinician to youth ratio was 1:262 which we determined to be more than adequate for the population size and medical acuity. At our February 2008 visit to the Northern California Youth Correctional Complex (NCYCC) we noted that the complex consisted of NA Chaderjian (population 210), OH Close (population 184), and Dewitt Nelson (population 183). Dewitt Nelson was scheduled to close by 7/31/08. The Complex is budgeted for a Chief Medical Officer, three physicians, and a 0.7 FTE nurse practitioner for approximately 580 youth. This is a clinician to youth ratio of one to 123 youth. In addition we noted supplemental physician staffing on a regular basis.

⁴ OH Close does not have its own infection control nurse. There is a NCYCC registered nurse who has been designated the infection control nurse for the complex and this area was previously evaluated in February 2008 during the N.A Chaderjian visit.

⁵ The facility has the actual funds for the health care budget.

⁶ Day shift: 2 RNs, 0 MTAs or LVNs, Evening Shift 2 RNs , Night Shift none at OH Close but in the OHU..

⁷ Two correctional officers were correctional officer escorts. Staff expressed concern that there was no correctional officer in the area available to respond to emergencies while staff are seeing patients. Correctional officers in the control room are unable to leave the area in an event of an emergency.

⁸ Only one facility orientation in six months.

⁹ The folder of TDO's show 29 not 32 policies; the local policy manual has only 27 policies in the folder instead of 32. There is no local policy nursing sick call; dental care; table of organization; peer review and credentialing. Prenatal care not applicable. Staff have not been trained in the local policies.

¹⁰ A nurse documented a progress note on the physician order form on 5/13/08.

¹¹ Asthma, mitral valve prolapse, mild tricuspid regurgitation.

¹² The nurse did not complete the lower portion of the intrasystem transfer form documenting WNL for the appearance, assessment and plan. The patient had a history of asthma and ADD. The patient's blood pressure was 157/84 mm/hg but the nurse did not note the elevated blood pressure.

¹³ The patient's blood pressure was 164/91mm/hg and 160/90 mm/hg when rechecked. The nurse did not inquire as to whether or not he had his medication or consult a physician.

¹⁴ The physician did not develop a plan regarding the patient's obesity (BMI >32).

¹⁵ This patient had an order for Loratadine 10 mg daily prior to his arrival to OH Close. Upon his arrival the physician wrote an order for Loratadine 10 mg daily as needed for 3 months. Medication initiated on 5/13/08.

¹⁶ The physician did not order the patient's blood pressure medication until the day after his arrival and the patient did not receive his blood pressure medication for another 24 hours afterward, although it was

moderately elevated. The patient missed his medication 3/25 and 3/26/08. This is a disruption in continuity of his blood pressure medication particularly since his blood pressure was elevated.

¹⁷ There is no January 2008 MAR in the record that shows that he received his Adderall through 1/31/08.

¹⁸ The nurse did not document the date on the MAR that the youth was given his Albuterol inhaler.

¹⁹ The previous facility physician enrolled the patient in the obesity program but this was not followed up by the physician at OH Close.

²⁰ While at Preston YCF this patient's blood count showed that he had a low total white blood cell count (3.0, normal =4.2-11) and was neutropenic (27.8% normal =48.9-69.9%). A physician reviewed the result but did not comment upon the result or repeat it or listed on the Problem List. This was not noted or addressed upon his arrival at OH Close.

²¹ This 16 year old arrived at DJJ through SYCRCC on 4/3/07. His medical history included TB infection in 2000. In April 2007 he was prescribed Isoniazid 900 mg twice weekly. A baseline chest x-ray was not performed until June 2007 two months after he started INH. His baseline liver function tests were normal (bilirubin =0.9, AST= 25 ALT= 11, Alkaline phosphatase = 183. The patient's bilirubin increased from 0.9 to 1.6 in June 2007 and alkaline phosphatase increased to 244. His bilirubin and alk phos continued to increase (1.8 and 177 respectively) until September 2007. The patients liver function tests have not been checked since September 2007. Normal transaminases with elevations of bilirubin and Alk phosphatase is an unusual response to INH therapy. These abnormal labs were not noted or addressed. The youth did not have a baseline chest x-ray prior to starting INH but has had two x-rays since then. The second one was unnecessary.

²² This youth has a history of a mood disorder and ADHD and was previously on psychotropic medication. On 1/14/08 a psychiatrist saw him and requested follow-up in 6 weeks. This has not taken place.

²³ The facility does not have a nursing sick call policy.

²⁴ During the week at 0700 the HRT goes to the housing units to pick up HSRs. She enters them onto the Sick call log name, ID number and time received. The RN reviews them and documents the disposition onto the sick call log.

²⁵ The room has not been terminally cleaned in some time. There is accumulation of dirt and/or corrosion on the floors underneath an alcove.

²⁶ They are not conducting nurse sick call at the facility.

²⁷ There are no statewide nursing protocols that have been developed so nurses could be trained.

²⁸ Nurses are not performing sick call and therefore records were not reviewed.

²⁹ No history related to nature, intensity, location, etc of abdominal pain; frequency and nature of diarrhea not noted

³⁰ Self limited problem for which there were no orders beyond initial treatment

³¹ Self limited problem for which there were no orders beyond initial treatment

³² Self limited problem for which there were no orders beyond initial treatment

³³ Self limited problem for which there were no orders beyond initial treatment

³⁴ Self limited problem for which there were no orders beyond initial treatment

³⁵ Self limited problem for which there were no orders beyond initial treatment

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- ³⁶ Self limited problem for which there were no orders beyond initial treatment
- ³⁷ Self limited problem for which there were no orders beyond initial treatment
- ³⁸ Self limited problem for which there were no orders beyond initial treatment
- ³⁹ Self limited problem for which there were no orders beyond initial treatment
- ⁴⁰ MD ordered an x-ray. There is no documentation of x-ray results.
- ⁴¹ MD ordered an x-ray. There is no documentation of x-ray results.
- ⁴² Self limited problem for which there were no orders beyond initial treatment
- ⁴³ Self limited problem for which there were no orders beyond initial treatment
- ⁴⁴ Self limited problem for which there were no orders beyond initial treatment
- ⁴⁵ Self limited problem for which there were no orders beyond initial treatment
- ⁴⁶ Self limited problem for which there were no orders beyond initial treatment
- ⁴⁷ MD ordered an x-ray and return to clinic the next day. The x-ray was done (normal) but patient not seen for ordered follow-up. MD reviewed and signed x-ray report on 5/2 but did not write progress note.
- ⁴⁸ Youth with asthma. No initial history related to hospitalizations, ER visits, inhaled steroid use, etc.
- ⁴⁹ Youth with asthma. No initial history related to ER visits, inhaled steroid use, etc.
- ⁵⁰ Youth with asthma and hypertension. No initial history related to ER visits, inhaled steroid use, family history, etc
- ⁵¹ Youth with asthma. No initial history related to ER visits, inhaled steroid use, etc.
- ⁵² Youth with hypertension, renal disease, and hyperlipidemia. Past history and family history not documented.
- ⁵³ Youth with asthma. No history related to prior hospitalizations or ER visits, etc.
- ⁵⁴ Lipids drawn in 1/08 were elevated. MD ordered repeat study when he saw patient in March, but did not document the problem in his progress note. The lab test was not done.
- ⁵⁵ Youth was seen in chronic care for asthma on 1/10/08. Order to return in 3 months. Not seen until 5/28/08.
- ⁵⁶ New arrival
- ⁵⁷ New arrival
- ⁵⁸ MD did not order lipid panel.
- ⁵⁹ Youth saw nephrologist 11/07 who stated that a definitive diagnosis would require a biopsy. On 5/13 youth was referred back to nephrologist after he [youth] asked if he still needed a biopsy and when it could be done. This case was discussed with Dr. Tseng.
- ⁶⁰ Youth with asthma did not receive flu vaccine.
- ⁶¹ New arrival
- ⁶² New arrival
- ⁶³ OH Close does not have its own infection control nurse. There is a registered nurse who performs this function for the complex. This was previously evaluated at N.A. Chaderjian in February 2008.

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- ⁶⁴ OH Close does not have its own infection control nurse. There is a registered nurse who performs this function for the complex. This was previously evaluated at N.A. Chaderjian in February 2008.
- ⁶⁵ There is an infection control manual, however it is dated 2005. It should be reviewed and updated annually.
- ⁶⁶ This area was previously evaluated during the Chad visit.
- ⁶⁷ Patient had come from the OHU and his medication and MAR had not yet returned.
- ⁶⁸ There is no stock medication in the O.H. Close clinic. The nurse did not obtain the medication by going to a Documed and/or calling the pharmacist.
- ⁶⁹ Trileptal order dated 5/12/08
- ⁷⁰ Adderall and Prozac order dated 5/21/08.
- ⁷¹ Order dated 3/10/08. The physician indicated to begin medication only after the mother has signed the consent form. This was done on 3/16/08.
- ⁷² Multiple order dated 4/28/08.
- ⁷³ Prozac order dated 5/14/08.
- ⁷⁴ Lisinopril, Hydrochlorothiazide and Lipitor order dated 3/18/08.
- ⁷⁵ INH order dated 3/20/08.
- ⁷⁶ INH order dated 5/5/08.
- ⁷⁷ Wellbutrin order dated 5/19/08.
- ⁷⁸ Imodium order dated 4/17/08.
- ⁷⁹ No documentation of route of administration.
- ⁸⁰ No documentation of route of administration.
- ⁸¹ No documentation of route of administration.
- ⁸² Order dated, not timed.
- ⁸³ Order dated, not timed.
- ⁸⁴ Order dated, not timed.
- ⁸⁵ Order dated, not timed.
- ⁸⁶ Order dated, not timed.
- ⁸⁷ The nurse documented the date of transcription, but not the time. Medication label placed over the nurse transcribed order, partially covering the nurses' signature.
- ⁸⁸ The nurse documented the date of transcription, but not the time.
- ⁸⁹ The nurse did not transcribe the order. Only the pharmacy label is present. The pharmacy label indicates that there is no consent on file.
- ⁹⁰ The nurse did not transcribe the order. Only the pharmacy label is present. The pharmacy label indicates that there is no consent on file.
- ⁹¹ The nurse did not transcribe the order. Only the pharmacy label is present.
- ⁹² The nurse did not transcribe the order. Only the pharmacy label is present.

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- ⁹³ The nurse added “po’, or by mouth to the order although the physician did not write this. Credit given. Continuing problem. Preprinted and punched holes in the MAR obliterate the date of the MAR. This should be corrected.
- ⁹⁴ The nurse did not transcribe the 3/20/08 order onto the MAR. Pharmacy preprinted MARs for April and May show the January order. The nurses have documented continuation of the INH for the January order.
- ⁹⁵ The nurse did not transcribe the order. Only the pharmacy label is present.
- ⁹⁶ The nurse did not transcribe the order. Only the pharmacy label is present.
- ⁹⁷ The physician indicated to begin medication only after the mother has signed the consent form. This was done on 3/16/08.
- ⁹⁸ The nurse did not document the date that the youth was given the Cleo in T and Mizoram cream.
- ⁹⁹ A parent signed the consent on 5/14/08 the same day the order was written but the prescription was not filled and the patient did not receive a dose until 5/16/08.
- ¹⁰⁰ The Wellbutrin order was dated 5/19/08. The medication was not administered until 5/21/08.
- ¹⁰¹ No time of administration was documented to reflect that it was being given stat.
- ¹⁰² No documentation of administration status for March 20 am dose and March 21 morning and evening dose.
- ¹⁰³ No documentation of administration status for May 20 for Prozac 10 mg daily and no documentation for Prozac 20 mg for 5/22 and 5/23/08.
- ¹⁰⁴ No documentation of administration status for April 6, 7 and 20, 2008.
- ¹⁰⁵ No documentation of administration status for May 31, 2008.
- ¹⁰⁶ The nurse did not document the date of discontinuation and signature. The nurse crossed out the original order.
- ¹⁰⁷ Continuing problem. Preprinted and punched holes in the MAR obliterate the date of the MAR. February and March 2008 MAR. This should be corrected.
- ¹⁰⁸ Not all youth who are sent to the emergency room are noted in the log
- ¹⁰⁹ No emergency training has been conducted.
- ¹¹⁰ No entry in log (5/12/08)
- ¹¹¹ No entry in log (5/20/08)
- ¹¹² Entry in log is incomplete
- ¹¹³ No entry in log (5/1/08)
- ¹¹⁴ Subjective information in objective section
- ¹¹⁵ Subjective information in objective section
- ¹¹⁶ Subjective information in objective section
- ¹¹⁷ Referred directly to MD, not seen by nurse
- ¹¹⁸ Not evaluated by nurse
- ¹¹⁹ Subjective information in objective section
- ¹²⁰ Subjective information in objective section

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- ¹²¹ Subjective information in objective section; subjective and objective information under assessment
- ¹²² Did not evaluate strength or gait
- ¹²³ Inadequate history and physical. Should have checked orthostatic vital signs.
- ¹²⁴ Left hand pain following altercation – no further description (i.e., location) and no exam for tenderness. Did not note location of wound or if related to fight. Concern would be for human bite injury.
- ¹²⁵ Inadequate history related to headache
- ¹²⁶ Patient complaining of chest pain, probably musculoskeletal. Nurse did not palpate chest wall for tenderness
- ¹²⁷ Nurse did not adequately evaluate patient. Should have consulted MD prior to calling for ambulance.
- ¹²⁸ Unable to evaluate due to inadequate history
- ¹²⁹ There is no assessment, only lists patient's medications.
- ¹³⁰ Nurse did not document an assessment
- ¹³¹ No nursing note upon return from SJCH ER
- ¹³² Returned from SJCH ER on 5/28; not seen by MD until 5/30
- ¹³³ Facility has recently implemented a system using outguides, not everyone is using it yet
- ¹³⁴ BMI 24.1. Weight not addressed.
- ¹³⁵ BMI 24.2. Weight not addressed.
- ¹³⁶ BMI 26.3. Weight not addressed.
- ¹³⁷ BMI 27.5 Weight not addressed.
- ¹³⁸ BMI 26.6. Weight not addressed.
- ¹³⁹ BMI 26.8. Weight not addressed.
- ¹⁴⁰ BMI 32.7. Weight not addressed.
- ¹⁴¹ BMI 26.3. Weight not addressed.
- ¹⁴² BMI 25.9. Weight not addressed.
- ¹⁴³ MD did not note timeframe for consult
- ¹⁴⁴ Seen by ENT consultant on 1/18/08. No consult form in chart.
- ¹⁴⁵ Dermatology consult for acne. (4/1/08) MD did not document other medications that had been tried.
- ¹⁴⁶ Dermatology consult for acne. (11/21/07) MD did not document other medications that had been tried.
- ¹⁴⁷ Ortho consult for ankle injury. (3/24/08) No history of injury or physical findings.
- ¹⁴⁸ Inadequate history. No physical findings noted. (5/7/08)
- ¹⁴⁹ No physical findings noted. (4/28/08)
- ¹⁵⁰ No physical findings noted. (1/8/08)
- ¹⁵¹ On-site consultation
- ¹⁵² On-site consultation

¹⁵³ On-site consultation

¹⁵⁴ On-site consultation

¹⁵⁵ On-site consultation

¹⁵⁶ On-site consultation

¹⁵⁷ On-site consultation

¹⁵⁸ Seen by MD and admitted to OHU

¹⁵⁹ Seen by MD upon return

¹⁶⁰ Not reviewed until 7 days after consult

¹⁶¹ Did not see youth until 9 days after consult. In addition, youth is not being appropriately monitored for Accutane (CBC w/differential & platelets, LFTs, CPK, glucose, ESR). Specialist only ordered monitoring of lipids. Other tests should have been ordered by specialist, but since he did not, clinic MD should have ordered them. This was discussed with Dr. Tseng.

¹⁶² MD did not see patient until 7 days after consult

¹⁶³ Did not see youth following consult. In addition, youth is not being appropriately monitored for Accutane (CBC w/differential & platelets, LFTs, CPK, glucose, ESR). Specialist only ordered monitoring of lipids. Other tests should have been ordered by specialist, but since he did not, clinic MD should have ordered them. This was discussed with Dr. Tseng.

**CALIFORNIA DEPARTMENT OF
CORRECTIONS
AND REHABILITATION
DIVISION OF JUVENILE JUSTICE**

**Preston Youth Correctional Facility
Health Care Audit
September 5-6, 2007**

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INTRODUCTION

The Health Care Remedial Plan (HCRP) requires the Division of Juvenile Justice (DJJ) to make a number of specific changes in the medical, mental health, and dental care programs. To measure DJJ compliance with the requirements of the Health Care Remedial Plan, the Medical Experts developed this audit instrument with clearly defined standards and criteria, and thresholds of compliance. The audit instrument is comprised of indicators selected from:

- The Health Care Remedial Plan
- DJJ policies and procedures developed in consultation with the Medical Experts
- National Commission on Correctional Health Care (NCCCHC) Standards for Health Services in Juvenile Detention and Confinement Facilities, 2004 Edition
- The American Medical Association's Guidelines for Adolescent Preventive Services (GAPS)
- US Preventive Services Task Force (USPSTF)
- Guidelines for the evaluation and treatment of other disease such as those published by the Centers for Disease Control and Prevention (CDC)

Regarding those areas related to nursing and medical care practice, the Medical Experts will use their professional judgment to assess compliance.

NOTE: This audit instrument does not address mental health. The Mental Health Experts will develop the Mental Health Audit Instrument.

Audit Instrument and Compliance Thresholds

The audit instrument will be used by the Medical Experts to evaluate compliance with the HCRP. It is also intended for use by the DJJ Office of Health Services Quality Management Team and by the local facility Quality Management Team to evaluate progress consistent with the HCRP. The audit instrument includes indicators from sources cited above, which the Medical Experts judge to be critical in establishing an adequate health care system. Some indicators allow for partial compliance if the facility is close to, but has not yet achieved substantial compliance.

A facility is in substantial compliance when all of the following conditions are satisfied:

- a. The facility receives a score of 85% or higher during an audit conducted by the Court experts. When determining overall compliance, areas that are determined to be in partial compliance will be considered non-compliant. The experts shall have the discretion to find a facility providing adequate medical care in compliance if it achieves a score of no less than 75%.

- b. Medical assessments and treatment plans provided to youth comply with the policies and procedures, as determined by the medical experts. The medical assessment and treatment plans provided to the youth shall be deemed adequate and appropriate under these policies and procedures, only under any one of the following conditions:

- (1) The assessment or treatment plan is consistent with guidelines specifically adopted in the policies and procedures; or

- (2) The practitioner documents in the medical notes that he/she is deviating from adopted policies and procedures, and that such deviation is consistent with the community standard; or

- (3) Where no treatment guidelines are specifically adopted in these policies and procedures, the assessment or plan is consistent with the community standard.

- c. The facility is conducting minimally adequate death reviews and quality management proceedings.
- d. The facility has tracking, scheduling, and medication administration systems adequately in place.
- e. Both experts have concluded that there is not a pattern or practice that is likely to result in serious violations of wards' rights that is not being adequately addressed.

The medical experts have developed audit instrument instruction to clarify interpretations and scoring of the audit instrument. We are available to answer questions as well as provide training to staff regarding the audit instrument.

Preston Site Visit Summary

The Farrell Medical Experts visited Preston Youth Correctional Facility on September 5-6, 2007. Since our last visit in November 2006, the population at the facility has decreased from approximately 400 to 350 youth. Overall, a number of improvements have been made since our last visit. The facility scored 553 out of 714 screens/questions for a score of 77%. The outpatient housing unit and medication administration in the housing units were not evaluated during this visit.

Dr. Evalyn Horowitz is the Health Care Manager. In addition, the facility now has two full-time physicians (Drs. Wisdom and Wong) and a Health Care Administrator (HCA) (George Watanabe). Nurse staffing has been increased to 18 RN positions with two RN vacancies for which they are still recruiting. Staff reported that it is difficult to recruit because of uncertainty about relocation of programs and the recent law that was passed that limits DJJ from taking nonviolent offenders.

There are still no finalized agency, health care, or institutional tables of organization. This has led to confusion among reporting relationships at the institutional level, particularly among nursing staff and has resulted in the publication of two memoranda seeking to clarify the reporting relationships.

Dr. Horowitz believes she has full authority over hiring decisions, but does not have control of the budget. The HCA was given a budget for major and minor equipment, but not other aspects of the health care budget. In addition, Youth Correctional Counselor (YCC) positions and overtime are charged to the medical budget, but when staff tried to find out how many YCC positions were assigned to the health care budget they were not provided this information. The HCA reported that the business office had informed him that he was over budget. When he investigated, he discovered that they were over budget because over \$700,000 had been charged to the medical budget for YCC overtime.

The HCA also reported that the cost of equipment and supplies, including computers, is to be automatically budgeted with new positions, but they have had difficulty obtaining these supplies and equipment in a timely manner when new employees are hired. They reported having no problems ordering medical supplies, but office supplies take longer. Apparently there is no statewide contract for purchase of office supplies, computers, copiers, etc. This may result in medical purchasing items (e.g. copiers) different from what is purchased by the business office. For example, the facility contracts that support copiers for one user group may not support copiers for another user group.

The facility had four Medical Technical Assistant (MTA) positions, but one was reclassified to a Youth Correctional Officer position (YCO). MTAs are being paid from the medical budget and perform medical duties. There is currently a 24/7 correctional officer assigned to the medical unit at the front desk and a 1.0 FTE in medical reception. These 3.85 YCO positions providing coverage in the medical unit are paid for from the medical budget. They advised us that a Budget Change Proposal (BCP) for additional YCOs was approved.

Health care leadership stated that they currently have enough nurses however, if the medical

reception mission is moved and the nurses are transferred with it, then they may not have enough nurses. Also, if they lose medical reception, they are told the correctional officer position will be reassigned, yet this officer also supervises other areas in the medical section, (doctor's sick call, dental, and lab).

Staff reported issues regarding obtaining access to youth due to scheduling issues, and lack of sufficient numbers of correctional officer escorts. There are no dedicated officers for medical transports. Custody is making an effort and they are much improved from last year.

New employees are oriented in the personnel office and receive an abbreviated security orientation. A more comprehensive three-day training is only conducted once or twice a year by custody. Following the security orientation, the health care orientation lasts 3-4 weeks, and is extended if necessary. The TDO's are still in effect and policies have not been finalized.

Sanitation in the main hallway was good but poor in some individual treatment rooms and offices. This is despite the hiring of a new janitorial position. There have been leaks in the ceiling in the x-ray room for some time but they have not been definitively repaired. Plaster and water have dripped down onto the uncovered x-ray equipment, with the potential to damage it.

Summary of Health Care Review

- Medical reception scored 72% compliance. Areas needing improvement are the quality of the medical history and physical examination, notation of current medical problems on the Problem List, and documentation of a treatment plan addressing all current problems.
- Intrasystem Transfer scored 56%. Areas needing improvement are ensuring that a reliable system exists for notification of health care staff of transferring youth, the physician legibly signing, dating and timing review of the intrasystem transfer form upon arrival, and providing continuity of essential medications.
- Nursing Sick Call scored 51%. Nursing sick call is not being conducted in a clinical setting, instead is being conducted in the dayrooms, without adequate privacy, equipment and the health record. Nurses have not been trained in health assessment and use of nursing protocols and not unexpectedly, the quality of assessments is poor. Nursing referrals to a physician are working well.
- Medical Care scored 83%. Improvement is needed in documentation of patient education and documentation of implementation of the physician treatment plan.
- Chronic Disease Management scored 82%. Improvement is needed in the quality of the database medical history and physical examinations, and administration of appropriate vaccinations.
- Infection Control scored 100%. Congratulations!
- Pharmacy Services scored 67%. Areas needing improvement include sanitation, implementation of monthly inspections and quarterly pharmacy and therapeutics meetings, and computer software capability to identify drug-drug interactions.
- Medication Administration Process scored 92% (we did not review medication administration in the specialized treatment units and will do so at the next visit). The

only area of improvement needed was to separate and label internal from external medications.

- Medication Administration Health Record Review scored 87%. Areas that need attention include clinician documentation of route of administration with each order, and accurate transcription onto the MAR (the pharmacy is documenting date prescription was filled, not date of physician order).
- Urgent/Emergent Care scored 88%. Areas needing improvement include implementation and documentation of emergency response drills, the quality of nursing assessments and timeliness of physician referrals.
- Health Records scored 25%. Areas needing improvement include implementation of statewide and local policies regarding health record management, development of a laboratory and consultation tracking report system, and a record tracking system.
- Preventive Services scored 96%. Congratulations!
- Consultations scored 91%. Areas needing improvement include the development and implementation of a consultation tracking log (that addresses tracking of consultation reports; timely review of the consultant's findings, and meeting with the patient to discuss the recommended treatment plan).
- Peer Review scored 20%. Areas needing improvement include development and implementation of statewide and local peer review policies and peer review activities.
- Credentialing scored 71%. Areas needing improvement include the development and implementation of statewide and local credentialing policies and credentialing files that contain all required elements.
- Quality Management scored 50%. Areas needing improvement include implementation of quality management meetings and studies, physician peer review and annual Quality Management Report to the Statewide Medical Director.

Recognizing that there are areas requiring improvement, we wish to congratulate staff on their progress to date.

Facility Leadership, Budget, Staffing, Orientation and Training

Interview facility leadership. Review staffing and vacancy reports, facility health care budget, staff credentials and licensure, and orientation and training documentation. Key: SC =Substantial Compliance, PC=Partial Compliance, NC =Noncompliance, NA = Not Applicable, NE =Not evaluated

		SC	PC	NC	NA
Question #1	Key facility health care leadership positions (Chief Medical Officer [CMO], Supervising Registered Nurse [SRN], Pharmacist, etc.) are filled or are being effectively recruited. Pay parity exists with CDCR.	1			
Question #2	Each facility has a full-time CMO who is board-certified or eligible in a primary care field. The NCYCC shall have one full-time CMO responsible for all complex facilities. The CMO's duties are consistent with the HCSR (see page 14).	1			
Question #3	In both policy and actual practice, the facility is assigned a health care budget that is under the control of the CMO.			0 ¹	
Question #4	Budgeted and actual physician staffing hours are sufficient to meet policy and procedures requirements, and to provide quality medical services.	1			
Question #5	Budgeted and actual registered nurse staffing hours are sufficient to meet policy and procedures requirements and to provide quality nursing services.	1			
Question #6	Medical Technical Assistant's (MTA) primary responsibilities will be the performance of health care duties.	1			
Question #7	Escort staffing and cooperation are sufficient to assure that youth attend on-site health care appointments		0 ²		
Question #8	The CMO ensures that an accurate and complete system exists for tracking professional and DEA licensure; and that CPR certification is in place. All licensed staff has a current and valid license.	1			
Question #9	Newly hired staff receives a structured orientation program within 30 days of arrival. Documentation of orientation is kept in personnel files.	1			
Question #10	Existing staff is trained regarding changes in new policies and procedure within 60 days of distribution.				N/A
	Totals:	7	1	1	

Compliance = 77% (7 of 9 Applicable Questions)

Medical Reception

Select 10 to 20 health records of youth completing medical reception within the past 60-90 days. Include youth with known Latent TB infection and other health problems. Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable

		SC	PC	NC	NA
Question #1	The medical reception process is conducted in a confidential and private manner. Signage (in English and Spanish) regarding confidentiality is in the medical area.	1			
Question #2	There is a comprehensive verbal and written orientation program (minimum English and Spanish) for youth in a language they understand.			0 ³	
Question #3	Youth are educated on how to access routine and emergent dental care.	1			
	For calculating score, only give credit for applicable questions in substantial compliance.				

Write the youth's ID number in top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	N/A	N/A	N/A	N/A	N/A	1	1	0 ⁴	1	N/A
Screen # 3	1	0 ⁵	1	1	1	1	1	1	1	1
Screen # 4	0 ⁶	0 ⁷	0 ⁸	1	1	1	1	0 ⁹	1	1
Screen # 5	1	1	1	1	1	1	1	1	1	1
Screen # 6	1	0 ¹⁰	1	1	0 ¹¹	0 ¹²	1	0 ¹³	0 ¹⁴	1
Screen # 7	0 ¹⁵	1	0 ¹⁶	N/A	1	1	0 ¹⁷	1	0 ¹⁸	1
Screen # 8	0 ¹⁹	0 ²⁰	0 ²¹	N/A	1	0 ²²	0 ²³	0 ²⁴	0 ²⁵	1
Screen # 9	N/A	N/E	N/A	N/A	1	1	0 ²⁶	1	1	1
Screen # 10	N/A	1	N/A	N/A	N/A	1	1	1	1	N/A

- Screen # 1 A nurse completed the Receiving Health Screening form on the day of arrival. The nurse referred to, or contacted a clinician for all youth with acute medical, mental health, or dental conditions; with symptoms of TB; or on essential medications.
- Screen # 2 A clinician ordered essential medications (e.g., chronic disease, mental health) on the day of arrival. Medications were administered within 24 hours. No insulin, TB, or HIV doses were missed.
- Screen # 3 A nurse measured the youth's height and weight, vital signs, visual acuity, initiated the immunization history, and planted a PPD (unless previously positive) within 24 hours of arrival. The TB test was read and documented within 72 hours.
- Screen # 4 A nurse obtained routine laboratory tests (RPR, GC, and Chlamydia, voluntary HIV antibody test, pregnancy screen, disease specific tests) within 72 hours and results were communicated to youth either at the time the physical exam was performed or when the youth was brought back for counseling. The clinician appropriately addressed abnormal laboratory findings, including counseling the youth as appropriate.
- Screen # 5 A nurse or clinician documented HIV Post-Test notification and counseling.
- Screen # 6 A clinician performed a history and physical including a testicular exam for males and pelvic examination for females (if clinically indicated) within seven calendar days of arrival. The clinician integrated information from the health screening examination, laboratory tests, and medical history into the physical exam process.
- Screen # 7 A clinician (MD, NP, or PA) initiated a Problem List noting all significant medical, dental, and mental health diagnoses.
- Screen # 8 A clinician documented an appropriate treatment plan on the History and Physical Exam Form or in the Progress Notes. The plan included appropriate diagnostic, therapeutic measures, patient education, and clinical monitoring (if indicated).
- Screen # 9 The UHR reflects that all medical reception physician orders were implemented as ordered.

Screen # 10

Youth with chronic diseases (e.g., asthma, diabetes) were enrolled in the chronic disease management program and clinically evaluated by a clinician for their chronic disease within 30 days of arrival.

Medical Reception Summary:

Screen #	# Records Reviewed	#N/A	Final # of Records	# of Compliant Records	COMMENTS
1	10	0	10	10	
2	10	6	4	3	
3	10	0	10	9	
4	10	0	10	6	
5	10	0	10	10	
6	10	0	10	5	
7	10	1	9	5	
8	10	1	9	2	
9	10	4	6	5	
10	10	5	5	5	
Total	100	17	80	60	Plus 2 of 3 Applicable Questions

Compliance = 72% (62 of 86 Applicable Questions + Screens)

Intrasystem Transfer

Select 10 to 20 health records from the Intrasystem Transfer Log and corresponding Medical Administration Records (MAR's) of youth transferred to the facility in the previous 120 days. Review pertinent scheduling logs (consultation, chronic illness clinic, etc.).

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy and procedure. The statewide Transfer Form is in use.	1			
Question #2	There is a process whereby health care staff is notified of pending transfers from the facility one business day in advance of transfer. Process is not consistently reliable because its person dependent rather than system dependent. Not a system		0 ²⁷		
For calculating score, only give credit for applicable questions in substantial compliance.					

Write the youth's ID number in top row.

State ID# →	1	2	3	4	5	6	7	8	9	10
Date of arrival	8/9/07	6/20/07	6/6/07	7/2/07	8/30/07	7/10/07	7/5/07	7/11/07	4/18/07	8/16/07
Screen # 1	1	1	1	1	0 ²⁸	1	1	0 ²⁹	1	0 ³⁰
Screen # 2	1	1	1	0 ³¹	1	1	1	0 ³²	1	0 ³³
Screen # 3	N/A	N/A	N/A	N/A	N/A	N/A	0 ³⁴	1	N/A	N/A
Screen # 4	1	0 ³⁵	0 ³⁶	0 ³⁷	0 ³⁸	0 ³⁹	1	0 ⁴⁰	0 ⁴¹	N/A
Screen # 5	1	N/A	0 ⁴²	N/A	1	N/A	N/A	0 ⁴³	1	N/A
Screen # 6	N/A	1	0 ⁴⁴	0 ⁴⁵	1	N/A	N/A	1	0 ⁴⁶	N/A
Screen # 7	N/A	N/A	N/A	N/A	1	N/A	N/A	N/A	N/A	N/A

- Screen # 1 A sending facility nurse reviewed the youth's record prior to transfer and documented required health information on the statewide transfer form. If the sending facility nurse did not complete the transfer form, the receiving nurse documented that she notified the facility of this (minimum information is the sending facility and who the nurse spoke to).
- Screen # 2 Upon arrival, a nurse interviewed the youth and reviewed the UHR. The nurse completed the form noting any additional information related to acute and chronic medical or mental health conditions, current medications, pending or recently completed consultations, and any other health condition requiring follow-up or special housing on the transfer form.
- Screen # 3 The receiving nurse referred youth with acute medical, dental, or mental health conditions on the day of arrival.
- Screen # 4 The receiving physician reviewed the health record of each youth within one business day of arrival and legibly signed and dated the Intrasystem form. The clinician addressed any significant medical problems.
- Screen # 5 A clinician evaluated youth with chronic diseases within 3 business days and enrolled the youth into the chronic disease program.
- Screen # 6 The MAR showed that continuity of essential medications (e.g., chronic disease, mental health, antibiotics, etc.) was provided.
- Screen # 7 The UHR shows that medical care ordered at the previous facility (e.g., vaccinations, consultations, laboratory tests) was carried out following arrival, or a clinical progress note provided an appropriate rationale for doing otherwise.

Intrasystem Transfer Summary:

Screen #	# Records Reviewed	# N/A	Final # of Records	# of Compliant Records	COMMENTS
1	10	0	10	7	
2	10	0	10	7	
3	10	8	2	1	
4	10	1	9	2	
5	10	5	5	3	
6	10	4	6	3	
7	10	9	1	1	
Total	70	27	43	24	Plus 1 of 2 Applicable Questions

Compliance = 56% (25 of 45 Applicable Questions + Screens)

Nursing Sick Call

Select 10 to 20 health records from general population nursing sick call encounters during the last 120 days. Key: SC =Substantial Compliance, PC=Partial Compliance, NC = Noncompliance, NA = Not Applicable

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy. The statewide health services request form is in use.	1			
Question #2	Youth can confidentially submit Health Services Request forms (HSRF) daily into a locked box accessed only by health care staff. Health care staff collects and triages the forms daily.	1			
Question #3	Upon youth request, custody or health care staff assists youth with completion of the HSRFs. Sign language and translation services are available.	1			
Question #4	Nursing sick call is conducted in clean, adequately equipped, and supplied rooms with access to a sink for hand-washing or alcohol-based sanitizer with a sink nearby.			0 ⁴⁷	
Question #5	Nursing sick call is conducted 5 days a week for each housing unit, excluding weekends and holidays.	1			
Question #6	All registered nurses conducting sick call have been trained and demonstrate competency in health assessment and use of nursing protocols.			0 ⁴⁸	
Question #7	The UHR is available and present for sick call encounters including in specialized housing units and during lockdowns.			0 ⁴⁹	
Question #8	Nurses conduct sick call with, at a minimum, auditory privacy, and also with visual privacy if a physical examination is performed.			0 ⁵⁰	
Question #9	There is signage in all health care delivery areas stating that staff shall maintain the confidentiality of medical information.			0 ⁵¹	
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	4		5	

State ID# →	1	2	3	4	5	6	7	8	9	10
Triage Date HSR →	8/4/07	7/6/07	8/19/07	undated	8/21/07	8/5/07	undated	8/10/07	8/26/07	8/23/07
Date NSC →	8/4/07	undated	8/20/07	8/1/07	8/21/07	8/5/07	7/5/07	8/10/07	8/26/07	8/24/07
Complaint	Rash/dysuria	Lesion R eye	Back Pain	Abdominal pain	Cold symptoms	Severe Fatigue, right hand pain	Vomiting	Severe Headache	Ear Pain	Dizziness Tooth Pain
Screen # 1	1	0 ⁵²	1	N/E	1	1	N/E	1	1	1
Screen # 2	1	0 ⁵³	1	N/E	1	1	N/E	1	1	1
Screen # 3	0 ⁵⁴	0 ⁵⁵	0 ⁵⁶	0 ⁵⁷	0 ⁵⁸	1	0 ⁵⁹	0 ⁶⁰	0 ⁶¹	0 ⁶²
Screen # 4	0 ⁶³	0 ⁶⁴	0 ⁶⁵	0 ⁶⁶	0 ⁶⁷	0 ⁶⁸	0 ⁶⁹	0 ⁷⁰	N/A ⁷¹	0 ⁷²
Screen # 5	0 ⁷³	0 ⁷⁴	0 ⁷⁵	0 ⁷⁶	0 ⁷⁷	1	0 ⁷⁸	0 ⁷⁹	N/A	0 ⁸⁰
Screen # 6	1	1	0 ⁸¹	0 ⁸²	0 ⁸³	0 ⁸⁴	1	0 ⁸⁵	N/A	1
Screen # 7	1	1	1	1	1	1	N/A	0 ⁸⁶	N/A	1
Screen # 8	0 ⁸⁷	0	1	1	1	1	1	1	N/A	1
Screen # 9	1	1	1	1	1	1	N/A	0 ⁸⁸	N/A	1

- Screen # 1 The nurse performed same-day triage of the Health Services Request Form and documented an appropriate disposition.
- Screen # 2 The nurse saw youth with urgent complaints on the same day, or youth with routine complaints the following business day.
- Screen # 3 The nursing subjective history was appropriate to the patient's complaint and included a description of onset of symptoms.
- Screen # 4 The nursing physical assessment and collection of objective data was appropriate to the complaint (e.g., vital signs, Snellen test, urine dipstick, etc.).
- Screen # 5 The nursing diagnosis/assessment was appropriate based on the clinical findings.
- Screen # 6 The plan of care and nursing intervention were consistent with case history, physical findings, and the applicable nursing protocol.
- Screen # 7 The nurse referred the patient to a clinician in accordance with the criteria for referral found in the nursing protocol, or accepted in accordance with good clinical judgment.
- Screen # 8 The nurse legibly dated, timed, and signed the form.
- Screen # 9 The referral visit to the clinician took place according to protocol: stat-immediate, urgent-same day, routine-within 5 business days.

Nursing Sick Call Summary:

	# of Records	#N/A	Final #Records	# of Compliant Records	COMMENTS
Screen #1	10	2	8	7	
Screen #2	10	2	8	7	
Screen #3	10	0	10	1	
Screen #4	10	1	9	0	
Screen #5	10	1	9	1	
Screen #6	10	1	9	4	
Screen #7	10	2	8	7	
Screen #8	10	1	9	7	
Screen #9	10	2	8	7	
Total	90	12	78	41	Plus 4 of 9 Applicable Questions

Compliance = 51% (45 of 87 Applicable Questions + Screens)

Medical Care

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Did the clinician sign all medical encounters? If the signature was illegible, was a stamp with the clinician's name and credentials used?	1			

Select 10 to 20 records of youth seen by an MD, NP, or PA for medical encounters (return from hospitalization, infirmary, sick call referral, etc.) in the past 180 days.

State ID# →	1	2	3	4	5	6	7	8	9	10
Visit date:	8/3/07	8/31/07	8/9/07	8/7/07	8/23/07	6/19/07	8/21/07	8/3/07	8/15/07	8/11/07
Clinician name:	Dr. A	Dr. A	Dr. A	Dr. A	Dr. B	Dr. B	Dr. B	Dr. A	Dr. B	Dr. B
Nature of visit:	cellulitis	conjunctivitis	Hand trauma	Hand trauma	Back pain	Diarrhea	Ear pain	Boil on face	Headache	Chest pain
Screen # 1	1	1	1	1	1	1	1	1	0 ⁸⁹	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	1	1	1	1	1	0 ⁹⁰	1	1	1
Screen # 4	1	1	1	1	1	1	N/A	1	N/A	1
Screen # 5	1	0 ⁹¹	1	1	1	1	N/A	0 ⁹²	N/A	1
Screen # 6	1	1	1	1	0 ⁹³	0 ⁹⁴	0 ⁹⁵	1	0 ⁹⁶	0 ⁹⁷
Screen # 7	1	1	1	0 ⁹⁸	0 ⁹⁹	1	N/A	1	N/A	1

- Screen # 1 The clinician addressed the patient's current complaint by obtaining a history of the present illness and appropriate review of systems.
- Screen # 2 The nurse or clinician measured a full set of vital signs when clinically appropriate (including weight, if clinically indicated).
- Screen # 3 The clinician documented all pertinent physical findings, laboratory, and diagnostic results or other related objective data.
- Screen # 4 The clinician made an appropriate assessment based upon the patient's medical history, laboratory, and physical findings.
- Screen # 5 The clinician documented an appropriate treatment plan that included diagnostic and therapeutic measures, clinical monitoring, and follow-up.
- Screen # 6 The clinician documented appropriate patient education related to the diagnosis and treatment plan.
- Screen # 7 All aspects of the treatment plan occurred as ordered within a clinically appropriate time.

Medical Care Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	9	
Screen #2	10	0	10	10	
Screen #3	10	0	10	9	
Screen #4	10	2	8	8	
Screen #5	10	2	8	6	
Screen #6	10	0	10	5	
Screen #7	10	2	8	6	
Total	70	6	64	53	

Compliance = 83% (54 of 65 Applicable Questions + Screens)

Chronic Disease Management

Number of patients enrolled in clinic 59

Percent of clinic health records reviewed 17%

Select 10 to 20 health records or 10% of this clinic population. Avoid records of youth arriving within the past 90 days. Write the youth's ID number in top row below:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	0 ¹⁰⁰	0 ¹⁰¹	0 ¹⁰²	0 ¹⁰³	1	1	1	1	0 ¹⁰⁴	0 ¹⁰⁵
Screen # 3	1	1	N/A	N/A	N/A	N/A	N/A	1	1	1
Screen # 4	N/A	1	1	1	1	1	1	1	1	1
Screen # 5	N/A	0 ¹⁰⁶	1	1	1	1	1	1	1	1
Screen # 6	1	0 ¹⁰⁷	1	1	1	1	1	1	1	1
Screen # 7	1	1	1	1	1	1	1	1	0 ¹⁰⁸	1
Screen # 8	1	0	1	1	1	1	1	1	1	1
Screen # 9	1	1	1	1	1	1	1	1	1	1
Screen # 10	N/A	N/A	0 ¹⁰⁹	0 ¹¹⁰	0 ¹¹¹	0 ¹¹²	0 ¹¹³	1	N/A	0 ¹¹⁴

- Screen # 1 All chronic diseases are listed on the Problem List.
- Screen # 2 For the initial chronic care visit the clinician performed an appropriate medical history, physical examination pertinent to the management of the chronic disease.
- Screen # 3 Baseline and ongoing follow up laboratory/diagnostic data (HbA_{1c}, serum drug levels, if ordered, etc.) were completed prior to the scheduled clinic visit and the clinician addressed results during the clinic visit.
- Screen # 4 The clinician saw the patient quarterly or more frequently as clinically indicated (i.e., based on degree of disease control). Appropriate exceptions are documented in the UHR.
- Screen # 5 The clinician's evaluation of the youth was clinically appropriate (interval history, physical examination, laboratory tests, etc.).
- Screen # 6 The clinician accurately assessed degree of disease control (i.e., good, fair, poor).
- Screen # 7 The clinician's treatment plan documented appropriate diagnostic & therapeutic measures based upon disease control and indicates when the patient is to be seen for the next clinic follow up visit.
- Screen # 8 The clinician's or nurse's notes document appropriate patient education regarding disease process, diagnostic tests, treatment goals, medication purpose, and side effects, etc.
- Screen # 9 There were no lapses in medication continuity. The clinician's assessment of medication adherence is consistent with the MAR. If the patient was non-adherent, counseling is documented in the health record.
- Screen # 10 The clinician offered/ordered Pneumococcal and annual influenza immunizations as recommended. If accepted, the nurse documented the date of administration and initials on the Immunization and Communicable Disease Record. If refused, the clinician or nurse obtained refusal of treatment.

Chronic Disease Management Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	10	
Screen #2	10	0	10	4	
Screen #3	10	5	5	5	
Screen #4	10	1	9	9	
Screen #5	10	1	9	8	
Screen #6	10	0	10	9	
Screen #7	10	0	10	9	
Screen #8	10	0	10	9	
Screen #9	10	0	10	10	
Screen #10	10	3	7	1	
Total	100	10	90	74	

Compliance = 82% (74 of 90 Applicable Screens)

Infection Control

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable

		SC	PC	NC	NA
Question # 1	There is a Local Operating Procedure (LOP) describing the facility's infection control program that is consistent with statewide policy.	1			
Question # 2	There is a licensed health care provider who is designated as having public health/infection control duties and who has received appropriate orientation and training.	1			
Question # 3	There is a functional system for reporting diseases and laboratory test results, which are required by State and Federal Law (e.g., AIDS cases, positive HIV results, Hepatitis A, B, or C, syphilis, etc.).	1			
Question # 4	There are exposure control plans in place for airborne and blood borne pathogens that include: a) Documentation of new hire and annual training regarding exposure control plans yes b) A policy describing use of standard precautions to prevent contact with blood or other potentially infectious materials (OPIM) yes c) A policy describing engineering (sharps disposal, specimen handling) and work practice controls intended to eliminate or minimize employee exposure yes d) A policy describing housekeeping procedures used to maintain a clean and sanitary environment, including a written schedule for cleaning and methods of decontamination yes	1			
Question # 5	Engineering Controls: a) Sharps containers are secure and easily accessible in areas where sharps are used. Yes b) Hand wash facilities are in or near all work areas and antiseptic hand cleaner is available when needed. Yes c) An eyewash station is present and tested quarterly for functionality. The eyewash station functions properly. Yes d) Specimen containers are used for transport of biological specimens (e.g., blood, urine). Yes e) Biohazard storage bins are available. Yes f) Blood and body fluid spills are cleaned appropriately per policy. NE	1			
Question # 6	Compliance with work practice controls: a) Food and drink are not kept in refrigerators, freezers, shelves, cabinets, or counter tops where blood, laboratory specimens, or other potentially infectious materials are kept. Yes b) Staff observes Standard Precautions. NE c) Refrigerators are labeled appropriately (biohazard for specimens, food only, or medication only). Yes d) Personal Protective Equipment is immediately available in health care delivery areas. Yes e) Staff performs hand-washing as required. NE	1			

Infection Control Continued:						SC	PC	NC	NA
Question #7	Are Infection Control Meetings held quarterly (minimum 4 meetings per year)?					1			
Question #8	If Question 7 is SC or PC , do the minutes address the following areas? (Put Y if topics are present or N if topic is missing, for each quarter in space provided):					1			
		QTR 1	QTR 2	QTR 3	QTR 4				
	a) TB skin testing programs for staff and youth	1	1	1	N/A				
	b) Exposure control plans and training regarding airborne and blood borne pathogens	1	1	1	N/A				
	c) Hepatitis B training and vaccination programs (e.g., number of employees trained, number accepting vaccine, and number completing vaccination series)	1	1	1	N/A				
	d) Staff compliance with work practice controls	0	1	1	N/A				
	e) Reporting communicable diseases for the previous quarter, noting any trends present	0	1	1	N/A				
f) Sanitation reports (institutional and infection control) and any follow-up action taken	0	1	1	N/A					
Question #9	If respiratory isolation rooms are used for the purposes of respiratory isolation they are functional as evidenced by routine testing (at least monthly when not in use and daily when in use). Is staff fit-tested for N-95 respirators?								N/A
	For calculating score, only give credit for applicable questions in substantial compliance.								
	Totals:					8/8			

Compliance = 100% (8 of 8 Applicable Questions)

Pharmacy Services

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable

		SC	PC	NC	NA
Question #1	Is the pharmacy currently licensed?	1			
Question #2	Are the pharmacy and medication rooms adequately lit, organized, clean , and provide sufficient space to prepare medications?			0 ¹¹⁵	
Question #3	Does the facility pharmacist or pharmacy tech conduct monthly inspections of the pharmacy, medications rooms, and all areas of the facility where medications are stored? Does the facility pharmacist or designee develop and implement a plan to correct identified deficiencies?			0 ¹¹⁶	
Question #4	Does the pharmacy have computers and software programs to track medication usage, inventory, cost, drug-drug interactions, and clinical prescribing patterns?		0 ¹¹⁷		
Question #5	Does the pharmacist dispense all prescriptions into appropriate containers labeled with the youth's name, ID number, and medication information as required by state law?	1			
Question #6	Is there strict accountability for all medications dispensed from the pharmacy, including medications administered from a night locker?	1			
Question #7	Is there a pharmacy system for monitoring patient adverse drug reactions and drug-drug interactions?				N/A ₁₁₈
Question #8	Does the facility have a 24-hour prescription service or other mechanism to provide essential medications 24 hours per day (e.g., night locker)?	1			
Question #9	Are stock bottles of legend medications kept inside the pharmacy (except for biological agents such as insulin and vaccines under proper storage conditions)?	1			
Question #10	Is there a facility Pharmacy and Therapeutics Committee that meets quarterly? Do P & T meeting minutes reflect meaningful content and initiatives to improve pharmacy services?			0 ¹¹⁹	
Question #11	Are youth with asthma permitted to keep inhalers in their possession (except for cause documented in the health record)? Are youth permitted to keep other medications in their possession as determined by the CMO?	1			
Question #12	Does the pharmacy provide continuity of medications for youth transferring into the facility?				NE
Question #13	The pharmacist provides a monthly report detailing pharmacy utilization costs, drug stop lists, monthly lists of drugs used by class, and daily physician prescribing lists.	1			
Question #14	When a youth paroled, is medication continuity provided in accordance with the policy?	1			
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	8	1	3	2

Compliance = 67% (8 of 12 Applicable Questions)

Medication Administration Process

Observe all areas where medications are stored and administered. Observe the medication administration process.

Key: SC =Substantial Compliance, PC=Partial Compliance, NC =Noncompliance, NA = Not Applicable

		SC	PC	NC	NA
Question #1	Are medications administered from centralized medication rooms, except in specialized mental health units, SMP, TD, or BTP?	1			
Question #2	Is there a local policy for medication administration that is in compliance with the statewide policy and procedure?	1			
Question #3	Are the medication storage and administration rooms secure, clean, organized, and have adequate space, storage, lighting, and a sink or alcohol-based hand sanitizer?	1			
Question #4	Are all medications in the Documed or night locker current and accounted for (from a sample of 5 medications)?	1			
Question #5	Are all narcotics and other controlled substances double-locked, counted at every shift, and all accounted for (from a sample of 5 medications)?	1			
Question #6	Are all needles and syringes securely stored, counted at every shift, and all accounted for?	1			
Question #7	The medication room contains no medications that are discontinued or expired. (There is a 3-day window period to return these medications to the pharmacy.)	1			
Question #8	Are external medications stored separately from internal medications?			0 ¹²⁰	
Question #9	Does the nurse administer all legend medication from properly labeled containers and not from stock bottles?	1			
Question #10	Does custody staff provide continuous security during medication administration?	1			
Question #11	Medications that are to be administered at the hour of sleep are not administered before 2100 hours (one hour window permitted).	1			
Question #12	Is the medication refrigerator clean and used only to store medications (no food or specimens)? Does staff check and log the temperature daily?	1			
Question #13	Medications are not crushed except upon a physician order and for a valid reason (e.g., patient is known to hoard medication). Time-released medications are not crushed.				NE
Question #14	Observe the nurse administering medications to 5 to 10 youth, and answer the following elements.	1			
					Y or N
a.	The medication administration record (MAR) was available to the nurse during medication administration.				y
b.	The nurse confirmed the identity of the youth per policy.				y
c.	The nurse compared the medication container label to the MAR.				y
d.	The nurse placed the medications into a cup prior to administration.				y
e.	The nurse performed visual oral cavity checks for medications in accordance with medication administration policies.				y
f.	The nurse documented on the MAR at the time the medication is administered.				y
g.	If a medication was not available after hours, the nurse obtained the medication from the Documed or night locker and signed it out prior to administration.				y

Compliance = 92% (12 of 13 Applicable Questions)

Medication Administration Health Record Review

Select 10 to 20 health records and corresponding MAR's of patients receiving medications in the preceding 180 days to review. Write the youth's ID number in top row below:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	0 ¹²¹	0 ¹²²	0 ¹²³	0 ¹²⁴	0 ¹²⁵	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	1	1	1	1	1	1	1	0 ¹²⁶	1
Screen # 4	1	1	1	1	1	1	1	1	1	1
Screen # 5	1	0 ¹²⁷	1	1	1	0 ¹²⁸	1	0 ¹²⁹	1	1
Screen # 6	1	1	1	1	1	1	1	1	1	N/A
Screen # 7	1	1	1	1	1	1	1	0 ¹³⁰	1	1
Screen # 8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Screen # 9	1	1	1	1	1	1	1	1	1	1

- Screen #1 The medication orders were complete (name of medication, strength, route of administration, frequency, duration, and number of refills).
- Screen #2 The clinician order was dated, timed, and legibly signed (if the signature is not legible, a signature stamp must also be used).
- Screen #3 The clinician documented an appropriate clinical note that corresponds with the initial medication order.
- Screen #4 The nurse dated and timed the medication order transcription (routine orders within 4 hours, urgent orders within 2 hours, and stat orders within 1 hour).
- Screen #5 The nurse and/or pharmacy accurately transcribed the physician order onto the MAR.
- Screen #6 The MAR reflected that all medications were initiated within 24 hours of the order being written or on the start date ordered.
- Screen #7 There is documentation of medication administration status (e.g., administered, refused, etc.) for every dose ordered for the youth.
- Screen #8 For discontinued medications, the nurse discontinued medications according to policy.
- Screen #9 The MAR is neat and legible, and contains legible initials, signatures, and credentials of nursing staff who have administered medications to youth.

MAR Review Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	5	
Screen #2	10	0	10	10	
Screen #3	10	0	10	9	
Screen #4	10	0	10	10	
Screen #5	10	0	10	7	
Screen #6	10	1	9	9	
Screen #7	10	0	10	9	
Screen #8	10	10	0	N/A	
Screen #9	10	0	10	10	
Total	90	11	79	69	

Compliance = 87% (69 of 79 Applicable Screens)

Pharmacy notes date of order on MAR as date the pharmacy received it/dispensed it, not date of physician order.

- #1 Order 5/14/07
- #2 Order 8/22/07
- #3 Order 6/6/07
- #4 Order 8/22/07
- #5-Order 8/9/07.
- #6 Order 4/11/07
- #7 Order 8/17/07
- #8 Order 5/2/07
- #9-Order 7/3/07
- #10 Order 8/27/07

Urgent/Emergent Care Services

Select 10 to 20 health records from the Urgent/Emergent Care Tracking Log in the previous 180 days. Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable

		SC	PC	NC	NA
Question # 1	There is an Urgent/Emergent Tracking Log that records all unscheduled health care encounters. Md does not sign weekly	1			
Question # 2	Emergency equipment and supplies at the facility are consistent with the statewide policy and procedure. The facility has at least one automated external defibrillator (AED). AED electrodes are expired	1			
Question # 3	The emergency equipment, medications, and supplies are in proper working order. An equipment checklist log shows that health care staff inspects equipment and supplies each shift.	1			
Question # 4	There is documentation that health care providers have been trained regarding emergency response. There is documentation of the last three emergency drills and one disaster drill, which delineates the events of the drill and identifies strengths and weaknesses.			0 ¹³¹	
Question # 5	Interview nurses, physicians, nurse practitioners, physicians assistants, and dentists to ensure that all know how to properly operate the emergency equipment (O ₂ , Ambu bag, cardiac monitor, AED, etc.). Not evaluated.				NE
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:				

Write the youth's ID number in the top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	1	0 ¹³²	1	1	1	1	1	0 ¹³³	0 ¹³⁴
Screen # 4	1	1	N/A	1	1	1	1	1	1	1
Screen # 5	1	1	0 ¹³⁵	N/A	1	0 ¹³⁶	1	1	1	0 ¹³⁷
Screen # 6	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Screen # 7	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

- Screen # 1 The entry in the Urgent/Emergent Log is complete, legible, and there is a corresponding progress note in the health care record.
- Screen # 2 The nurse documented the date and time of the encounter and documented an assessment in SOAP format.
- Screen # 3 The nurse's subjective and objective evaluation was appropriate given the nature of the complaint (e.g., vital signs, SOB = peak flow meter, abdominal pain =abdominal assessment)
- Screen # 4 The nurse's assessment and plan were appropriate, including notification or referral to the clinician when clinically indicated.
- Screen # 5 If the nurse referred the youth to a clinician, the follow-up visit was timely and clinically appropriate.
- Screen # 6 For patients returning from the emergency room, nursing staff contacted the physician on-call to obtain follow-up orders.
- Screen # 7 If the youth was sent to an outside facility, the physician saw the youth the following business day.

Urgent/Emergent Care Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	10	
Screen # 2	10	0	10	10	
Screen # 3	10	0	10	7	
Screen # 4	10	1	9	9	
Screen # 5	10	1	9	6	
Screen # 6	10	8	2	2	
Screen # 7	10	8	2	2	
Total	70	18	52	46	

Compliance = 88% (49 of 56 Applicable Questions + Screens)

Health Records

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable

		SC	PC	NC	NA
Question # 1	Local policies are consistent with statewide policies and procedures, and address all aspects of health record management. (See Audit Tool Instructions.)			0 ¹³⁸	
Question # 2	The Movement and Problem List is visible upon opening the UHR.	1			
Question # 3	There is a functional tracking system for laboratory, diagnostic, and consultation reports.		0 ¹³⁹		
Question # 4	The facility has a functional system for UHR accountability, filing, and retrieval. See below		0 ¹⁴⁰		
	Totals:				
	For calculating score, only give credit for questions in substantial compliance.				

Compliance = 25% (1 of 4 Applicable Questions)

Preventive Services

Select 10 to 20 health records of youth who have been in DJJ over one year.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable

		SC	PC	NC	NA
Question #1	There is a policy and procedure regarding preventive services that is consistent with the US Preventive Services Task Force (USPSTF) and American Medical Association Guidelines for Adolescent Preventive Services (GAPS) in areas that are applicable to DJJ youth.	1			

Write the youth's ID number in the top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Screen # 3	1	1	1	1	1	1	1	1	1	1
Screen # 4	1	1	0 ¹⁴¹	1	1	1	1	0 ¹⁴²	1	1
Screen # 5	1	1	1	1	1	1	1	1	1	1
Screen # 6	1	1	N/A	N/A	1	1	1	1	1	N/A

- Screen # 1 TB skin testing was performed annually. If previously positive, a nurse conducted a TB symptom screen.
- Screen # 2 Annual pap smears were performed (at a minimum) beginning 3 years after initiation of sexual intercourse and 2 consecutive years thereafter. If there are 3 consecutive normal annual pap smears, then they are performed every 3 years thereafter. Management of abnormal pap smears was appropriate, including referral.
- Screen # 3 A nurse measures the youth's blood pressure annually. The nurse refers youth with abnormal blood pressure to a clinician.
- Screen # 4 A nurse measures the youth weight annually. Obesity is addressed if clinically indicated (BMI >24 %).
- Screen # 5 Hepatitis A and B vaccinations are current, as applicable.
- Screen # 6 Youth are offered Tetanus-Diphtheria Booster if not received within ten years.

Preventive Services Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	10	
Screen # 2	10	10	0	0	
Screen # 3	10	0	10	10	
Screen # 4	10	0	10	8	
Screen # 5	10	0	10	10	
Screen # 6	10	3	7	7	
Total	60	13	47	45	

Compliance = 96% (46 of 48 Applicable Questions + Screens)

Consultation and Specialty Services

Interview staff responsible for specialty service contracts and consultation tracking. Review the Consultation Tracking log. Select 10 health records from the facility of youth who received consultation services in the last 180 days.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable

		SC	PC	NC	NA
Question #1	There is a local consultation policy and procedure that is consistent with the statewide policy.	1			
Question #2	The facility has implemented the outside specialty care log to include receipt of reports. Staff maintains it accurately and contemporaneously.			0	
Question #3	There is sufficient custody staffing and cooperation to transport youths to outside medical appointments.	1			
	For calculating score, only give credit for questions in substantial compliance.				
	Totals:	2			

Write the youth's ID number in top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	1	1	1	1	1	1	1	1	1
Screen # 4	1	1	1	1	1	1	1	1	1	1
Screen # 5	1	1	1	1	N/A	1	0 ¹⁴³	1	0 ¹⁴⁴	1
Screen # 6	1	1	1	1	1	1	1	1	0 ¹⁴⁵	0 ¹⁴⁶
Screen # 7	1	1	1	1	1	1	0 ¹⁴⁷	0 ¹⁴⁸	1	1
Screen # 8	1	1	1	1	1	1	1	1	1	1
Screen # 9	1	1	1	1	1	1	1	1	0 ¹⁴⁹	1

- Screen # 1 The health record contained a Consultation Request Form. The clinician legibly documented the service requested, urgency (routine or urgent), and dated and signed the form.
- Screen # 2 The clinician legibly documented the history of the present illness, physical findings, and lab data that supports the rationale for the service on the Consultation Request Form.
- Screen # 3 The clinician legibly documented the medical history, physical and laboratory findings, and an assessment that supports the need for the consult in the Progress Notes.
- Screen # 4 The record reflects that the youth was seen by the consultant within the required time frames (90 days for routine, 10 ten days for urgent unless indicated sooner).
- Screen # 5 Upon the patient's return from the consultation appointment, the nurse reviewed the consultant's recommendations and addressed any urgent recommendations.
- Screen # 6 The clinician reviewed, dated, and initialed the consultation report within 3 business days of the youth's return to the facility or receipt of the report.
- Screen # 7 The UHR shows that the clinician met with the youth 5 business days (sooner if clinically indicated) to review results of the consult with the youth and develop a treatment plan.
- Screen # 8 The health record reflected that the consultant's recommendations were ordered and implemented, or a valid reason for **not** implementing the recommendations was documented (i.e., patient is out to court, refused, etc.). If the physician disagrees with the consultant's recommendations, an appropriate alternate plan of care was ordered and implemented.
- Screen # 9 The health record reflected that the clinician monitored the youth to ensure that the treatment plan was implemented and the desired clinical outcome was achieved, or the treatment plan was amended.

Consultation and Specialty Services Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	10	
Screen # 2	10	0	10	10	
Screen # 3	10	0	10	10	
Screen # 4	10	0	10	10	
Screen # 5	10	1	9	7	
Screen # 6	10	0	10	8	
Screen # 7	10	0	10	8	
Screen # 8	10	0	10	10	
Screen # 9	10	0	10	9	
Total	90	1	89	82	

Compliance = 91% (84 of 92 Applicable Questions + Screens)

Peer Review

Review the local and statewide peer review policies and procedures, interview staff, inspect peer review file storage locations.

Review peer review files to ensure compliance with policy and the Health Care Remedial Plan.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable

		SC	PC	NC	NA
Question # 1	The local peer review policy and procedure, and actual practice are consistent with the statewide policy and procedure, NCCHC standards, and the Health Care Remedial Plan.			0	
Question # 2	The Statewide DJJ Medical Director, Health Care Director, or clinical service chief monitors the peer review process, which includes regular reporting from the facilities on peer review activities and regular quality management meetings at least annually.			0	
Question # 3	The CMO reviews sentinel events (unexpected hospitalizations, medical errors) and the Statewide Medical Director/Chief Psychiatrist reviews the reports of these investigations. The Statewide Medical Director/Chief Psychiatrist reviews all deaths.	1			
Question # 4	There is biannual peer review for MDs, PAs, and NPs at each facility. These files are marked "Peer Review" and kept in a secure location. There is documentation that findings have been shared with applicable staff		0 ¹⁵⁰		
Question # 5	The peer review process includes a meaningful corrective and adverse action process up to, and including, suspending privileges for inappropriate care or unprofessional behavior.		0 ¹⁵¹		
	For calculating score, only give credit for questions in substantial compliance. Totals:	1	2	2	

Compliance = 20% (1 of 5 Questions)

Credentialing

Review the local and statewide credentialing policies and procedures, interview staff, and inspect storage locations of credential files.

Review credentials files to ensure compliance with policy and the Remedial Plan.

Key: SC =Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable

		SC	PC	NC	N/A
Question # 1	The local credential policies and procedures, and actual practice are consistent with statewide policies and procedures, NCHC standards, and the Health Care Remedial Plan.			0	
Question # 2	Credential files are stored in a locked cabinet with access limited to those with a legitimate need to know.	1			
Question # 3	Specific staff is assigned to maintain the credential files. Inspection shows that the files are current and well-maintained.	1			
Question # 4	Review all credential files. They contain the required elements of the Health Care Remedial Plan: a) Curriculum Vitae that includes relevant personal information; undergraduate, graduate, and postgraduate education b) Employment history and hospital appointments (including disciplinary action and loss of privileges) c) Academic appointments and society memberships, if applicable d) Copies of all current licenses, registrations, board certifications, and Drug Enforcement Agency (DEA) licenses e) Statement of physical and mental health f) Drug and alcohol dependence history, if any g) Results of National Practitioner Data Bank Inquiry h) Prior and current malpractice claims and judgments i) Prior professional liability coverage and current coverage for contractors, if not covered by State of California j) ECFMG certificate, if applicable k) Authorization for release of information for any information required to complete the application process, including confidential material l) Three references			0 ¹⁵²	
Question # 5	Review of credentialing process listed in question #4 reveals no substantial problems or concerns regarding the clinician's mental fitness, clinical competence, or moral character.				N/A
Question # 6	Recredentialing occurs bi-annually. All files are current.	1			
Question # 7	Physicians, nurse practitioners, and physician assistants do not begin work until the credentialing process is completed. Under extenuating circumstances, temporary privileges may be granted until the credentialing process is completed, not to exceed 3 months.	1			
Question # 8	Physicians or nurse practitioners treating chronically ill youth are board certified or eligible in a primary care-related field.	1			
Question # 9	Physicians treating HIV infected youth are board certified in infectious diseases (ID) or have completed a primary care residency with additional HIV related training, and are experienced in the treatment of HIV patients. If no facility clinician meets this requirement, ID consultants are used.				N/A
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	5		2	

Compliance = 71% (5 of 7 Applicable Questions)

Quality Management

Review the local and statewide Quality Management Program policy and procedure. Review the composition of the QM Committee and meeting minutes. Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable

		SC	PC	NC	NA	
Question # 1	There is a local policy and procedure that is consistent with the statewide policy and procedure.	1				
Question # 2	The facility has a Quality Management (QM) Committee that meets quarterly or more often as needed, as determined by Statewide policy.		0 ¹⁵³			
Question # 3	The composition of the institutional QM Committee meetings meets policy requirements.	1				
Question # 4	Minutes of the QM Committee are available for review.	1				
Question # 5	QM studies for the previous 2 quarters from the date of the last audit are available for review.			0		
Question # 6	The reasons for the QM studies performed by the facility are specified on the tools or in meeting minutes, and are related to suspected problems identified by staff, Health Care Service audits, Superintendents, and youth, etc. (high risk, high volume, problem prone aspects of care).				N/A	
Question # 7	The most recent Corrective Action Plan (CAP) developed as part of a QM study is reviewed for the following: Enter date of CAP reviewed: _____				N/A	
	a) The CAP identified specific improvements needed.					
	b) The CAP identified specific staff members responsible for improvements.					
	c) The CAP had a targeted completion date.					
	d) There was documentation to indicate any recommended training was held.					
	e) Follow-up studies were done to determine whether or not corrective actions solved the problem or issue.*					
Question # 8	Physician Chart Reviews: a) There will be quarterly review of nursing sick call records based upon criteria developed by the QM Committee (a minimum of 5 records per nurse performing sick call) b) Outpatient Housing Unit: 10% or 10 records/ quarter. Findings are addressed at QM meetings.		0 ¹⁵⁴			
Question # 9	The Supervising Nurse reviews 10 records monthly of each nurse who conducts nursing sick call, urgent care, or outpatient housing unit care. There is documentation that findings from chart reviews have been discussed with the applicable staff members. As performance improves, reviews may be performed quarterly.	1				
Question # 10	On at least an annual basis, the Chief Medical Officer develops a Quality Management report for the Statewide Medical Director that focuses on high risk, problem prone aspects of patient care; identifies deficiencies; makes recommendations for improvements; and provides direction for quality improvement activities.			0		
For calculating score, only give credit for applicable questions in substantial compliance.		Totals:	4	2	2	2

Compliance = 50% (4 of 8 Applicable Questions)

Endnotes

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- ¹ The CMO reported that she was not in control of the budget. They were given a budget for major equipment and supplies but nothing else. YCC positions and overtime are charged to the medical budget, however when staff tried to find out how many YCC positions were assigned to the health care budget they were not able to find out this information.
- ² Staff report that there are problems with access to youth due to program scheduling conflicts and sufficient numbers of correctional officer escorts. There are no officers dedicated to escorting youth for medical appointments.
- ³ There is no comprehensive, written orientation program for youth in English and Spanish, only signage on the wall.
- ⁴ Youth arrived on 8/16/07 and medication for hypothyroidism not ordered until 8/17/07.
- ⁵ Vital signs not documented on physical examination form.
- ⁶ Labs drawn 7 days after arrival.
- ⁷ On 8/28/07 a nurse notified the patient of lab tests results, but no documentation of abnormal test results and patient understanding. Physicians should document notification and counseling of abnormal lab tests with patient.
- ⁸ Labs not obtained for seven days after arrival, and physician did not review labs for seven days after report available.
- ⁹ Labs not obtained for 5 days and reported on 8/23/07. Abnormal LFT's (226/175) and glucose levels (281) were found. Documentation is not entirely clear that labs were discussed with patient and his understanding of his condition.
- ¹⁰ 17 year old with 2 year history of unilateral gynecomastia. Physician does not fully address in review of symptoms. Notes breast enlargement but does not examine for masses or discharge.
- ¹¹ The patient had a history of head trauma and complained of headaches upon arrival. The physician did not explore this in the review of symptoms. Medical records later showed that the patient had an open, depressed skull fracture requiring surgery.
- ¹² Youth had a positive TB skin test. Clinician did not auscultate lungs.
- ¹³ Clinician did not document thyroid examination in this patient with hypothyroidism.
- ¹⁴ The patient had a history of head trauma and upon arrival complained to the nurse of headaches. The physician did not explore the patient's history or symptoms.
- ¹⁵ Youth had a history of tobacco, drug and alcohol abuse. Not listed on the Problem List.
- ¹⁶ Clinician did not document youth's history of alcohol abuse on the Problem List.
- ¹⁷ 17 year old with hypertension and proteinuria. Questionably abnormal renal ultrasound not listed on Problem List.
- ¹⁸ The clinician did not document the patient's history of head trauma and headaches on the Problem List.
- ¹⁹ Youth had a history of tobacco, drug and alcohol abuse. No treatment plan documented.
- ²⁰ No plan of care documented on physical examination form or progress notes.
- ²¹ Clinician did not document plan of care for treatment of alcohol abuse.
- ²² Clinician did not document complete plan for treatment of TB infection to include monitoring and patient education.
- ²³ Physician requested old medical records regarding renal ultrasound and echocardiogram but did not follow-up.
- ²⁴ The clinician treatment plan consists only of listing of patient's medical problems with no plan of care.
- ²⁵ The Clinician did not document a treatment plan for the patient's history of head trauma and headaches.
- ²⁶ Orders to retrieve old medical records not implemented in a timely manner.
- ²⁷ Staff reported there was not a reliable system for timely notification of youth to be transferred from Preston. CMO has requested email or written notification of key staff members so that the system does not rely on the verbal notification of one person who may not be available.
- ²⁸ The youth was sent from Preston to SYCRCC on 7/5/07 and returned to Preston on 8/30/07. Preston did not complete the sending portion of the form.
- ²⁹ Neither the sending nor receiving facility completed an intrasystem transfer form.
- ³⁰ Youth listed on the intrasystem transfer log as arriving on 8/16/07 from a CTC and was sent to Sequoia. No intrasystem transfer form or any documentation in the record since 7/13/07.
- ³¹ Sending facility filled out top section of form, but bottom section not completed by Preston. Preston staff filled out the lower portion of a separate form suggesting record was not present when review was completed. Nurse did not note chronic otitis media, traumatic brain injury or mental health history.
- ³² The nurse wrote a progress note, but did not fully document the patient's medical problems.

-
- ³³ No documentation of review of youth's medical and mental health problems.
- ³⁴ The youth complained of dental pain upon arrival. The nurse did not perform an assessment or determine the severity of the pain.
- ³⁵ The physician did not sign the intra-system transfer form signifying review of the form/record
- ³⁶ The physician signed but did not date and time the form, thus timeliness of review not determined.
- ³⁷ The physician signed but did not date the form, thus timeliness of review not determined to have occurred within one business day.
- ³⁸ The physician signed but did not date the form, thus timeliness of review not determined to have occurred within one business day.
- ³⁹ Physician did not time the intrasystem transfer form. Did not address 7/10/07 elevated blood pressure readings of 155/98 mm/hg and 154/100 mm/hg .
- ⁴⁰ Youth has a history of Williams's syndrome, glaucoma, diabetes, and schizoaffective disorder. Patient's blood pressure was 144/103 and 160/113. Physician saw the patient the following day and did not address patient's increased BP
- ⁴¹ Physician did not time signature.
- ⁴² Patient with asthma not seen within 3 days.
- ⁴³ Youth was not enrolled into the chronic disease program.
- ⁴⁴ Patient was on Azmacort and Albuterol. No documentation that medication was received or continued.
- ⁴⁵ Data not recorded.
- ⁴⁶ MAR shows the youth did not receive Dilantin and mental health medications on the day of arrival.
- ⁴⁷ In housing units, nursing sick call is conducted in the dayrooms without adequate equipment or supplies, privacy and access to hand-washing or hand sanitizer.
- ⁴⁸ Health Care Services has not yet published nursing protocols and trained staff.
- ⁴⁹ The nurse does not bring the UHR to the housing units to conduct sick call.
- ⁵⁰ Nursing sick call is conducted in the day rooms without adequate privacy.
- ⁵¹ There is no signage in the main medical clinic, but in housing units where sick call is being conducted in open areas.
- ⁵² The form is undated and unsigned. Timeliness not determined.
- ⁵³ Form undated, timeliness not determined.
- ⁵⁴ Patient complained of itching on neck, shoulders and genitals, as well as dysuria. The nurse did not describe history of onset of symptoms.
- ⁵⁵ No description of onset of symptoms.
- ⁵⁶ The nurse did not document onset of the back pain, or the quality, intensity, radiation or associated symptoms.
- ⁵⁷ The nursing history did not include quality or severity of pain, associated symptoms.
- ⁵⁸ The nurse did not document onset of illness or associated symptoms.
- ⁵⁹ No documentation of onset of vomiting, quality of emesis, associated symptoms such as chills, diarrhea, abdominal pain.
- ⁶⁰ The nurse did not describe the onset, quality, location and radiation of the patient's headache.
- ⁶¹ The nurse did not obtain a history of the onset of the ear pain or related symptoms.
- ⁶² This patient has a history of sickle cell anemia and splenectomy and did not take a history of the illness.
- ⁶³ The nurse did not document an assessment or obtain a urinalysis.
- ⁶⁴ The nurse did not describe the lesion.
- ⁶⁵ The nurse did not perform an examination of the back.
- ⁶⁶ No general description of patient or adequate assessment of the abdomen.
- ⁶⁷ The nurse did not document vital signs or examine the patient.
- ⁶⁸ The nurse did not document vital signs or examination of the right hand.
- ⁶⁹ The nurse did not take vital signs or perform an assessment.
- ⁷⁰ The nurse measured vital signs but did not evaluate level of consciousness, gait, strength or neurological assessment.
- ⁷¹ Patient Refused
- ⁷² The nurse did not review or note relevant labs or perform a physical assessment.
- ⁷³ The nurse did not document a nursing diagnosis/assessment.
- ⁷⁴ The nurse did not document a nursing diagnosis/assessment.

-
- ⁷⁵The nurse did not document a nursing diagnosis/assessment.
- ⁷⁶The nurse did not document a nursing assessment or diagnosis.
- ⁷⁷ The nurse did not document a nursing diagnosis/assessment.
- ⁷⁸ The nurse did not document a nursing diagnosis/assessment.
- ⁷⁹ The nurse did not document a nursing diagnosis/assessment.
- ⁸⁰The nurse did not document a nursing diagnosis/assessment.
- ⁸¹The nurse's plan did not address the patient's pain.
- ⁸²The nurse did not document a plan.
- ⁸³The nurse did not document a plan.
- ⁸⁴The nurse did not document a plan.
- ⁸⁵The nurse's plan did not address the patient's pain.
- ⁸⁶The nurse made a routine referral for a patient complaining of severe headache.
- ⁸⁷The nurse's signature was not legible and not contained on the signature form.
- ⁸⁸The routine referral took place in 5 days, but should have been made urgently. The patient returned on 8/16 with severe headache and fever of 101.5 and was kept in the OHU for 5 days with febrile illness. On 8/12/07 the patient requested HIV and other STD testing. The patient had also acquired a new tattoo one month prior to the febrile illness that was infected on or about the time of the illness. This case was discussed with the CMO. The patient should be tested for sexually transmitted and blood-borne infections (HIV, HBV, and HCV).
- ⁸⁹ Inadequate history – no history related to severity, location, radiation, possible triggers, time of day, associated symptoms, history of trauma, etc.
- ⁹⁰ Ear exam documented clear TM's, but did not note findings related to canal. Assessment was otitis externa.
- ⁹¹ Patient treated with antibiotic eye drops. Dr. Wong ordered follow-up prn. Patient should be scheduled for follow-up.
- ⁹² Patient treated with antibiotics for probable staph infection. Dr. Wong ordered follow-up prn. Patient should be scheduled for follow-up.
- ⁹³ No documentation of education.
- ⁹⁴ No documentation of education.
- ⁹⁵ No documentation of education.
- ⁹⁶ No documentation of education.
- ⁹⁷ No documentation of education.
- ⁹⁸ Ordered follow-up did not occur
- ⁹⁹ Ordered follow-up did not occur
- ¹⁰⁰ No history related to symptoms of hypothyroidism
- ¹⁰¹ No chronic care intake visit
- ¹⁰² Ear exam documented clear TM's, but did not note findings related to canal. Assessment was otitis externa.
- ¹⁰³ Ear exam documented clear TM's, but did not note findings related to canal. Assessment was otitis externa.
- ¹⁰⁴ Ear exam documented clear TM's, but did not note findings related to canal. Assessment was otitis externa.
- ¹⁰⁵ Ear exam documented clear TM's, but did not note findings related to canal. Assessment was otitis externa.
- ¹⁰⁶ Inadequate history, i.e., 8/22 visit history is "no complaints"
- ¹⁰⁷ Blood pressure was 112/96 on 8/22. Assessment was good control, stable (prior blood pressures had been wnl)
- ¹⁰⁸ 17 year old youth who arrived on 4/11/07 with history of hypertension (on 3 medications) and proteinuria. Health care summary from Bakersfield Juvenile Hall notes that patient was to have a 24 hour urine for protein and creatinine clearance, and a renal consult in 5/07. No further evaluation of renal disease at Preston.
- ¹⁰⁹ Not offered pneumococcal vaccine
- ¹¹⁰ No documentation of education.
- ¹¹¹ No documentation of education.
- ¹¹² No documentation of education.
- ¹¹³ No documentation of education.
- ¹¹⁴ No documentation of education.

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- ¹¹⁵The pharmacy was not clean.
- ¹¹⁶The pharmacist has not been conducting monthly inspections.
- ¹¹⁷Pharmacy program can produce cost and utilization but cannot produce drug-drug interactions to caution clinicians regarding potentially adverse outcomes.
- ¹¹⁸This question is duplicative of Question #4
- ¹¹⁹The pharmacy and therapeutics committee has not yet been started.
- ¹²⁰Internal and external medications were stored together and not labeled.
- ¹²¹Order does not contain route of administration.
- ¹²²Order does not contain route of administration.
- ¹²³Order does not contain route of administration.
- ¹²⁴Order does not contain route of administration.
- ¹²⁵Order does not contain route of administration.
- ¹²⁶Clinician ordered medication without documentation of a clinical evaluation.
- ¹²⁷MAR shows incorrect date of order (8/23/07 instead of 8/22/07). This was a pharmacy not nursing error.
- ¹²⁸MAR shows incorrect date of order (4/12/07 instead of 4/11/07). This was a pharmacy not nursing error.
- ¹²⁹MAR shows incorrect date of order (5/3/07 instead of 5/2/07). This was a pharmacy not nursing error.
- ¹³⁰The nurse did not document status of administration on 6/29/07.
- ¹³¹No emergency response drills have been conducted.
- ¹³²Patient seen on 8/10 complaining of weakness, headache and bilateral flank pain. Nurse did not obtain adequate history of weakness, headache or flank pain, did not listen to lungs, and did not obtain urinalysis. Assessment was possible dehydration – did not obtain postural vital signs.
- ¹³³Patient complaining of wrist pain s/p group disturbance. Nurse did not palpate for tenderness or check range of motion.
- ¹³⁴Patient seen by nurse night of 8/25. Complaining of ear pain. Had TM perforation in same ear 6/07. Nurse noted patient afebrile, pain 8/10, clear drainage, increased pain with movement of outer ear. Noted unable to see inner ear d/t otoscope not working. Given patient's history and level of pain, should have found working otoscope. (There are 3 otoscopes in the OHU building).
- ¹³⁵The nurse contacted Dr. Wong who gave a verbal order for Tylenol, but no follow-up.
- ¹³⁶Patient seen by nurse on 8/8 complaining of headache, nausea and vomiting after lunch. The physician did not obtain an appropriate history related to these symptoms.
- ¹³⁷Nurse contacted on call physician He ordered ear drops and follow-up on 8/27. Given patient's history and level of pain, the physician should have instructed nurse to find otoscope. In addition, patient should have been checked the next day.
- ¹³⁸There are no health record policies that address all aspects of health record management.
- ¹³⁹There is no tracking system for consultation reports
- ¹⁴⁰Staff track records that are sent outside the main medical clinic, but do not have a tracking system for within the medical unit, i.e. who has the record on a given day.
- ¹⁴¹Patient is 6'2" and 234 lbs. BMI is 30. Weight is not addressed.
- ¹⁴²Patient is 5'9" and 174 lbs. BMI is 25.7. Weight is not addressed
- ¹⁴³Upon the patient's return from the consultation appointment, the nurse did not review the consultant's recommendations and addressed any urgent recommendations.
- ¹⁴⁴Upon the patient's return from the consultation appointment, the nurse did not review the consultant's recommendations and addressed any urgent recommendations.
- ¹⁴⁵The clinician did not review, date, and initial the consultation report within 3 business days of the youth's return to the facility or receipt of the report.
- ¹⁴⁶The clinician did not review, date, and initial the consultation report within 3 business days of the youth's return to the facility or receipt of the report.
- ¹⁴⁷The UHR does not show that the clinician met with the youth 5 business days (sooner if clinically indicated) to review results of the consult with the youth and develop a treatment plan.
- ¹⁴⁸The UHR does not show that the clinician met with the youth 5 business days (sooner if clinically indicated) to review results of the consult with the youth and develop a treatment plan.
- ¹⁴⁹Patient with thumb fracture. Saw orthopedist 6/14 who casted fx and ordered f/u in 4 weeks. Youth removed cast on 6/22. Nurse d/c'd follow-up with orthopedist. Dr. Wong saw patient on 6/26 and noted fx was clinically stable. Dr. Wong wrote an order for an x-ray and "follow-up with orthopedic as scheduled 4 wks from 6/14. The ortho appointment was not rescheduled. The x-ray was done on 6/27 and revealed that the fx was unchanged. Dr. Wong reviewed the results on 7/2. His plan was to "await orthopedic follow-up." There has been no subsequent follow-up with orthopedics or with a physician at Preston.
- ¹⁵⁰Dr. Horowitz has begun the peer review process. There is currently no documentation of the reviews.
- ¹⁵¹Some corrective plans have been implemented, but there is no documentation.

¹⁵² Do not have e, g, or l in files

¹⁵³ The QM Committee held its first meeting on August 2, 2007.

¹⁵⁴ OHU records are reviewed and discussed at staff meetings. Nursing sick call records are not occurring as above.

**CALIFORNIA DEPARTMENT OF CORRECTIONS
AND REHABILITATION**

DIVISION OF JUVENILE JUSTICE

**Heman G. Stark Youth Correctional Facility
Health Care Audit
October 30-November 1, 2007**

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INTRODUCTION

The Health Care Remedial Plan (HCRP) requires the Division of Juvenile Justice (DJJ) to make a number of specific changes in the medical, mental health, and dental care programs. To measure DJJ compliance with the requirements of the Health Care Remedial Plan, the Medical Experts developed this audit instrument with clearly defined standards and criteria, and thresholds of compliance. The audit instrument is comprised of indicators selected from:

- The Health Care Remedial Plan
- DJJ policies and procedures developed in consultation with the Medical Experts
- National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Juvenile Detention and Confinement Facilities, 2004 Edition
- The American Medical Association's Guidelines for Adolescent Preventive Services (GAPS)
- US Preventive Services Task Force (USPSTF)
- Guidelines for the evaluation and treatment of other disease such as those published by the Centers for Disease Control and Prevention (CDC)

Regarding those areas related to nursing and medical care practice, the Medical Experts will use their professional judgment to assess compliance.

NOTE: This audit instrument does not address mental health. The Mental Health Experts will develop the Mental Health Audit Instrument.

Audit Instrument and Compliance Thresholds

The audit instrument will be used by the Medical Experts to evaluate compliance with the HCRP. It is also intended for use by the DJJ Office of Health Services Quality Management Team and by the local facility Quality Management Team to evaluate progress consistent with the HCRP. The audit instrument includes indicators from sources cited above, which the Medical Experts judge to be critical in establishing an adequate health care system. Some indicators allow for partial compliance if the facility is close to, but has not yet achieved substantial compliance.

A facility is in substantial compliance when all of the following conditions are satisfied:

- a. The facility receives a score of 85% or higher during an audit conducted by the Court experts. When determining overall compliance, areas that are determined to be in partial compliance will be considered non-compliant. The experts shall have the discretion to find a facility providing adequate medical care in compliance if it achieves a score of no less than 75%.

- b. Medical assessments and treatment plans provided to youth comply with the policies and procedures, as determined by the medical experts. The medical assessment and treatment plans provided to the youth shall be deemed adequate and appropriate under these policies and procedures, only under any one of the following conditions:
 - (1) The assessment or treatment plan is consistent with guidelines specifically adopted in the policies and procedures; or
 - (2) The practitioner documents in the medical notes that he/she is deviating from adopted policies and procedures, and that such deviation is consistent with the community standard; or
 - (3) Where no treatment guidelines are specifically adopted in these policies and procedures, the assessment or plan is consistent with the community standard.
- c. The facility is conducting minimally adequate death reviews and quality management proceedings.
- d. The facility has tracking, scheduling, and medication administration systems adequately in place.
- e. Both experts have concluded that there is not a pattern or practice that is likely to result in serious violations of wards' rights that is not being adequately addressed.

The medical experts have developed audit instrument instruction to clarify interpretations and scoring of the audit instrument. We are available to answer questions as well as provide training to staff regarding the audit instrument.

Heman G. Stark Site Visit Summary

Executive Summary

Overall, the facility scored 64%. The facility population at the time of our visit was less than 800 youth. The medical experts found that there was an increase in collaboration and cooperation between custody and health care staff since our last visit. Satellite health care clinics have been equipped and supplied and are actively in use. The Superintendent has dedicated correctional officers for medical escort purposes in the housing units, with the exception of a mental health unit, which is currently having problems with youth escorts for medication administration.

Summary of Health Care Areas Reviewed

- Facility Leadership, Budget, Staffing, Orientation and Training scored 33%. See description below:

The CMO is a board-certified family practitioner who has been in place since May 2007. The SRN III and both SRN II positions are filled. Staff reports that one of their key positions, a Correctional Health Services Administrator II position is occupied by an individual in headquarters and not available to be filled. Nursing staff reported there is not pay parity with CDCR, and that for example, a nurse at the CDCR adult facility, Correctional Institution for Men which is also located in Chino, are paid more than a nurse at HGSYCF. We were not able to confirm this during our visit and it should be explored further by headquarters staff.

The CMO reported that he does not have a health care budget and that he does not know how much money is allocated for health care expenditures. At this time, they only track what they are spending. We attended a Farrell implementation meeting. The Superintendent indicated that not only was there no medical budget, that DJJ had not established institutional budgets and that they were operating in deficit spending. Staff also reported that they had ordered printers for the satellite clinics, and forwarded it to purchasing and the printers were ordered and arrived. However, the person in charge of information technology took them and put them elsewhere in the institution in non-medical areas because they were “too nice for medical.” While the medical experts understand the need for coordination of computers and related software purchases, it is inappropriate that these medically purchased items were reallocated to another institutional department.

With respect to policies and procedures, the superintendent was concerned that the medical TDOs were distributed and implemented prior to training being provided for other non-health care managers. He believes that implementation of the TDOs was hampered because they were not distributed through normal channels with timely training.

The SRN III is concerned that he has insufficient nurse staffing to meet the expectations of the new policies and procedures, and that existing staff are not matched to the appropriate duties. For example, registered nurses are assigned to administer medications instead of licensed vocational nurses (LVNs). He believes that he may not require more nursing positions if, in collaboration with mental health, he had the authority to clinically assign all nursing staff, including Psych Techs, . The Health Care Remedial Plan indeed requires that all nursing personnel are under the clinical supervision of the nursing chain of command, however this is not the case at this time. Finally, the SRN reported that he was told that the additional nurses he received were to be dedicated to mental health even if the BCP Farrell Position spread sheet stated that a positions was designated HC (health care) instead of MH (mental health).

- Medical reception scored 43%. Although Heman G. Stark is not a reception center, by policy youth who enter the system through parole revocation are to undergo the medical reception process. Although nurses are completing the initial screening form, in only 1 of 9 records are physicians completing a history and physical examination, documenting an appropriate treatment plan and updating the Problem List. Staff reported that the physicians are resistant to using the new history and physical examination form due to its length (4 pages). Visual acuity (VA) is not being consistently measured for new arrivals, even when the most recent VA documented is several years old.
- Intrasystem Transfer scored 54%. Areas requiring improvement include the completeness of nursing documentation upon the youth's arrival, timeliness of physician review, signature and dating of the intra-system transfer.
- Nursing Sick Call scored 48%. The nursing protocols and health assessment training have not yet been implemented system wide. Areas needing improvement include the quality of the nurse's history and physical examinations, nursing diagnoses and plan of care.
- Medical Care scored 71%. Areas requiring improvement included the history and plan, and ensuring that the plan is implemented in a timely manner.
- Chronic Disease Management scored 53%. The program is in the early stages of implementation. Areas requiring improvement included the initial history, frequency of chronic care visits, the assessment, the treatment plan, education, and vaccinations.
- Infection Control scored 71%. Areas requiring improvement include training of the infection control nurse and scheduling and consistent implementation of sanitation activities and inspection.
- Pharmacy Services scored 93%. Congratulations. While the facility met the goal of 85%, an area that could be improved is that the computer software does not have the capability to identify drug-drug interactions.
- Medication Administration Process scored 66%. Areas requiring improvement include sanitation in satellite areas where medications are prepared and administered, implementation of needle and syringe control, security escorts during medication administration in the mental health unit (Unit 1, lower level) and ensuring that the designated time for administration of hour of sleep (HS) medications is 2100 hours. This includes a one hour window period before and after (2000-2200) to accomplish medication administration.
- Medication Administration Health Record Review scored 75%. Areas requiring improvement include physician order completeness and accuracy, and documentation of a clinical note explaining the rationale for the order. In one case the physician documented an incorrect dose for an HIV medication that was corrected by the pharmacy, however the original order was not corrected.

- Urgent/Emergent Care scored 81%. Areas requiring improvement included the accuracy of the log, emergency equipment checks, training, nursing evaluations, and physician follow-up.
- Outpatient Housing Unit-This area was not evaluated because the facility does not have an OHU at this time. Staff currently transfers youth requiring OHU services to Southern Regional Youth Correctional Facility (SRYRCC).
- Health Records scored 50%. Areas requiring improvement included development of a local policy and the filing of the problem list.
- Preventive Services scored 85%. While the facility met the goal of 85%, an area that could be improved is clinician identification and development of a treatment plan for youth who are obese.
- Consultations scored 74%. Areas requiring improvement included timeliness of consults and follow-up after the consultation.
- Peer Review scored 0%. Areas requiring improvement include development and implementation of statewide and local peer review policies and peer review activities.
- Credentialing scored 71%. Areas requiring improvement include the development and implementation of statewide and local credentialing policies and having credentialing files for all physicians that contain all required elements.
- Quality Management scored 50%. Areas requiring improvement include ongoing quality management meetings and studies, physician review of nursing sick call, SRN review of nursing sick call and annual Quality Management Report to the Statewide Medical Director.

Recognizing that there are areas requiring improvement, we wish to congratulate staff on their progress to date.

Facility Leadership, Budget, Staffing, Orientation and Training

Interview facility leadership. Review staffing and vacancy reports, facility health care budget, staff credentials and licensure, and orientation and training documentation. Key: SC =Substantial Compliance, PC=Partial Compliance, NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Key facility health care leadership positions (Chief Medical Officer [CMO], Supervising Registered Nurse [SRN], Pharmacist, etc.) are filled or are being effectively recruited. Pay parity exists with CDCR.			0 ¹	
Question #2	Each facility has a full-time CMO who is board-certified or eligible in a primary care field. The NCYCC shall have one full-time CMO responsible for all complex facilities. The CMO's duties are consistent with the HCSR (see page 14).	1			
Question #3	In both policy and actual practice, the facility is assigned a health care budget that is under the control of the CMO.			0 ²	
Question #4	Budgeted and actual physician staffing hours are sufficient to meet policy and procedures requirements, and to provide quality medical services.	1 ³			
Question #5	Budgeted and actual registered nurse staffing hours are sufficient to meet policy and procedures requirements and to provide quality nursing services.		0 ⁴		
Question #6	Medical Technical Assistant's (MTA) primary responsibilities will be the performance of health care duties.	1 ⁵			
Question #7	Escort staffing and cooperation are sufficient to assure that youth attend on-site health care appointments		0 ⁶		
Question #8	The CMO ensures that an accurate and complete system exists for tracking professional and DEA licensure; and that CPR certification is in place. All licensed staff has a current and valid license.		0 ⁷		
Question #9	Newly hired staff receives a structured orientation program within 30 days of arrival. Documentation of orientation is kept in personnel files.		0 ⁸		
Question #10	Existing staff is trained regarding changes in new policies and procedure within 60 days of distribution.				N/A ⁹
	Totals:				

Compliance = 33% (3 of 9 applicable questions)

Medical Reception

Select 10 to 20 health records of youth completing medical reception within the past 60-90 days. Include youth with known Latent TB infection and other health problems. Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	The medical reception process is conducted in a confidential and private manner. Signage (in English and Spanish) regarding confidentiality is in the medical area.		0 ¹⁰		
Question #2	There is a comprehensive verbal and written orientation program (minimum English and Spanish) for youth in a language they understand.		0 ¹¹		
Question #3	Youth are educated on how to access routine and emergent dental care.	1			
	For calculating score, only give credit for applicable questions in substantial compliance.	Totals:			

Write the youth's ID number in top row:

State ID# →	1 ¹²	2 ¹³	3 ¹⁴	4 ¹⁵	5 ¹⁶	6 ¹⁷	7 ¹⁸	8 ¹⁹	9 ²⁰	10 ²¹
Screen # 1	1	1	1	1	1	1	1	1	1	0 ²²
Screen # 2	N/A	N/A	N/A	1	0 ²³	N/A	N/A	1	0 ²⁴	N/A
Screen # 3	0 ²⁵	0 ²⁶	0 ²⁷	0 ²⁸	0 ²⁹	1	0 ³⁰	0 ³¹	0 ³²	1
Screen # 4	0 ³³	1	1	0 ³⁴	1	0 ³⁵	1 ³⁶	0 ³⁷	0 ³⁸	1
Screen # 5	0 ³⁹	1	1	0	0 ⁴⁰	N/A	1	0 ⁴¹	1	0 ⁴²
Screen # 6	0 ⁴³	0 ⁴⁴	0 ⁴⁵	0	0	1	0 ⁴⁶	0 ⁴⁷	0 ⁴⁸	0 ⁴⁹
Screen # 7	0 ⁵⁰	0 ⁵¹	0 ⁵²	0 ⁵³	0 ⁵⁴	N/A	0 ⁵⁵	1 ⁵⁶	0 ⁵⁷	0
Screen # 8	0 ⁵⁸	0	1 ⁵⁹	0 ⁶⁰	1	N/A	1 ⁶¹	1	1	1
Screen # 9	1	1	1	0 ⁶²	1	N/A	N/A	0 ⁶³	1	1
Screen # 10	N/A	N/A	N/A	0 ⁶⁴	0 ⁶⁵	N/A	N/A	0 ⁶⁶	0 ⁶⁷	N/A

- Screen # 1 A nurse completed the Receiving Health Screening form on the day of arrival. The nurse referred to, or contacted a clinician for all youth with acute medical, mental health, or dental conditions; with symptoms of TB; or on essential medications.
- Screen # 2 A clinician ordered essential medications (e.g., chronic disease, mental health) on the day of arrival. Medications were administered within 24 hours. No insulin, TB, or HIV doses were missed.
- Screen # 3 A nurse measured the youth's height and weight, vital signs, visual acuity, initiated the immunization history, and planted a PPD (unless previously positive) within 24 hours of arrival. The TB test was read and documented within 72 hours.
- Screen # 4 A nurse obtained routine laboratory tests (RPR, GC, and Chlamydia, voluntary HIV antibody test, pregnancy screen, disease specific tests) within 72 hours and results were communicated to youth either at the time the physical exam was performed or when the youth was brought back for counseling. The clinician appropriately addressed abnormal laboratory findings, including counseling the youth as appropriate.
- Screen # 5 A nurse or clinician documented HIV Post-Test notification and counseling.
- Screen # 6 A clinician performed a history and physical including a testicular exam for males and pelvic examination for females (if clinically indicated) within seven calendar days of arrival. The clinician integrated information from the health screening examination, laboratory tests, and medical history into the physical exam process.
- Screen # 7 A clinician (MD, NP, or PA) initiated a Problem List noting all significant medical, dental, and mental health diagnoses.
- Screen # 8 A clinician documented an appropriate treatment plan on the History and Physical Exam Form or in the Progress Notes. The plan included appropriate diagnostic, therapeutic measures, patient education, and clinical monitoring (if indicated).
- Screen # 9 The UHR reflects that all medical reception physician orders were implemented as ordered.

Screen # 10

Youth with chronic diseases (e.g., asthma, diabetes) were enrolled in the chronic disease management program and clinically evaluated by a clinician for their chronic disease within 30 days of arrival.

Medical Reception Summary:

Screen #	# Records Reviewed	#N/A	Final # of Records	# of Compliant Records	COMMENTS
1	10	0	10	9	
2	10	6	4	2	
3	10	0	10	2	
4	10	0	10	5	
5	10	0	10	4	
6	10	1	9	1	
7	10	1	9	1	
8	10	1	9	6	
9	10	2	8	6	
10	10	6	4	0	
Total	100	17	83	33	Plus credit for 1 of 3 questions

Compliance = 43% (37 of 86 applicable Questions + Screens)

Intrasystem Transfer

Select 10 to 20 health records from the Intrasystem Transfer Log and corresponding Medical Administration Records (MARs) of youth transferred to the facility in the previous 120 days. Review pertinent scheduling logs (consultation, chronic illness clinic, etc.).

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy and procedure. The statewide Transfer Form is in use.	1 ⁶⁸			
Question #2	There is a process whereby health care staff is notified of pending transfers from the facility one business day in advance of transfer.	1			
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	2			

Write the youth's ID number in top row.

State ID# →	1 ⁶⁹	2 ⁷⁰	3 ⁷¹	4 ⁷²	5 ⁷³	6 ⁷⁴	7 ⁷⁵	8 ⁷⁶	9 ⁷⁷	10 ⁷⁸
Date of arrival	7/24/07	7/10/07	7/5/07	8/7/07	8/29/07	6/22/07	7/25/07	8/15/07	8/9/07	8/2/07
Screen # 1	1	1	1	1	0 ⁷⁹	0	1	1	1	1
Screen # 2	1	1	1	0 ⁸⁰	1	0 ⁸¹	0 ⁸²	0 ⁸³	1	1
Screen # 3	0 ⁸⁴	N/A	N/A	N/A	N/A	N/A	1	N/A	N/A	N/A
Screen # 4	0 ⁸⁵	0 ⁸⁶	1	0 ⁸⁷	0 ⁸⁸	N/A	0 ⁸⁹	0 ⁹⁰	0 ⁹¹	0 ⁹²
Screen # 5	N/A	N/A	N/A	0 ⁹³	N/A	N/A	1	1	N/A	0 ⁹⁴
Screen # 6	N/A	0 ⁹⁵	N/A	0 ⁹⁶	N/A	N/A	N/A	N/A	1	1
Screen # 7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

- Screen # 1 A sending facility nurse reviewed the youth's record prior to transfer and documented required health information on the statewide transfer form. If the sending facility nurse did not complete the transfer form, the receiving nurse documented that she notified the facility of this (minimum information is the sending facility and who the nurse spoke to).
- Screen # 2 Upon arrival, a nurse interviewed the youth and reviewed the UHR. The nurse completed the form noting any additional information related to acute and chronic medical or mental health conditions, current medications, pending or recently completed consultations, and any other health condition requiring follow-up or special housing on the transfer form.
- Screen # 3 The receiving nurse referred youth with acute medical, dental, or mental health conditions on the day of arrival.
- Screen # 4 The receiving physician reviewed the health record of each youth within one business day of arrival and legibly signed and dated the Intrasystem form. The clinician addressed any significant medical problems.
- Screen # 5 A clinician evaluated youth with chronic diseases within 3 business days and enrolled the youth into the chronic disease program.
- Screen # 6 The MAR showed that continuity of essential medications (e.g., chronic disease, mental health, antibiotics, etc.) was provided.
- Screen # 7 The UHR shows that medical care ordered at the previous facility (e.g., vaccinations, consultations, laboratory tests) was carried out following arrival, or a clinical progress note provided an appropriate rationale for doing otherwise.

Intrasystem Transfer Summary:

Screen #	# Records Reviewed	# N/A	Final # of Records	# of Compliant Records	COMMENTS
1	10	0	10	8	
2	10	0	10	6	
3	10	8	2	1	
4	10	1	9	1	
5	10	6	4	2	
6	10	6	4	2	
7	10	10	0	N/A	
Total	70	31	39	20	Plus 2 Questions both of which received credit

Compliance = 54% (22 of 41 Applicable Questions + Screens)

Nursing Sick Call

Select 10 to 20 health records from general population nursing sick call encounters during the last 120 days. Key: SC =Substantial Compliance, PC=Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy. The statewide health services request form is in use.	1			
Question #2	Youth can confidentially submit Health Services Request forms (HSRF) daily into a locked box accessed only by health care staff. Health care staff collects and triages the forms daily.	1 ⁹⁷			
Question #3	Upon youth request, custody or health care staff assists youth with completion of the HSRFs. Sign language and translation services are available.				N/E
Question #4	Nursing sick call is conducted in clean, adequately equipped, and supplied rooms with access to a sink for hand-washing or alcohol-based sanitizer with a sink nearby.		0 ⁹⁸		
Question #5	Nursing sick call is conducted 5 days a week for each housing unit, excluding weekends and holidays.	1			
Question #6	All registered nurses conducting sick call have been trained and demonstrate competency in health assessment and use of nursing protocols.			0	
Question #7	The UHR is available and present for sick call encounters including in specialized housing units and during lockdowns.	1			
Question #8	Nurses conduct sick call with, at a minimum, auditory privacy, and also with visual privacy if a physical examination is performed.				N/E
Question #9	There is signage in all health care delivery areas stating that staff shall maintain the confidentiality of medical information.	1			
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	5			

Write youth's ID number in the top row:

State ID# →	1 ⁹⁹	2 ¹⁰⁰	3 ¹⁰¹	4 ¹⁰²	5 ¹⁰³	6	7	8	9	10
Triage Date HSR →	9/22/07	10/13/07	9/20/07	3/25/07	10/25/07					
Date NSC →	9/25/07	10/14/07	Undated	Undated	10/25/07					
Screen # 1	1	1	0 ¹⁰⁴	N/E ¹⁰⁵	1					
Screen # 2	0 ¹⁰⁶	1	0 ¹⁰⁷	N/E	1					
Screen # 3	0 ¹⁰⁸	0 ¹⁰⁹	0 ¹¹⁰	0 ¹¹¹	0 ¹¹²					
Screen # 4	0 ¹¹³	0 ¹¹⁴	0 ¹¹⁵	0 ¹¹⁶	0 ¹¹⁷					
Screen # 5	1	0 ¹¹⁸	0 ¹¹⁹	0 ¹²⁰	0 ¹²¹					
Screen # 6	1	1	0 ¹²²	1	1					
Screen # 7	1	1	N/A	1	N/A					
Screen # 8	0 ¹²³	1	0 ¹²⁴	0 ¹²⁵	1					
Screen # 9	1	1	0 ¹²⁶	0 ¹²⁷	1					

Screen # 1 The nurse performed same-day triage of the Health Services Request Form and documented an appropriate disposition.

- Screen # 2 The nurse saw youth with urgent complaints on the same day, or youth with routine complaints the following business day.
- Screen # 3 The nursing subjective history was appropriate to the patient’s complaint and included a description of onset of symptoms.
- Screen # 4 The nursing physical assessment and collection of objective data was appropriate to the complaint (e.g., vital signs, Snellen test, urine dipstick, etc.).
- Screen # 5 The nursing diagnosis/assessment was appropriate based on the clinical findings.
- Screen # 6 The plan of care and nursing intervention were consistent with case history, physical findings, and the applicable nursing protocol.
- Screen # 7 The nurse referred the patient to a clinician in accordance with the criteria for referral found in the nursing protocol, or accepted in accordance with good clinical judgment.
- Screen # 8 The nurse legibly dated, timed, and signed the form.
- Screen # 9 The referral visit to the clinician took place according to protocol: stat-immediate, urgent-same day, routine-within 5 business days.

Nursing Sick Call Summary:

	# of Records	#N/A	Final #Records	# of Compliant Records	COMMENTS
Screen #1	5	1	4	3	
Screen #2	5	1	4	2	
Screen #3	5	0	5	0	
Screen #4	5	0	5	0	
Screen #5	5	0	5	1	
Screen #6	5	0	5	4	
Screen #7	5	2	3	3	
Screen #8	5	0	5	2	
Screen #9	5	0	5	3	
Total	45	4	41	18	Plus 5 of 7 applicable questions

Compliance =48% (23 of 48 applicable Questions + Screens)

Medical Care

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Did the clinician sign all medical encounters? If the signature was illegible, was a stamp with the clinician's name and credentials used?	1			

Select 10 to 20 records of youth seen by an MD, NP, or PA for medical encounters (return from hospitalization, infirmary, sick call referral, etc.) in the past 180 days.

State ID# →	1	2	3	4	5	6	7	8	9	10
Visit date:	10/24/07	10/29/07	9/24/07	10/22/07	9/18/07	10/26/07	7/27/07	7/16/07	8/16/07	9/6/07
Clinician name:	A	C	B	B	D	C	B	A	A	D
Nature of visit:	Abdominal pain	Abdominal pain	Neck mass	Shoulder pain	Knee Pain	Acne	Eye problem	Facial trauma	Shortness of breath	Hand injury
Screen # 1	0 ¹²⁸	1	1	1	1	1	1	0 ¹²⁹	0 ¹³⁰	1
Screen # 2	1	1	0	1	1	1	1	N/A	0 ¹³¹	1
Screen # 3	0 ¹³²	1	1 ¹³³	1	1	1	1	1	1	1
Screen # 4	N/A	1	1	1	1	1	1	0 ¹³⁴	N/A	1
Screen # 5	0 ¹³⁵	1	1	1	1	1	1	1	N/A	1
Screen # 6	0	1	0	1	1	1	0	0	0	1
Screen # 7	N/A	N/A	0 ¹³⁶	1	N/A	N/A	0 ¹³⁷	0 ¹³⁸	0 ¹³⁹	1

- Screen # 1 The clinician addressed the patient's current complaint by obtaining a history of the present illness and appropriate review of systems.
- Screen # 2 The nurse or clinician measured a full set of vital signs when clinically appropriate (including weight, if clinically indicated).
- Screen # 3 The clinician documented all pertinent physical findings, laboratory, and diagnostic results or other related objective data.
- Screen # 4 The clinician made an appropriate assessment based upon the patient's medical history, laboratory, and physical findings.
- Screen # 5 The clinician documented an appropriate treatment plan that included diagnostic and therapeutic measures, clinical monitoring, and follow-up.
- Screen # 6 The clinician documented appropriate patient education related to the diagnosis and treatment plan.
- Screen # 7 All aspects of the treatment plan occurred as ordered within a clinically appropriate time.

State ID# →	11	12	13	14	15	16					
Visit date:	10/23/07	9/11/07	10/31/07	10/24/07	7/24/07	9/18/07					
Clinician name:	B	D	C	A	A	A					
Nature of visit:	Ingrown hair in pubic area	Abdominal pain	? seizure history	Runny nose	Wrist injury	Follow-up for tumor					
Screen # 1	1	1	1	0 ¹⁴⁰	1	1					
Screen # 2	1	N/A	1	1	N/A	1					
Screen # 3	1	1	1	0 ¹⁴¹	1	1					
Screen # 4	1	1	1	N/A	1	1					
Screen # 5	1	0 ¹⁴²	1	N/A	0 ¹⁴³	0 ¹⁴⁴					
Screen # 6	0	1	1	0	0	0					
Screen # 7	1	N/A	N/A	N/A	0 ¹⁴⁵	0 ¹⁴⁶					

Medical Care Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	16	0	16	12	
Screen #2	16	3	13	11	
Screen #3	16	0	16	14	
Screen #4	16	3	13	12	
Screen #5	16	2	14	10	
Screen #6	16	0	16	7	
Screen #7	16	7	9	3	
Total	112	15	97	69	Plus 1 of 1 Question

Compliance 71% (70 of 98 applicable Screens +Questions)

Chronic Disease Management

Number of patients enrolled in clinic _____

Percent of clinic health records reviewed _____ %

Select 10 to 20 health records or 10% of this clinic population. Avoid records of youth arriving within the past 90 days. Write the youth's ID number in top row below:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	0	1	1	1	1	1	1	1	0 ¹⁴⁷	1
Screen # 2	1	0 ¹⁴⁸	1	0 ¹⁴⁹	1	0 ¹⁵⁰	0 ¹⁵¹	0 ¹⁵²	0 ¹⁵³	1
Screen # 3	N/A	1	N/A	N/A	N/A	N/A	1	N/A	N/A	N/A
Screen # 4	0 ¹⁵⁴	0	0	0	0	0	0	0	N/A	0
Screen # 5	N/A	1	1	1	N/A	N/A	0 ¹⁵⁵	N/A	N/A	1
Screen # 6	N/A	1	1	0 ¹⁵⁶	0	0	0	N/A	N/A	1
Screen # 7	N/A	1	0 ¹⁵⁷	0 ¹⁵⁸	0 ¹⁵⁹	1	0	N/A	N/A	1
Screen # 8	0	1	1	1	0	1	0	0	N/A	1
Screen # 9	N/A	1	1	N/A	1	1	1	1	N/A	1
Screen # 10	0 ¹⁶⁰	0 ¹⁶¹	0 ¹⁶²	0 ¹⁶³	1	1	N/A	N/A	N/A	0 ¹⁶⁴

- Screen # 1 All chronic diseases are listed on the Problem List.
- Screen # 2 For the initial chronic care visit the clinician performed an appropriate medical history, physical examination pertinent to the management of the chronic disease.
- Screen # 3 Baseline and ongoing follow up laboratory/diagnostic data (HbA_{1c}, serum drug levels, if ordered, etc.) were completed prior to the scheduled clinic visit and the clinician addressed results during the clinic visit.
- Screen # 4 The clinician saw the patient quarterly or more frequently as clinically indicated (i.e., based on degree of disease control). Appropriate exceptions are documented in the UHR.
- Screen # 5 The clinician's evaluation of the youth was clinically appropriate (interval history, physical examination, laboratory tests, etc.).
- Screen # 6 The clinician accurately assessed degree of disease control (i.e., good, fair, poor).
- Screen # 7 The clinician's treatment plan documented appropriate diagnostic & therapeutic measures based upon disease control and indicates when the patient is to be seen for the next clinic follow up visit.
- Screen # 8 The clinician's or nurse's notes document appropriate patient education regarding disease process, diagnostic tests, treatment goals, medication purpose, and side effects, etc.
- Screen # 9 There were no lapses in medication continuity. The clinician's assessment of medication adherence is consistent with the MAR. If the patient was non-adherent, counseling is documented in the health record.
- Screen # 10 The clinician offered/ordered Pneumococcal and annual influenza immunizations as recommended. If accepted, the nurse documented the date of administration and initials on the Immunization and Communicable Disease Record. If refused, the clinician or nurse obtained refusal of treatment.

Chronic Disease Management Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	8	
Screen #2	10	0	10	4	
Screen #3	10	8	2	2	
Screen #4	10	1	9	0	
Screen #5	10	5	5	4	
Screen #6	10	3	7	3	
Screen #7	10	3	7	3	
Screen #8	10	1	9	5	
Screen #9	10	3	7	7	
Screen #10	10	3	7	2	
Total	100	27	73	38	

Compliance =52% (38 of 73 applicable screens)

Infection Control

	Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated	SC	PC	NC	NA
Question # 1	There is a Local Operating Procedure (LOP) describing the facility's infection control program that is consistent with statewide policy.	1			
Question # 2	There is a licensed health care provider who is designated as having public health/infection control duties and who has received appropriate orientation and training.		0 ¹⁶⁵		
Question # 3	There is a functional system for reporting diseases and laboratory test results, which are required by State and Federal Law (e.g., AIDS cases, positive HIV results, Hepatitis A, B, or C, syphilis, etc.).	1			
Question # 4	There are exposure control plans in place for airborne and blood borne pathogens that include: a) Documentation of new hire and annual training regarding exposure control plans yes. b) A policy describing use of standard precautions to prevent contact with blood or other potentially infectious materials (OPIM) yes c) A policy describing engineering (sharps disposal, specimen handling) and work practice controls intended to eliminate or minimize employee exposure yes d) A policy describing housekeeping procedures used to maintain a clean and sanitary environment, including a written schedule for cleaning and methods of decontamination		0 ¹⁶⁶		
Question # 5	Engineering Controls: a) Sharps containers are secure and easily accessible in areas where sharps are used. Yes. b) Hand wash facilities are in or near all work areas and antiseptic hand cleaner are available when needed. Yes. c) An eyewash station is present and tested quarterly for functionality. The eyewash station functions properly. yes d) Specimen containers are used for transport of biological specimens (e.g., blood, urine). yes e) Biohazard storage bins are available. yes f) Blood and body fluid spills are cleaned appropriately per policy. N/E	1			
Question # 6	Compliance with work practice controls: a) Food and drink are not kept in refrigerators, freezers, shelves, cabinets, or counter tops where blood, laboratory specimens, or other potentially infectious materials are kept. Yes. b) Staff observes Standard Precautions. yes c) Refrigerators are labeled appropriately (biohazard for specimens, food only, or medication only). yes d) Personal Protective Equipment is immediately available in health care delivery areas. Yes e) Staff performs hand-washing as required. N/E	1			

Infection Control Continued:						SC	PC	NC	NA
Question 7	Are Infection Control Meetings held quarterly (minimum 4 meetings per year)?					1			
Question 8	If Question 7 is SC or PC , do the minutes address the following areas? (Put Y if topics are present or N if topic is missing, for each quarter in space provided):	QTR 1	QTR 2	QTR 3	QTR 4				N/E
	a) TB skin testing programs for staff and youth								
	b) Exposure control plans and training regarding airborne and blood borne pathogens								
	c) Hepatitis B training and vaccination programs (e.g., number of employees trained, number accepting vaccine, and number completing vaccination series)								
	d) Staff compliance with work practice controls								
	e) Reporting communicable diseases for the previous quarter, noting any trends present								
	f) Sanitation reports (institutional and infection control) and any follow-up action taken								
Question 9	If respiratory isolation rooms are used for the purposes of respiratory isolation they are functional as evidenced by routine testing (at least monthly when not in use and daily when in use). Is staff fit-tested for N-95 respirators?								N/A
For calculating score, only give credit for applicable questions in substantial compliance. Totals:									

Compliance = 71% (5 of 7 applicable questions)

Pharmacy Services

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Is the pharmacy currently licensed?	1			
Question #2	Are the pharmacy and medication rooms adequately lit, organized, clean, and provide sufficient space to prepare medications?	1			
Question #3	Does the facility pharmacist or pharmacy tech conduct monthly inspections of the pharmacy, medications rooms, and all areas of the facility where medications are stored? Does the facility pharmacist or designee develop and implement a plan to correct identified deficiencies?	1			
Question #4	Does the pharmacy have computers and software programs to track medication usage, inventory, cost, drug-drug interactions, and clinical prescribing patterns?		0 ¹⁶⁷		
Question #5	Does the pharmacist dispense all prescriptions into appropriate containers labeled with the youth's name, ID number, and medication information as required by state law?	1			
Question #6	Is there strict accountability for all medications dispensed from the pharmacy, including medications administered from a night locker?	1 ¹⁶⁸			
Question #7	Is there a pharmacy system for monitoring patient adverse drug reactions and drug-drug interactions?	1			
Question #8	Does the facility have a 24-hour prescription service or other mechanism to provide essential medications 24 hours per day (e.g., night locker)?	1 ¹⁶⁹			
Question #9	Are stock bottles of legend medications kept inside the pharmacy (except for biological agents such as insulin and vaccines under proper storage conditions)?	1			
Question #10	Is there a facility Pharmacy and Therapeutics Committee that meets quarterly? Do P & T meeting minutes reflect meaningful content and initiatives to improve pharmacy services?	1			
Question #11	Are youth with asthma permitted to keep inhalers in their possession (except for cause documented in the health record)? Are youth permitted to keep other medications in their possession as determined by the CMO?	1			
Question #12	Does the pharmacy provide continuity of medications for youth transferring into the facility?	1			
Question #13	The pharmacist provides a monthly report detailing pharmacy utilization costs, drug stop lists, monthly lists of drugs used by class, and daily physician prescribing lists.	1			
Question #14	When a youth paroles, is medication continuity provided in accordance with the policy?	1			
	For calculating score, only give credit for applicable questions in substantial compliance. Totals:				

Compliance = 93 % (13 of 14 Questions)

Issue: Physician order date versus date of prescription being filled.

Medication Administration Process

Observe all areas where medications are stored and administered. Observe the medication administration process.

Key: SC =Substantial Compliance, PC=Partial Compliance, NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Are medications administered from centralized medication rooms, except in specialized mental health units, SMP, TD, or BTP?	1			
Question #2	Is there a local policy for medication administration that is in compliance with the statewide policy and procedure?	1			
Question #3	Are the medication storage and administration rooms secure, clean, organized, and have adequate space, storage, lighting, and a sink or alcohol-based hand sanitizer?		0 ¹⁷⁰		
Question #4	Are all medications in the Documed or night locker current and accounted for (from a sample of 5 medications)?				N/E
Question #5	Are all narcotics and other controlled substances double-locked, counted at every shift, and all accounted for (from a sample of 5 medications)?	1			
Question #6	Are all needles and syringes securely stored, counted at every shift, and all accounted for?		0 ¹⁷¹		
Question #7	The medication room contains no medications that are discontinued or expired. (There is a 3-day window period to return these medications to the pharmacy.)	1			
Question #8	Are external medications stored separately from internal medications?				N/A
Question #9	Does the nurse administer all legend medication from properly labeled containers and not from stock bottles?	1			
Question #10	Does custody staff provide continuous security during medication administration?		0 ¹⁷²		
Question #11	Medications that are to be administered at the hour of sleep are not administered before 2100 hours (one hour window permitted).		0 ¹⁷³		
Question #12	Is the medication refrigerator clean and used only to store medications (no food or specimens)? Does staff check and log the temperature daily?	1			
Question #13	Medications are not crushed except upon a physician order and for a valid reason (e.g., patient is known to hoard medication). Time-released medications are not crushed.	1			
Question #14	Observe the nurse administering medications to 5 to 10 youth, and answer the following elements.	1			
					Y or N
a.	The medication administration record (MAR) was available to the nurse during medication administration.				Yes
b.	The nurse confirmed the identity of the youth per policy.				Yes
c.	The nurse compared the medication container label to the MAR.				N/A ¹⁷⁴
d.	The nurse placed the medications into a cup prior to administration.				1
e.	The nurse performed visual oral cavity checks for medications in accordance with medication administration policies.				1
f.	The nurse documented on the MAR at the time the medication is administered.				1
g.	If a medication was not available after hours, the nurse obtained the medication from the Documed or night locker and signed it out prior to administration.				N/A

Compliance = 66% (8 of 12 applicable questions)

Medication Administration Health Record Review

Select 10 to 20 health records and corresponding MARs of patients receiving medications in the preceding 180 days to review. Write the youth's ID number in top row below:

State ID# →	1 ¹⁷⁵	2 ¹⁷⁶	3 ¹⁷⁷	4 ¹⁷⁸	5 ¹⁷⁹	6 ¹⁸⁰	7 ¹⁸¹	8 ¹⁸²	9	10
Screen # 1	1	1	1	0 ¹⁸³	1 ¹⁸⁴	1	0 ¹⁸⁵	1		
Screen # 2	1	1	1	1	1	1	1	1		
Screen # 3	0 ¹⁸⁶	0 ¹⁸⁷	0 ¹⁸⁸	1	0 ¹⁸⁹	0 ¹⁹⁰	0 ¹⁹¹	1		
Screen # 4	1	1	1	1	1	1	0 ¹⁹²	1		
Screen # 5	1	1	0 ¹⁹³	1 ¹⁹⁴	1	1	0 ¹⁹⁵	1		
Screen # 6	1	1	N/E	0 ¹⁹⁶	1	1	N/A	1		
Screen # 7	0 ¹⁹⁷	0	N/E	1	1	1	N/A	1		
Screen # 8	N/A	N/A	N/E	N/A	N/A	N/A	N/A	1		
Screen # 9	1	1	N/E	1	1	1	N/A	0 ¹⁹⁸		

- Screen #1 The medication orders were complete (name of medication, strength, route of administration, frequency, duration, and number of refills).
- Screen #2 The clinician order was dated, timed, and legibly signed (if the signature is not legible, a signature stamp must also be used).
- Screen #3 The clinician documented an appropriate clinical note that corresponds with the initial medication order.
- Screen #4 The nurse dated and timed the medication order transcription (routine orders within 4 hours, urgent orders within 2 hours, and stat orders within 1 hour).
- Screen #5 The nurse and/or pharmacy accurately transcribed the physician order onto the MAR.
- Screen #6 The MAR reflected that all medications were initiated within 24 hours of the order being written or on the start date ordered.
- Screen #7 There is documentation of medication administration status (e.g., administered, refused, etc.) for every dose ordered for the youth.
- Screen #8 For discontinued medications, the nurse discontinued medications according to policy.
- Screen #9 The MAR is neat and legible, and contains legible initials, signatures, and credentials of nursing staff who have administered medications to youth.

MAR Review Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	8	0	8	6	
Screen #2	8	0	8	8	
Screen #3	8	0	8	2	
Screen #4	8	0	8	7	
Screen #5	8	0	8	6	
Screen #6	8	2	6	5	
Screen #7	8	2	6	4	
Screen #8	8	7	1	1	
Screen #9	8	2	6	5	
Total	72	13	59	44	

Compliance =75 % (44 of 59 applicable screens)

Urgent/Emergent Care Services

Select 10 to 20 health records from the Urgent/Emergent Care Tracking Log in the previous 180 days. Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question # 1	There is an Urgent/Emergent Tracking Log that records all unscheduled health care encounters.		0		
Question # 2	Emergency equipment and supplies at the facility are consistent with the statewide policy and procedure. The facility has at least one automated external defibrillator (AED).	1			
Question # 3	The emergency equipment, medications, and supplies are in proper working order. An equipment checklist log shows that health care staff inspects equipment and supplies each shift.		0 ¹⁹⁹		
Question # 4	There is documentation that health care providers have been trained regarding emergency response. There is documentation of the last three emergency drills and one disaster drill, which delineates the events of the drill and identifies strengths and weaknesses.		0		
Question # 5	Interview nurses, physicians, nurse practitioners, physicians assistants, and dentists to ensure that all know how to properly operate the emergency equipment (O ₂ , Ambu bag, cardiac monitor, AED, etc.).				N/E
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:				

Write the youth's ID number in the top row:

State ID# →	1 9/11/07	2 9/4/07	3 9/3/07	4 9/13/07	5 9/21/07	6 9/12/07	7 8/22/07	8 9/18/07	9 9/19/07	10 9/17/04
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	0 ²⁰⁰	1 ²⁰¹	1	1	1	1	1	1	1
Screen # 3	1	1	1	0 ²⁰²	1	0 ²⁰³	1	1	1	0 ²⁰⁴
Screen # 4	1	1	1	1	1	0 ²⁰⁵	1	1	1	N/A
Screen # 5	1	0 ²⁰⁶	1	1	N/A	0 ²⁰⁷	1	1	1	N/A
Screen # 6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1	N/A	N/A
Screen # 7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1	N/A	N/A

- Screen # 1 The entry in the Urgent/Emergent Log is complete, legible, and there is a corresponding progress note in the health care record.
- Screen # 2 The nurse documented the date and time of the encounter and documented an assessment in SOAP format.
- Screen # 3 The nurse's subjective and objective evaluation was appropriate given the nature of the complaint (e.g., vital signs, SOB = peak flow meter, abdominal pain =abdominal assessment)
- Screen # 4 The nurse's assessment and plan were appropriate, including notification or referral to the clinician when clinically indicated.
- Screen # 5 If the nurse referred the youth to a clinician, the follow-up visit was timely and clinically appropriate.
- Screen # 6 For patients returning from the emergency room, nursing staff contacted the physician on-call to obtain follow-up orders.
- Screen # 7 If the youth was sent to an outside facility, the physician saw the youth the following business day.

Urgent/Emergent Care Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	10	
Screen # 2	10	0	10	9	
Screen # 3	10	0	10	7	
Screen # 4	10	1	9	8	
Screen # 5	10	2	8	6	
Screen # 6	10	9	1	1	
Screen # 7	10	9	1	1	
Total	70	21	49	42	Plus 1 of 4 applicable Questions

Compliance =81% (43 of 53 applicable Questions + Screens)

Outpatient Housing Unit

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy and procedure.				
Question #2	There is an Outpatient Housing Unit (OHU) log that lists all youth placed in the OHU in the past 180 days. The log contains youth name, I.D. number, reason for admission and admission and discharge dates.				
Question #3	There is a current, standardized nursing procedure manual in the OHU at all times.				
Question #4	There is in policy and actual practice a physician on call 24 hours per day, 7 days a week.				
Question #5	All youth placed in an OHU are within sight or sound of licensed health care staff at all times in accordance with policy				
	Totals:				

Select 10 to 20 health records of patients currently admitted or discharged from the OHU within the last 180 days Write the youth's ID number in the top row.

State ID# →	1	2	3	4	5	6	7	8	9	10
Placement date: →										
Discharge date: →										
Screen # 1										
Screen # 2										
Screen # 3										
Screen # 4										
Screen # 5										
Screen # 6										
Screen # 7										
Screen # 8										
Screen # 9										

- Screen #1 The clinician (MD, NP, PA, or psychologist) wrote or gave a verbal order to place the youth in the OHU.
- Screen #2 The clinician orders include the initial impression: diagnostic and therapeutic measures, the frequency of vital signs, and other monitoring (e.g., peak flow meter and capillary glucose measurements, etc.), and clinical criteria for notifying the physician (change in clinical status).
- Screen #3 The youth's clinical condition/reason for admission did not exceed the criteria for placement in the OHU.
- Screen #4 A nurse documented an appropriate initial assessment, plan of care, and patient education (including orientation to the OHU).
- Screen #5 The clinician performed and documented a clinical assessment on the next business day or sooner, if clinically indicated.

- Screen #6 Nursing assessments are documented at least once every shift, or more often if clinically indicated, and are pertinent to the admitting diagnosis (es).
- Screen #7 A clinician conducts clinically appropriate rounds that are documented in the UHR daily, Monday through Friday.
- Screen #8 The UHR reflects that the clinical and nursing plan of care was implemented (e.g., vital signs recorded, lab tests performed, medications administered, etc.).
- Screen #9 A physician and nursing discharge note was completed at the time of release from the OHU.

Outpatient Housing Unit Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1					
Screen # 2					
Screen # 3					
Screen # 4					
Screen # 5					
Screen # 6					
Screen # 7					
Screen # 8					
Screen # 9					
Total					

Compliance _____ % Questions + Screens

Stark does not have an Outpatient Housing Unit.

Health Records

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question # 1	Local policies are consistent with statewide policies and procedures, and address all aspects of health record management. (See Audit Tool Instructions.)			0 ²⁰⁸	
Question # 2	The Movement and Problem List is visible upon opening the UHR.			0 ²⁰⁹	
Question # 3	There is a functional tracking system for laboratory and x-ray results..	1			
Question # 4	The facility has a functional system for UHR accountability, filing, and retrieval.	1			
	For calculating score, only give credit for questions in substantial compliance.				
	Totals:				

Compliance = 50 % (2/4)

Preventive Services

Select 10 to 20 health records of youth who have been in DJJ over one year.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question #1	There is a policy and procedure regarding preventive services that is consistent with the US Preventive Services Task Force (USPSTF) and American Medical Association Guidelines for Adolescent Preventive Services (GAPS) in areas that are applicable to DJJ youth.			0	

Write the youth's ID number in the top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Screen # 3	1	1	1	1	1	1	1	1	0 ²¹⁰	1
Screen # 4	1	1	0 ²¹¹	1	0 ²¹²	0 ²¹³	1	0 ²¹⁴	1	1
Screen # 5	1	1	1	1	1	1	1	1	1	1
Screen # 6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Screen # 1 TB skin testing was performed annually. If previously positive, a nurse conducted a TB symptom screen.

Screen # 2 Annual pap smears were performed (at a minimum) beginning 3 years after initiation of sexual intercourse and 2 consecutive years thereafter. If there are 3 consecutive normal annual pap smears, then they are performed every 3 years thereafter. Management of abnormal pap smears was appropriate, including referral.

Screen # 3 A nurse measures the youth's blood pressure annually. The nurse refers youth with abnormal blood pressure to a clinician.

Screen # 4 A nurse measures the youth weight annually. Obesity is addressed if clinically indicated (BMI >24 %).

Screen # 5 Hepatitis A and B vaccinations are current, as applicable.

Screen # 6 Youth are offered Tetanus-Diphtheria Booster if not received within ten years.

Preventive Services Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	10	
Screen # 2	10	10	0	-	
Screen # 3	10	0	10	9	
Screen # 4	10	0	10	6	
Screen # 5	10	0	10	10	
Screen # 6	10	10	0	-	
Total	60	20	40	35	Plus 0 of 1 applicable Question

Compliance = 85% (35 of 41 applicable Questions + Screens)

Consultation and Specialty Services

Interview staff responsible for specialty service contracts and consultation tracking. Review the Consultation Tracking log. Select 10 health records from the facility of youth who received consultation services in the last 180 days.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local consultation policy and procedure that is consistent with the statewide policy.	1			
Question #2	The facility has implemented the outside specialty care log to include receipt of reports. Staff maintains it accurately and contemporaneously.		0 ²¹⁵		
Question #3	There is sufficient custody staffing and cooperation to transport youths to outside medical appointments.			0 ²¹⁶	
	For calculating score, only give credit for questions in substantial compliance.	Totals:			

Write the youth's ID number in top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	0 ²¹⁷	1	1	1	1	1	1	1	1
Screen # 3	1	1	1	1	1	1	1	1	1	1
Screen # 4	0 ²¹⁸	1	1	1	0 ²¹⁹	1	1	0 ²²⁰	1	1
Screen # 5	1	1	1	1	1	1	1	1	1	1
Screen # 6	0	1	1	1	1	0	1	1	1	1
Screen # 7	1	1	1	1	0	0	1	0	0	0
Screen # 8	N/A	1	1	1	0 ²²¹	0	0 ²²²	0 ²²³	1	0
Screen # 9	0 ²²⁴	1	1	1	0 ²²⁵	0	0 ²²⁶	0 ²²⁷	1	0 ²²⁸

- Screen # 1 The health record contained a Consultation Request Form. The clinician legibly documented the service requested, urgency (routine or urgent), and dated and signed the form.
- Screen # 2 The clinician legibly documented the history of the present illness, physical findings, and lab data that supports the rationale for the service on the Consultation Request Form.
- Screen # 3 The clinician legibly documented the medical history, physical and laboratory findings, and an assessment that supports the need for the consult in the Progress Notes.
- Screen # 4 The record reflects that the youth was seen by the consultant within the required time frames (90 days for routine, 10 ten days for urgent unless indicated sooner).
- Screen # 5 Upon the patient's return from the consultation appointment, the nurse reviewed the consultant's recommendations and addressed any urgent recommendations.
- Screen # 6 The clinician reviewed, dated, and initialed the consultation report within 3 business days of the youth's return to the facility or receipt of the report.
- Screen # 7 The UHR shows that the clinician met with the youth 5 business days (sooner if clinically indicated) to review results of the consult with the youth and develop a treatment plan.
- Screen # 8 The health record reflected that the consultant's recommendations were ordered and implemented, or a valid reason for **not** implementing the recommendations was documented (i.e., patient is out to court, refused, etc.). If the physician disagrees with the consultant's recommendations, an appropriate alternate plan of care was ordered and implemented.
- Screen # 9 The health record reflected that the clinician monitored the youth to ensure that the treatment plan was implemented and the desired clinical outcome was achieved, or the treatment plan was amended.

Consultation and Specialty Services Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	10	
Screen # 2	10	0	10	9	
Screen # 3	10	0	10	10	
Screen # 4	10	0	10	7	
Screen # 5	10	0	10	10	
Screen # 6	10	0	10	8	
Screen # 7	10	0	10	5	
Screen # 8	10	1	9	4	
Screen # 9	10	0	10	4	
Total	90	1	89	67	Plus 1 of 3 applicable Questions

Compliance = 74% (68 of 92 applicable Questions + Screens)

Peer Review

Review the local and statewide peer review policies and procedures, interview staff, inspect peer review file storage locations.

Review peer review files to ensure compliance with policy and the Health Care Remedial Plan.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question # 1	The local peer review policy and procedure, and actual practice are consistent with the statewide policy and procedure, NCCHC standards, and the Health Care Remedial Plan.			0	
Question # 2	The Statewide DJJ Medical Director, Health Care Director, or clinical service chief monitors the peer review process, which includes regular reporting from the facilities on peer review activities and regular quality management meetings at least annually.			0	
Question # 3	The CMO reviews sentinel events (unexpected hospitalizations, medical errors) and the Statewide Medical Director/Chief Psychiatrist reviews the reports of these investigations. The Statewide Medical Director/Chief Psychiatrist reviews all deaths.			0	
Question # 4	There is biannual peer review for MDs, PAs, and NPs at each facility. These files are marked "Peer Review" and kept in a secure location. There is documentation that findings have been shared with applicable staff		0 ²²⁹		
Question # 5	The peer review process includes a meaningful corrective and adverse action process up to, and including, suspending privileges for inappropriate care or unprofessional behavior.				N/A
	For calculating score, only give credit for questions in substantial compliance.				
	Totals:		1	3	1

Compliance = 0% (0 of 4 applicable Questions)

Credentialing

Review the local and statewide credentialing policies and procedures, interview staff, and inspect storage locations of credential files.

Review credentials files to ensure compliance with policy and the Remedial Plan.

Key: SC =Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	N/A
Question # 1	The local credential policies and procedures, and actual practice are consistent with statewide policies and procedures, NCHC standards, and the Health Care Remedial Plan.			0	
Question # 2	Credential files are stored in a locked cabinet with access limited to those with a legitimate need to know.	1			
Question # 3	Specific staff is assigned to maintain the credential files. Inspection shows that the files are current and well-maintained.	1			
Question # 4	Review all credential files. They contain the required elements of the Health Care Remedial Plan: a) Curriculum Vitae that includes relevant personal information; undergraduate, graduate, and postgraduate education b) Employment history and hospital appointments (including disciplinary action and loss of privileges) c) Academic appointments and society memberships, if applicable d) Copies of all current licenses, registrations, board certifications, and Drug Enforcement Agency (DEA) licenses e) Statement of physical and mental health f) Drug and alcohol dependence history, if any g) Results of National Practitioner Data Bank Inquiry h) Prior and current malpractice claims and judgments i) Prior professional liability coverage and current coverage for contractors, if not covered by State of California j) ECFMG certificate, if applicable k) Authorization for release of information for any information required to complete the application process, including confidential material l) Three references		0 ²³⁰		
Question # 5	Review of credentialing process listed in question #4 reveals no substantial problems or concerns regarding the clinician's mental fitness, clinical competence, or moral character.				N/A
Question # 6	Recredentialing occurs bi-annually. All files are current.	1			
Question # 7	Physicians, nurse practitioners, and physician assistants do not begin work until the credentialing process is completed. Under extenuating circumstances, temporary privileges may be granted until the credentialing process is completed, not to exceed 3 months.	1			
Question # 8	Physicians or nurse practitioners treating chronically ill youth are board certified or eligible in a primary care-related field.	1			
Question # 9	Physicians treating HIV infected youth are board certified in infectious diseases (ID) or have completed a primary care residency with additional HIV related training, and are experienced in the treatment of HIV patients. If no facility clinician meets this requirement, ID consultants are used.	1			
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	6	1	1	1

Compliance = 75% (6 of 8 applicable Questions)

Quality Management

Review the local and statewide Quality Management Program policy and procedure. Review the composition of the QM Committee and meeting minutes. Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question # 1	There is a local policy and procedure that is consistent with the statewide policy and procedure.	1			
Question # 2	The facility has a Quality Management (QM) Committee that meets quarterly or more often as needed, as determined by Statewide policy.		0 ²³¹		
Question # 3	The composition of the institutional QM Committee meetings meets policy requirements.	1			
Question # 4	Minutes of the QM Committee are available for review.	1			
Question # 5	QM studies for the previous 2 quarters from the date of the last audit are available for review.				N/E
Question # 6	The reasons for the QM studies performed by the facility are specified on the tools or in meeting minutes, and are related to suspected problems identified by staff, Health Care Service audits, Superintendents, and youth, etc. (high risk, high volume, problem prone aspects of care).	1			
Question # 7	The most recent Corrective Action Plan (CAP) developed as part of a QM study is reviewed for the following: Enter date of CAP reviewed: _____	Y	N	NA	N/E
	a) The CAP identified specific improvements needed.				
	b) The CAP identified specific staff members responsible for improvements.				
	c) The CAP had a targeted completion date.				
	d) There was documentation to indicate any recommended training was held.				
	e) Follow-up studies were done to determine whether or not corrective actions solved the problem or issue.				
Question # 8	Physician Chart Reviews: a) There will be quarterly review of nursing sick call records based upon criteria developed by the QM Committee (a minimum of 5 records per nurse performing sick call) b) Outpatient Housing Unit: 10% or 10 records/ quarter. Findings are addressed at QM meetings.			0	
Question # 9	The Supervising Nurse reviews 10 records monthly of each nurse who conducts nursing sick call, urgent care, or outpatient housing unit care. There is documentation that findings from chart reviews have been discussed with the applicable staff members. As performance improves, reviews may be performed quarterly.			0	
Question # 10	On at least an annual basis, the Chief Medical Officer develops a Quality Management report for the Statewide Medical Director that focuses on high risk, problem prone aspects of patient care; identifies deficiencies; makes recommendations for improvements; and provides direction for quality improvement activities.			0	
For calculating score, only give credit for applicable questions in substantial compliance.					
Totals:		4	1	3	2

Compliance = 50% (4 of 8 applicable Questions)

Total Number of Questions and Screens Evaluated	=	657
Total Number of Questions and Screens in Substantial Compliance	=	421
Total Score	=	64%

¹ The Correctional Health Care Administrator position is allocated to Stark but occupied by a position in headquarters. Staff report there is no nursing pay parity.

² In practice the CMO is not in control of the health care budget. He has not been given a budget.

³ 1 CMO, 3 Physicians and Surgeon positions and 1 Nurse Practitioner. All positions filled. 2 physician board certified in family practice and one is not.

⁴ The SRN III believes he does not have enough nurse staffing to meet the health care policies and procedures.

⁵ There are 5 MTA positions, 4 of which are filled.

⁶ The YCC's do not provide consistent custody escorts for medications on Unit 1 lower level which is a mental health unit. There are currently custody staff dedicated for the purposes of medical escorts, but staff are concerned that because these are not dedicated posts that it is a fragile arrangement.

⁷ The licensure tracking log was not current. There were several nurses whose licenses were listed as having expired earlier in the year.

⁸ Dr. Close indicates that there is no documentation of physician orientation in the files.

⁹ TDO's were officially distributed in October 2007, thus 60 days for training is not yet expired.

¹⁰ In English only.

¹¹ In English only.

¹² []Identity removed. Paroled on 7/27/07 and returned on 9/11/07. Log states he arrived on 9/18/07.

¹³ []Identity removed. Paroled on 6/8/05 and returned on 10/2/07. The log states he arrived on 10/5/07.

¹⁴ []Identity removed. Paroled on 7/12/07 and returned on 10/2/07. The log states he arrived on 10/5/07.

¹⁵ []Identity removed. Paroled on 6/11/07 and returned on 7/31/07. This 22 y.o. patient has a history of hypertension and hyperthyroidism, perforated right tympanic membrane and ? pericarditis. On 7/31/07 the nurse screened the youth whose blood pressure (155/89) and pulse (108) were elevated, and referred the patient to a clinician who saw him the following day. The patient complained of weight loss and the clinician noted the patient's TSH was 0.06 in March 07. The clinician ordered am and pm pulse checks. We find no record of this. No labs were ordered at that time, and an intake history and physical examination was not performed. On 8/2/07 a physician saw the patient for complaints of chest pain, shortness of breath, and tachycardia. He noted that while the youth was on parole he was not taking his medications. The patient's pulse was 119 and BP 142/86 mm/hg. The physician sent the youth to the ER. I find no ER report in the record. The youth returned later that evening and the physician ordered stat TSH and T4. On 8/3 the nurse documented noncompliance counseling and planned to refer the patient to a clinician. I do not find an MAR for the month of August. On 8/3 the results were reported as abnormal (22 and 7.97). On 8/7/07 a clinician documented that the patient was not brought to the clinic to be evaluated for the abnormal labs, and

documented that the patient must come the following day. On 8/8/07 visit took place and the clinician learned the patient was going to be paroled the next day. This youth did not receive a timely and appropriate medical evaluation.

¹⁶ []Identity removed. This 21 y.o. youth paroled on 9/20/06 and returned on 9/20/07. His medical history included hypertension and asthma and he was taking Lisinopril and Albuterol inhaler. Upon arrival a nurse completed a receiving screening form. The patient's blood pressure was 165/95 and pulse was 99 beats/minute. The patient was morbidly obese 395 lbs. His medications were not renewed until 9/21/07 at 1320. He did not receive a medical reception physical examination. Labs were obtained and he tested positive for Chlamydia infection.

¹⁷ []Identity removed. This 24 y.o. was paroled on 2/28/07 and returned on 8/27/07.

¹⁸ []Identity removed. This 20 y.o. was paroled on 4/27/07 and returned on 10/2/07. Last PE was 2003. Upon arrival a nurse completed a receiving screening form. His medical history included TB infection, Lactose intolerance, fracture of his left foot in 3/07 and substance abuse.

¹⁹ []Identity removed. This 19 y.o. paroled on 4/2/07 and returned on 8/14/07. His medical history included asthma and mental health treatment and he was taking Wellbutrin.

²⁰ []Identity removed. This 23 y.o. paroled 8/25/05 and returned on 10/10/07. His medical history included hypertension and conjunctivitis. He was taking medications in the jail but the names of the medications were not listed. His blood pressure was 145/87 and pulse 96.

²¹ []Identity removed. This 24 y.o. paroled in February 2005 and returned on 9/18/07. His medical history included essential tremors for which he was treated with Atenolol. His receiving screening and SPAR form were dated 9/19/07.

²² Listed on the log as arriving 9/18 along with another youth but receiving form not completed until 9/19/07 at 1030.

²³ The physician did not order his antihypertensive and asthma medications for 24 hours after arrival.

²⁴ The nurse did not call the jail to find out what medications the patient was taking.

²⁵ Visual acuity not measured upon arrival. Most recent VA is 2005.

²⁶ Visual acuity not measured upon arrival. Most recent VA is 2002.

²⁷ Visual acuity not measured upon arrival. Most recent VA is 2004. Psych tech incorrectly documented that the youth refused influenza when it was actually administered.

²⁸ No TB skin test or visual acuity is documented. Last PE was 2000.

²⁹ No visual acuity.

³⁰ No visual acuity.

³¹ No TB skin test.

³² No TB skin test or visual acuity is documented.

-
- ³³ Patient refused to come to the clinic for evaluation following positive Chlamydia test. Treatment was initiated without documentation that the patient was informed of his diagnosis. Recommend that clinicians go to the satellite clinics and have youth escorted to the satellite clinic.
- ³⁴ Routine lab tests were performed and results available on 8/2/07. The patient's Thyroxine was abnormally increased to 22 (normal 4.5-10.9) and T3 is 7.97 (normal 0.0 and 1.81) as the patient had been refusing his medication. A clinician did not initial the lab report as being reviewed, however there is a progress acknowledging the abnormal lab on 8/8/07. The youth was leaving the following morning. This abnormal lab report was not addressed in a timely manner.
- ³⁵ No documentation that youth was counseled regarding test results.
- ³⁶ Clinician did not document discussion of possible HCV infection and recommend testing.
- ³⁷ Patient's glucose was 137. Unclear whether it was fasting. Not addressed.
- ³⁸ No Chlamydia or GC urine screen is found in the record.
- ³⁹ Health record documentation is unclear that patient was provided HIV post-test counseling.
- ⁴⁰ Health record documentation is unclear that patient was provided HIV post-test counseling.
- ⁴¹ Health record documentation is unclear that patient was provided HIV post-test counseling.
- ⁴² Health record documentation is unclear that patient was provided HIV post-test counseling.
- ⁴³ History and physical not completed until 10/25/07, 6 weeks after arrival.
- ⁴⁴ The nurse initiated the medical history, but the physical examination is not completed. The PE form is unsigned and undated.
- ⁴⁵ The nurse initiated the medical history, but the physical examination is not completed. It is unsigned and undated. Most recent PE is 2004.
- ⁴⁶ Performed on day 8.
- ⁴⁷ Medical reception history and physical examination not performed until 10/11/07 (Arrived 8/14/07).
- ⁴⁸ Medical reception history and physical examination not performed until 10/25/07 (Arrived 10/10/07).
- ⁴⁹ Medical reception history and physical examination not performed until 10/11/07 (Arrived 9/19/07).
- ⁵⁰ Chlamydia infection not listed on the Problem List. Patient is at risk for other STD's.
- ⁵¹ Chlamydia infection not listed on the Problem List. Patient is at risk for other STD's.
- ⁵² Chlamydia infection not listed on the Problem List. Patient is at risk for other STD's.
- ⁵³ Cannot locate Problem List.
- ⁵⁴ Cannot locate Problem List.
- ⁵⁵ Physician did not note fractured left foot in 3/07 or elevated liver function tests.
- ⁵⁶ Does not include mental health diagnosis.
- ⁵⁷ Hypertension not listed.

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- ⁵⁸ Physician documented “post-counseling” but it is unclear what this refers to and does not specify patient education regarding notification of HIV test results, risk of STD’s and harm reduction.
- ⁵⁹ FNP documented notification, treatment and counseling for STD.
- ⁶⁰ No intake treatment plan was documented.
- ⁶¹ Consider recommending hepatitis C antibody test.
- ⁶² Ordered pulse checks were not documented in the record.
- ⁶³ No MAR documentation that he received his Advair inhaler ordered 8/14/07 or that lab test result counseling was performed.
- ⁶⁴ Upon arrival, there was no order enrolling the patient into the chronic disease management program.
- ⁶⁵ Upon arrival, there was no physician order enrolling the patient into the chronic disease management program.
- ⁶⁶ Upon arrival, there was no physician order enrolling the patient into the chronic disease management program. Patient has not had physician baseline evaluation (only initial PE).
- ⁶⁷ Upon arrival, there was no physician order enrolling the patient into the chronic disease management program.
- ⁶⁸ The intrasystem transfer log has been in effect since June 2007. The log has been more consistently filled out in the last 60 days.
- ⁶⁹ []Identity removed arrived on 7/24/07.
- ⁷⁰ []Identity removed.
- ⁷¹ []Identity removed.
- ⁷² []Identity removed.
- ⁷³ []Identity removed.
- ⁷⁴ []Identity removed.
- ⁷⁵ []Identity removed.
- ⁷⁶ []Identity removed.
- ⁷⁷ []Identity removed.
- ⁷⁸ []Identity removed.
- ⁷⁹ Both top and bottom form completed by receiving institution. No documentation of notification of DWN SRN.
- ⁸⁰ The nurse did not document an assessment, plan or that written and verbal access to care instructions were given.
- ⁸¹ This mental health patient was sent out to Metro in January 2007 and returned to HGSYCF on 6/22/07. There is no documentation in the record that an intrasystem transfer form was completed. We discussed this with health care staff who found loose filing but was unable to locate the form. On 6/23/07 the patient attempted suicide and was sent to an outside hospital. It is unclear from the record when he returned, and the next note is an intrasystem transfer form from the CTC to HGSYCF.

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- ⁸² The patient has hepatitis C. The nurse did not document a plan to refer the patient to the physician or into the chronic disease program. However, the patient was seen on 7/27/07. This is primarily a documentation issue.
- ⁸³ Receiving nurse did not completely fill out the intrasystem transfer form. Form lacked an assessment, and referral of this asthmatic patient treated with an inhaler to a physician and the chronic disease program.
- ⁸⁴ The patient's blood pressure upon arrival was 180/90 mm/hg. The nurse did not note this and document a referral to the physician.
- ⁸⁵ No physician signature.
- ⁸⁶ Physician review took place 6 days after arrival.
- ⁸⁷ Form signed but undated.
- ⁸⁸ The physician signed the form within one business day of arrival but did not address the patient's history of "heart problems in 2004 x one year due to stress, treated at Kaiser Valejo, CA. A psychiatrist note indicates he was hospitalized for evaluation of his cardiac condition. At a minimum the physician should have interviewed and assessed the patient to determine the need for previous medical records.
- ⁸⁹ This tested positive for hepatitis C in April 2006 and had elevated LFT's. On 7/31/07 he tested hepatitis C antibody negative and has normal LFT's. On 8/14/07 the physician ordered a repeat HCV antibody test and viral load. This test was never completed. It is unclear what the patient has been told about his hepatitis C status. Discussed with CMO.
- ⁹⁰ No documentation of physician signature signifying review of the form.
- ⁹¹ No documentation of physician signature signifying review of the form.
- ⁹² Physician review took place 11 days after arrival.
- ⁹³ A nurse evaluated the patient for asthma on the day of arrival. This patient has a history of asthma and is not currently being treated, but should have been referred to physician for evaluation as to whether or not he should have been enrolled in the chronic disease program.
- ⁹⁴ Nurse scheduled physician to see youth with history of migraine headaches on 8/7/07 but youth was not seen until 8/14/07.
- ⁹⁵ Patient arrived on 7/10 but Seroquel not reordered until 7/12/07. MAR date of order shown as 7/14/07. MAR's show patient did not receive medication from 7/10-7/16.
- ⁹⁶ Patient was taking Tetracycline and Retin A gel ordered on 7/24/07 for 30 days. The medications were not continued following his arrival at the facility.
- ⁹⁷ In Unit 2, the unit manager reported they 'preferred' that CO's not nurses provide nursing sick call forms to youth. Upon further clarification, the unit manager indicated that there would be no objection to nurses' providing forms, however this is not the usual course of action.
- ⁹⁸ The satellite medical clinics are not clean. Staff report they are not satisfied with the contract janitorial service.

⁹⁹ []Identity removed. 22 y.o. submitted a HSRF dated 9/17/07. Patient complained: I'm in pain! "left leg/back problems, Help me Please" Documented as received and reviewed on Saturday, 9/22/07 at 1900. The nurse referred patient to NP who did not see the patient but verbally ordered Motrin 600 mg bid x 3 days. The nurse saw the patient on 9/25/07. He reported 9/10 pain. No vital signs or PE. Nurse referred patient urgently to clinician.

¹⁰⁰ []Identity removed. Submitted HSRF dated 10/12/07 complaining of swollen tonsils and allergies acting up.

¹⁰¹ []Identity removed. Submitted a HSRF dated 9/20/07 complaining of body pains and needing to see dental.

¹⁰² []Identity removed. Submitted an undated HSRF complaining of blood in his stool.

¹⁰³ []Identity removed. This 19 y.o. HIV positive youth submitted a HSRF dated 10/25/07 complaining of a rash on his shoulder and chest.

¹⁰⁴ The nurse did not sign or date triage of this request.

¹⁰⁵ Unable to evaluate because the youth did not date the form.

¹⁰⁶ Documentation is unclear that the nurse saw the patient versus paper triage.

¹⁰⁷ Unable to evaluate.

¹⁰⁸ No history of onset of leg pain, quality, duration, etc.

¹⁰⁹ No history of duration of symptoms, presence or absence of associated symptoms such as itchy eyes, rhinorrhea, cough, etc.

¹¹⁰ No documentation of the onset or duration of symptoms.

¹¹¹ No documentation of the onset, duration or associated symptoms such as abdominal pain.

¹¹² The nurse did not obtain a history of the rash, onset, (associated with medications).

¹¹³ No vital signs or examination of the back and leg.

¹¹⁴ The nurse did not take vital signs, examine the eyes, ears, nose and throat or listen to the patient's chest.

¹¹⁵ The nurse did not perform an abdominal exam in a patient complaining of nausea and abdominal 'ache'.

¹¹⁶ The nurse did not take vital signs, or examine the patient. Only noted 'pale lips'.

¹¹⁷ The nurse obtained partial vital signs, examined only the chest and not other areas of the body.

¹¹⁸ The nurse's assessment was alteration in comfort related to pain, which is an incomplete identification of the cause of the pain which was allergic in nature.

¹¹⁹ The nurse's assessment was pain, which does not accurately describe the patient's symptoms.

¹²⁰ No assessment documented.

¹²¹ No assessment was documented.

¹²² The nurse should have called a physician for a patient complaining of nausea, abdominal pain and inability to sleep, but routinely referred the patient.

¹²³ No signature.

-
- ¹²⁴ Nurse did not sign or date the form.
- ¹²⁵ Nurse did not sign or date the form
- ¹²⁶ The referral did not occur until 9/25/07.
- ¹²⁷ The urgent referral did not occur for 4 days.
- ¹²⁸ Inadequate history, i.e., no history related to location, severity, radiation, exacerbating/alleviating factors, etc.; PE does not mention +/- rebound or palpation for liver, spleen
- ¹²⁹ MD noted patient involved in altercation. No history related to location of injuries, pain, loss of consciousness, problems with vision, etc.
- ¹³⁰ MD noted that patient complained of feeling short of breath following running the week before. No further history.
- ¹³¹ No temperature or respiratory rate
- ¹³² PE does not mention +/- rebound or palpation for liver, spleen
- ¹³³ Consultative note – should have noted +/- tenderness
- ¹³⁴ MD did not note possible nasal or orbital fractures
- ¹³⁵ MD did not order follow-up
- ¹³⁶ Ordered follow-up with MD did not occur.
- ¹³⁷ Ordered follow-up in eye clinic for 7/30 did not occur until 10/1.
- ¹³⁸ Follow-up ordered in 2 days did not occur. Nasal x-ray did not occur until 8/8. It revealed a fracture, but there has not been any follow-up since return of x-ray results, X-ray of the orbit was also ordered, but not done. This case was referred to Dr. Close for follow-up.
- ¹³⁹ Ordered follow-up did not occur.
- ¹⁴⁰ Patient had seen nurse 10/22 and stated that he thought that symptoms could be due to allergies and that his asthma had been bothering him. MD did not obtain any history related to allergies or asthma.
- ¹⁴¹ MD did not examine lungs.
- ¹⁴² Ordered pepcid for 2 weeks, without documented clinical rationale.
- ¹⁴³ MD should have ordered urgent x-ray to rule out fracture and timelier follow-up
- ¹⁴⁴ The MD noted that he submitted referrals for laboratory and x-ray studies. There are no orders or referral slips in the medical records. The studies were not performed.
- ¹⁴⁵ X-ray ordered to rule out fracture not done until 8/6
- ¹⁴⁶ The MD ordered an oncology consult within one week. As of 10/31, it had not occurred.
- ¹⁴⁷ The patient is on the chronic care roster for hyperthyroidism. He has never been seen by a medical doctor for this problem. In fact, he is being treated with synthroid by a psychiatrist for possible hypothyroidism related to lithium. The only thyroid studies

I saw in the medical record were done on 8/29 and revealed a high TSH, indicating that he required a higher dose of synthroid. The psychiatrist had ordered repeat thyroid studies on 9/2 but they were not done. This case was referred to Dr. Close.

¹⁴⁸ No documentation of initial visit

¹⁴⁹ No documentation of initial visit

¹⁵⁰ Inadequate initial history, i.e., no family history or appropriate review of symptoms

¹⁵¹ No physical examination

¹⁵² No documentation of initial visit

¹⁵³ Patient is not being seen for chronic care.

¹⁵⁴ Patient is not being followed for his asthma.

¹⁵⁵ Seen 9/27 for chronic care, but MD did not address patient's hypertension.

¹⁵⁶ MD noted that patient had no current symptoms, but did not assess degree of control

¹⁵⁷ Follow-up ordered in 4 months

¹⁵⁸ No follow-up ordered

¹⁵⁹ Ordered follow-up in 3 months but repeat labs in 4 months

¹⁶⁰ Received flu vaccine, but no pneumococcal vaccine.(asthma)

¹⁶¹ No flu vaccine (diabetes)

¹⁶² No flu or pneumococcal vaccine (asthma)

¹⁶³ No flu or pneumococcal vaccine (asthma)

¹⁶⁴ No pneumococcal vaccine (asthma)

¹⁶⁵ There is a registered nurse who is designated as the infection control nurse but he has been provided no formal training. He believes he could benefit from additional training.

¹⁶⁶ A schedule of sanitation activities has not been developed and implemented. The environmental and sanitation policy does not require monthly sanitation inspections.

¹⁶⁷ Computer software does not identify drug-drug interactions. Pharmacist states that although computer does not track inventory, the vendor conducts an annual inventory.

¹⁶⁸ Medication Documeds provide strict medication accountability.

¹⁶⁹ Uses Walgreen's pharmacy for emergencies.

¹⁷⁰ Satellite medication rooms were not clean. Staff reported that the janitorial contractor is not meeting expectations.

¹⁷¹ Record of Inventory Count Logs show that needle and syringe control was maintained and checked on most units, however on Unit 1 lower level there was a gap from 9/2/07 until 10/17. Logs show that on Unit II, needle and syringe count logs were not accurate. Our count showed 8 3 cc 25 gauge needles and 9 3 cc 22 gauge needles.

172 YCC's do not provide consistent custody escorts and supervision on Unit 1 lower level
173 Currently his medications are ordered for 2000 meaning that medications may be given as early as 1900.
174 The medication was preprepared prior to the arrival of the monitor.
175 []Identity removed 9/7/07 order to continue Lexapro 20 mg daily and Melatonin 3 mg po for 30 days.
176 []Identity removed 9/25/07 order for Robaxin 500 mg po bid x 14 days and Neurontin 300 mg po bid x 30 days.
177 []Identity removed. 9/14/07 Vistaril order. Unable to locate progress note or MAR. Youth now out to court?
178 []Identity removed.
179 []Identity removed. 24 y.o. Insulin Dependent Diabetic 7/2/07 order for insulin.
180 []Identity removed. 23 y.o. with hypertension. 9/13/07 order for Dyazide.
181 []Identity removed. Mental Health patient on multiple medications. 8/21/07 order.
182 []Identity removed. Mental health patient. 9/5/07 order.
183 Viread dosage was incorrect: It read 30 mg versus 300 mg.
184 Physician ordered insulin per sliding scale, but it was not documented in the record.
185 Order for Lithium, Atarax, Wellbutrin on 8/21/07. Route of administration not documented.
186 Psychiatrist did not document a progress note.
187 Neurontin is not approved for the treatment of acute back pain.
188 No mental health progress note found.
189 No clinical note, just medication renewal.
190 No clinical note found.
191 No clinical note found.
192 Verbal order not transcribed.
193 MAR not in the record.
194 Pharmacy documented appropriate dose.
195 Verbal order not transcribed.
196 MAR's are confusing. There are 3 MAR's that appear to be related to August. The date at the top of the MAR is obliterated
and it is difficult to tell what month is involved.
197 Administration status not documented for 9/13 Lexapro and 9/18/07 Lexapro and Melatonin.
198 Portions of the MAR order were defaced.
199 There were lapses in checking compliance in the emergency logs from 9/2/07 until 10/17/07 in Unit .
200 Progress note did not include assessment or plan; on a consultative note, history was in objective section
201 Consultative note – history is in objective section

²⁰² Inadequate history and physical exam for chest pain, i.e., did not palpate chest for tenderness, did not ask if pain affected by movement or respiration; on a consultative note – subjective data was in objective section

²⁰³ RN did not obtain vital signs

²⁰⁴ Patient complaining of nausea and vomiting. RN did not obtain history related to pain and did not examine abdomen.

²⁰⁵ Patient with swollen, painful ear, pain rated at 10/10; Did not consult with MD and did not order pain meds

²⁰⁶ MD saw patient on day of injury. Did not document adequate exam to rule out orbital fracture. MD ordered follow-up in 2 days but did not see again until 13 days later.

²⁰⁷ Treated for cellulitis with keflex and sepra; 2 antibiotics not indicated. This case was discussed with Dr. Close.

²⁰⁸ There is no local policy.

²⁰⁹ In the majority of records reviewed, the Problem List was not visible when the record was opened.

²¹⁰ On 9/24/07 patient was evaluated following suicide attempt. Blood pressure was 160/90. Blood pressure was not re-checked. Prior blood pressure was 140/85 on 4/2/07.

²¹¹ BMI 25.8 and weight not addressed

²¹² BMI 30.7 and weight not addressed

²¹³ BMI 26,7 and weight not addressed

²¹⁴ BMI 28.5 and weight not addressed

²¹⁵ Staff is using the log. However, only reports from procedures or studies are being tracked. Receipt of consultation reports is not tracked. In addition, follow-up of missing reports does not consistently occurring. (89851 had head CT scan on 9/19 and 89851 had ultrasound on 9/19 and no reports as of 11/1)

²¹⁶ Staff reported that scheduled appointments were often cancelled due to lack of transportation

²¹⁷ MD did not document that x-ray revealed a fracture

²¹⁸ Consult ordered 7/10 on urgent basis, not seen until 9/19

²¹⁹ Cardiology consult ordered on 8/1 for one week. Not seen until 9/13.

²²⁰ Referred to orthopedics on 8/22 for evaluation and treatment of hand fracture on 8/19. Requested appointment within one week. Not seen until 9/17.

²²¹ Cardiologist recommended echo and f/u in one month. MD ordered follow-up but did not order echocardiogram. Echo not ordered until 10/22.

²²² Consultant recommended blood test. DJJ clinician did not order it.

²²³ Consultant recommended PT/OT. Not ordered. Discussed with Dr. Close.

²²⁴ DJJ MD ordered follow-up in one month. This did not occur.

²²⁵ Patient submitted sick call request on 10/19 requesting echocardiogram.

²²⁶ No follow-up since medication changed following consult on 9/12 despite patient requesting to be seen for follow-up on 10/2.

²²⁷ Patient seen on 9/25 by physician in response to grievance stating that he could not move finger and it hurt. Physician ordered repeat x-ray and ortho consult, but did not order PT/OT. MD also ordered follow-up in clinic in 2 weeks but has not occurred as of 10/31.

²²⁸ Youth re-injured hand 9/17. Emergent consult ordered on 10/2 that was scheduled for 11/19. Physician has not seen youth since consult requested. This was discussed with Dr. Close.

²²⁹ The peer review process has just begun.

²³⁰ There were no credentialing files for 2 of the physicians (one of whom was recently hired).

²³¹ The quality management program has recently been implemented and there has only been one meeting.

**CALIFORNIA DEPARTMENT OF
CORRECTIONS
AND REHABILITATION
DIVISION OF JUVENILE JUSTICE**

**Southern Youth Correctional Reception Center
and Clinic
Health Care Audit
January 29-January 31, 2008**

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Introduction

The Health Care Remedial Plan (HCRP) requires the Division of Juvenile Justice (DJJ) to make a number of specific changes in the medical, mental health, and dental care programs. To measure DJJ compliance with the requirements of the Health Care Remedial Plan, the Medical Experts developed this audit instrument with clearly defined standards and criteria, and thresholds of compliance. The audit instrument is comprised of indicators selected from:

- The Health Care Remedial Plan
- DJJ policies and procedures developed in consultation with the Medical Experts
- National Commission on Correctional Health Care (NCCCHC) Standards for Health Services in Juvenile Detention and Confinement Facilities, 2004 Edition
- The American Medical Association's Guidelines for Adolescent Preventive Services (GAPS)
- US Preventive Services Task Force (USPSTF)
- Guidelines for the evaluation and treatment of other disease such as those published by the Centers for Disease Control and Prevention (CDC)

Regarding those areas related to nursing and medical care practice, the Medical Experts will use their professional judgment to assess compliance.

NOTE: This audit instrument does not address mental health. The Mental Health Experts will develop the Mental Health Audit Instrument.

Audit Instrument and Compliance Thresholds

The audit instrument will be used by the Medical Experts to evaluate compliance with the HCRP. It is also intended for use by the DJJ Office of Health Services Quality Management Team and by the local facility Quality Management Team to evaluate progress consistent with the HCRP. The audit instrument includes indicators from sources cited above, which the Medical Experts judge to be critical in establishing an adequate health care system. Some indicators allow for partial compliance if the facility is close to, but has not yet achieved substantial compliance.

The Medical Experts have developed a companion document to the audit instrument entitled *Health Care Audit Instrument Instructions*. Its purpose is to clarify interpretations and scoring of the audit instrument. This document is available on request.

A facility is in substantial compliance when all of the following conditions are satisfied:

- a. The facility receives a score of 85% or higher during an audit conducted by the Court experts. When determining overall compliance, areas that are determined to be in partial compliance will be considered non-compliant. The experts shall have the discretion to find a facility providing adequate medical care in compliance if it achieves a score of no less than 75%.

- b. Medical assessments and treatment plans provided to youth comply with the policies and procedures, as determined by the medical experts. The medical assessment and treatment plans provided to the youth shall be deemed adequate and appropriate under these policies and procedures, only under any one of the following conditions:

- (1) The assessment or treatment plan is consistent with guidelines specifically adopted in the policies and procedures; or

- (2) The practitioner documents in the medical notes that he/she is deviating from adopted policies and procedures, and that such deviation is consistent with the community standard; or

- (3) Where no treatment guidelines are specifically adopted in these policies and procedures, the assessment or plan is consistent with the community standard.

- c. The facility is conducting minimally adequate death reviews and quality management proceedings.
- d. The facility has tracking, scheduling, and medication administration systems adequately in place.
- e. Both experts have concluded that there is not a pattern or practice that is likely to result in serious violations of wards' rights that is not being adequately addressed.

Southern Youth Correctional Reception Center and Clinic

Executive Summary

Overall, the facility scored 72% (500 of 693 indicators). The facility population at the time of our visit was 202 youth in 5 housing units. In addition to the main clinic areas, there are two satellite nursing stations, one in the Marshall Intensive Treatment Program (ITP) and a clinic in Drake for youthful offenders. Youth housed in Drake are brought to the main medical unit on Tuesdays for medical services. The Outpatient Housing Unit (OHU) currently uses five beds for medical/mental health purposes. SYCRCC provides infirmary services for the population of Heman G. Stark YCF. We would particularly like to thank Ms. Sharon Brooks, Health Care Administrator, for the assistance she provided us during the review.

Summary of Health Care Areas Reviewed

- **Facility, Leadership, Budget, Staffing, Orientation and Training scored 43%.** All key leadership positions are filled at SYCRCC. Staff reported that they did not have an institutional table of organization. An area of concern was that health care leadership did not have a complete set of health services policies (24 out of 32). Some local policies had been developed but were missing sections from the statewide policy and had numerous typographical errors. Thus staff has not been properly trained in health care policies and procedures. Although it was reported to us that the Chief Medical Officer was provided a health care budget, it is unclear to the medical experts that this is a functional budget. Staff reported that they have been given budget figures, but that the facility does not actually have the dedicated funds, and health care invoices are paid from a general fund.

Although there has been improved cooperation between medical and custody staff, staff reported that youth are not being consistently escorted to the medical unit, particularly when in temporary detention. Finally, although a formal staffing assessment was not conducted during this visit, we note that staff continues to be added to the facility despite the decreasing population. For example, with respect to clinical staffing, there is a Chief Medical Officer and nurse practitioner. Yet recently a full time physician was hired. Moreover, the facility has a Chief Dentist and 2 full-time dentists. At the time of our visit, the facility was interviewing candidates for a 4th dentist. In the face of the current state budget crisis, we recommend that DJJ re-evaluate staffing needs before hiring new staff.

- **Medical Reception scored 63%.** From the period of October-December 2007, the facility averaged 35 new arrivals per month. The staff uses the Medical Reception Tracking Log but it is not consistently filled out. The medical reception screening is not conducted in a manner that ensures visual and auditory privacy. Youth are not provided accurate written orientation materials. Review of medical records show that clinicians who perform the reception history and physical examination do not consistently obtain thorough histories and perform pertinent physical examinations. For example, a clinician did not document an adequate examination of the neck of a patient who reported a history of a neck mass that was potentially malignant. Moreover, in such cases previous medical records should have been requested. Clinicians

also do not complete accurate and complete Problem Lists and develop a treatment plan for each active problem. In our view, the history and physical examination form contributes to these problems.¹ Clinicians should also address known risk factors (obesity, tobacco, and substance abuse).

- **Intrasystem Transfer scored 59%.** The facility receives very few transfers. From the period of June to December 2007 the facility averaged 3.5 transfers per month. We requested 12 records but only 4 were available for review. In general the process is occurring in a timely manner. The nurses did not consistently complete all aspects of the form and clinicians do not sign the transfer form indicating that they have reviewed the form and the record for pertinent medical problems requiring follow-up. Youth eligible for the chronic disease management were not referred for enrollment.
- **Nursing Sick Call scored 60%.** The room where nurses conduct sick call in the main clinic is not properly equipped (no otoscope or ophthalmoscope). Youth health service requests are generally being collected and triaged in a timely manner, except for dental requests. Nurses forward all requests for dental services, including youth complaining of dental pain directly to the dentist without first seeing the youth. We found instances of requests not being triaged by a dentist in a timely manner, despite having 3 dentists at the facility. In one case, a youth complaining of pain was not seen for six days after he submitted his complaint². Areas requiring improvement include development of local policy, performance of nursing sick call in clinical areas with privacy, training of nursing staff regarding health assessment skills and nursing protocols, and a system for ongoing peer review and feedback to assist nurses in improving their assessment skills.
- **Medical Care scored 69%.** Areas requiring improvement include the documentation of the medical history, pertinent physical and laboratory findings, and the plan (follow-up).
- **Chronic Disease Management scored 51%.** Not all patients with chronic problems were on the chronic disease log, including 2 patients with thyroid disease. Other areas requiring improvement include the initial and periodic history, the assessment, and vaccinations. We also found that the providers need additional training on the treatment of asthma. Numerous patients had histories of using their inhalers on a daily basis and were not prescribed inhaled steroids. While some of these patients may not be using their inhalers correctly, and, in fact, may not require inhaled steroids, it is an indication that the providers are either not either treating appropriately or are not providing appropriate education.
- **Infection Control scored 63%.** The infection control program is in development. Staff currently is not submitting case reports to the health department as required by local, state or federal laws. Areas requiring improvement include provision of training to the infection control nurse, conducting infection control meetings a minimum of quarterly, and addressing key infection control indicators. As the program develops, staff should focus on data showing trends that health care staff should address (e.g. positive culture reports, % of TB skin test conversions, % of youth completing hepatitis vaccinations, etc.).
- **Pharmacy Services scored 100%. Congratulations!**

- **Medication Administration Process scored 75%.** In the main clinic, the medication room has old cabinets in disrepair with broken drawers and locks. Narcotic keys were kept in an unlocked drawer. The cabinetry and locks in this room should be replaced. An inspection of the medication cart showed that nurses pre-poured medications and did not document administration status on the MAR at the time of administration status³.
- **Medication Administration Health Record review scored 88%.** Congratulations! Although this area did generally well, there should be increased attention to proper documentation of discontinuation of medications.
- **Urgent/Emergent Care scored 70%.** Staff maintained two separate logs to record urgent/emergent events, one for the daytime and one for the nighttime. There should only be one log. Other areas requiring improvement include the quality of clinician history, physical examination, and assessments, checking emergency equipment and performance of emergency training and drills.
- **Outpatient Housing Unit scored 63%.** Patients housed in the OHU were not within sight or sound of the medical staff. Other areas requiring improvement included the admission and discharge nursing notes.
- **Health Records scored 100%.** Congratulations!
- **Preventive Services scored 88%.** While the facility met the goal of 85%, an area that could be improved is clinician identification and development of a treatment plan for youth who are obese.
- **Consultations scored 98%.** Congratulations!
- **Peer Review scored 67%.** Areas requiring improvement include development and implementation of statewide and local peer review policies.
- **Credentialing scored 67%.** Areas requiring improvement include the development and implementation of statewide and local credentialing policies and having credentialing files that contain all required elements.
- **Quality Management scored 63%.** Areas requiring improvement include QM studies, physician review of nursing sick call and OHU, and annual Quality Management Report to the Statewide Medical Director.

Recognizing that there are areas requiring improvement, we wish to congratulate staff on their progress to date.

The following section of this report shows the specific results of the audit during this visit. Each of the remaining sections shows the individual audit tool, and the results of each question and screen. Where a score of zero (0) was given, we inserted an endnote to describe the reasons for partial or noncompliance. Placing the cursor over the endnote will show the reviewers comment or the reviewer may click on the endnote to find the text at the end of the document that describes the reason for the finding. In the cases where non-compliance is self-explanatory, an endnote is not added.

Facility Leadership, Budget, Staffing, Orientation and Training

Interview facility leadership. Review staffing and vacancy reports, facility health care budget, staff credentials and licensure, and orientation and training documentation. Key: SC =Substantial Compliance, PC=Partial Compliance, NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Key facility health care leadership positions (Chief Medical Officer [CMO], Supervising Registered Nurse [SRN], Pharmacist, etc.) are filled or are being effectively recruited. Pay parity exists with CDCR.	1			
Question #2	Each facility has a full-time CMO who is board-certified or eligible in a primary care field. The NCYCC shall have one full-time CMO responsible for all complex facilities. The CMO's duties are consistent with the HCSR (see page 14).		0 ⁴		
Question #3	In both policy and actual practice, the facility is assigned a health care budget that is under the control of the CMO.				N/E
Question #4	Budgeted and actual physician staffing hours are sufficient to meet policy and procedures requirements, and to provide quality medical services.	1 ⁵			
Question #5	Budgeted and actual registered nurse staffing hours are sufficient to meet policy and procedures requirements and to provide quality nursing services.				N/E
Question #6	Medical Technical Assistant's (MTA) primary responsibilities will be the performance of health care duties.				N/A
Question #7	Escort staffing and cooperation are sufficient to assure that youth attend on-site health care appointments		0 ⁶		
Question #8	The CMO ensures that an accurate and complete system exists for tracking professional and DEA licensure; and that CPR certification is in place. All licensed staff has a current and valid license.	1			
Question #9	Newly hired staff receives a structured orientation program within 30 days of arrival. Documentation of orientation is kept in personnel files.		0 ⁷		
Question #10	Existing staff is trained regarding changes in new policies and procedure within 60 days of distribution.		0 ⁸		
	Totals:	3	4		3

Compliance = 43% (3 of 7 Applicable Questions)

Medical Reception

Select 10 to 20 health records of youth completing medical reception within the past 60-90 days. Include youth with known Latent TB infection and other health problems. Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	The medical reception process is conducted in a confidential and private manner. Signage (in English and Spanish) regarding confidentiality is in the medical area.		0 ⁹		
Question #2	There is a comprehensive verbal and written orientation program (minimum English and Spanish) for youth in a language they understand.		0 ¹⁰		
	For calculating score, only give credit for applicable questions in substantial compliance.	Totals:			

Write the youth's ID number in top row:

State ID# →	1 ¹¹	2 ¹²	3 ¹³	4 ¹⁴	5 ¹⁵	6 ¹⁶	7 ¹⁷	8 ¹⁸	9 ¹⁹	10 ²⁰
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	1 ²¹	1 ²²	N/A	1	N/A	0 ²³	N/A	N/A	1
Screen # 3	1	1	1	0 ²⁴	1	1	0 ²⁵	0 ²⁶	1	1
Screen # 4	1	0 ²⁷	0 ²⁸	1	1	1	1	1	0 ²⁹	1
Screen # 5	1	1	0	1	1	1 ³⁰	1	1	0 ³¹	1
Screen # 6	0 ³²	0 ³³	0 ³⁴	1	0 ³⁵	0 ³⁶	1	1	0 ³⁷	0 ³⁸
Screen # 7	0 ³⁹	0 ⁴⁰	N/A	0 ⁴¹	1	0 ⁴²	0 ⁴³	0 ⁴⁴	1	1
Screen # 8	0 ⁴⁵	0 ⁴⁶	0 ⁴⁷	1	1	0 ⁴⁸	0 ⁴⁹	1	1	1
Screen # 9	N/A	1	N/A	N/A	N/A	0 ⁵⁰	N/A	N/A	1 ⁵¹	1
Screen # 10	1	0 ⁵²	N/A	N/A	1	N/A	0 ⁵³	N/A	N/A	1

- Screen # 1 A nurse completed the Receiving Health Screening form on the day of arrival. The nurse referred to, or contacted a clinician for all youth with acute medical, mental health, or dental conditions; with symptoms of TB; or on essential medications.
- Screen # 2 A clinician ordered essential medications (e.g., chronic disease, mental health) on the day of arrival. Medications were administered within 24 hours. No insulin, TB, or HIV doses were missed.
- Screen # 3 A nurse measured the youth's height and weight, vital signs, visual acuity, initiated the immunization history, and planted a PPD (unless previously positive) within 24 hours of arrival. The TB test was read and documented within 72 hours.
- Screen # 4 A nurse obtained routine laboratory tests (RPR, GC, and Chlamydia, voluntary HIV antibody test, pregnancy screen, disease specific tests) within 72 hours and results were communicated to youth either at the time the physical exam was performed or when the youth was brought back for counseling. The clinician appropriately addressed abnormal laboratory findings, including counseling the youth as appropriate.
- Screen # 5 A nurse or clinician documented HIV Post-Test notification and counseling.
- Screen # 6 A clinician performed a history and physical including a testicular exam for males and pelvic examination for females (if clinically indicated) within seven calendar days of arrival. The clinician integrated information from the health screening examination, laboratory tests, and medical history into the physical exam process.
- Screen # 7 A clinician (MD, NP, or PA) initiated a Problem List noting all significant medical, dental, and mental health diagnoses.
- Screen # 8 A clinician documented an appropriate treatment plan on the History and Physical Exam Form or in the Progress Notes. The plan included appropriate diagnostic, therapeutic measures, patient education, and clinical monitoring (if indicated).
- Screen # 9 The UHR reflects that all medical reception physician orders were implemented as ordered.
- Screen # 10 Youth with chronic diseases (e.g., asthma, diabetes) were enrolled in the chronic disease management program and clinically evaluated by a clinician for their chronic disease within 30 days of arrival.

Medical Reception Summary:

Screen #	# Records Reviewed	#N/A	Final # of Records	# of Compliant Records	COMMENTS
1	10	0	10	10	
2	10	4	6	5	
3	10	0	10	7	Visual acuity not performed in 3 records.
4	10	0	10	7	Two youth not counseled regarding test results, One youth should have had additional tests ordered based upon his history
5	10	0	10	8	
6	10	0	10	3	
7	10	1	9	3	
8	10	0	10	5	
9	10	6	4	3	
10	10	5	5	3	
Total	100	16	84	54	Plus 0 of 2 Questions

Compliance = 63% (54 of 86 Applicable Questions + Screens)

Intrasystem Transfer

Select 10 to 20 health records from the Intrasystem Transfer Log and corresponding Medical Administration Records (MARs) of youth transferred to the facility in the previous 120 days. Review pertinent scheduling logs (consultation, chronic illness clinic, etc.).

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy and procedure. The statewide Transfer Form is in use.		0 ⁵⁴		
Question #2	There is a process whereby health care staff is notified of pending transfers from the facility one business day in advance of transfer.	1			
	For calculating score, only give credit for applicable questions in substantial compliance.	Totals:			

Write the youth's ID number in top row.

State ID# →	1 ⁵⁵	2 ⁵⁶	3 ⁵⁷	4 ⁵⁸
Date of arrival	1/2/08	8/16/07	10/3/07	10/5/07
Screen # 1	1	1	1	1
Screen # 2	1	1	0 ⁵⁹	0 ⁶⁰
Screen # 3	N/A	N/A	1	1 ⁶¹
Screen # 4	0 ⁶²	0 ⁶³	0 ⁶⁴	0 ⁶⁵
Screen # 5	N/A	N/A	1	1
Screen # 6	1	N/A	1	N/A
Screen # 7	0 ⁶⁶	0 ⁶⁷	N/A	N/A

- Screen # 1 A sending facility nurse reviewed the youth's record prior to transfer and documented required health information on the statewide transfer form. If the sending facility nurse did not complete the transfer form, the receiving nurse documented that she notified the facility of this (minimum information is the sending facility and who the nurse spoke to).
- Screen # 2 Upon arrival, a nurse interviewed the youth and reviewed the UHR. The nurse completed the form noting any additional information related to acute and chronic medical or mental health conditions, current medications, pending or recently completed consultations, and any other health condition requiring follow-up or special housing on the transfer form.
- Screen # 3 The receiving nurse referred youth with acute medical, dental, or mental health conditions on the day of arrival.
- Screen # 4 The receiving physician reviewed the health record of each youth within one business day of arrival and legibly signed and dated the Intrasystem form. The clinician addressed any significant medical problems.
- Screen # 5 A clinician evaluated youth with chronic diseases within 3 business days and enrolled the youth into the chronic disease program.
- Screen # 6 The MAR showed that continuity of essential medications (e.g., chronic disease, mental health, antibiotics, etc.) was provided.
- Screen # 7 The UHR shows that medical care ordered at the previous facility (e.g., vaccinations, consultations, laboratory tests) was carried out following arrival, or a clinical progress note provided an appropriate rationale for doing otherwise.

Intrasystem Transfer Summary:

Screen #	# Records Reviewed	# N/A	Final # of Records	# of Compliant Records	COMMENTS
1	4	0	4	4	
2	4	0	4	2	
3	4	2	2	2	
4	4	0	4	0	
5	4	2	2	2	
6	4	2	2	2	
7	4	2	2	0	
Total	28	8	20	12	Plus 1 of 2 Questions

Compliance = 59 % (13 of 22 Applicable Questions + Screens)

Note: We requested twelve records of youth who transferred into the facility, however only 4 records were available for review.

Nursing Sick Call

Select 10 to 20 health records from general population nursing sick call encounters during the last 120 days. Key: SC =Substantial Compliance, PC=Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy. The statewide health services request form is in use.			0 ⁶⁸	
Question #2	Youth can confidentially submit Health Services Request forms (HSRF) daily into a locked box accessed only by health care staff. Health care staff collects and triages the forms daily.	1			
Question #3	Upon youth request, custody or health care staff assists youth with completion of the HSRFs. Sign language and translation services are available.				N/E
Question #4	Nursing sick call is conducted in clean, adequately equipped, and supplied rooms with access to a sink for hand-washing or alcohol-based sanitizer with a sink nearby.		0 ⁶⁹		
Question #5	Nursing sick call is conducted 5 days a week for each housing unit, excluding weekends and holidays.	1			
Question #6	All registered nurses conducting sick call have been trained and demonstrate competency in health assessment and use of nursing protocols.			0 ⁷⁰	
Question #7	The UHR is available and present for sick call encounters including in specialized housing units and during lockdowns.	1			
Question #8	Nurses conduct sick call with, at a minimum, auditory privacy, and also with visual privacy if a physical examination is performed.			0 ⁷¹	
Question #9	There is signage in all health care delivery areas stating that staff shall maintain the confidentiality of medical information.	1			
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	4	1	3	

Write youth's ID number in the top row:

State ID# →	1 ⁷²	2 ⁷³	3 ⁷⁴	4 ⁷⁵	5 ⁷⁶	6	7 ⁷⁷	8 ⁷⁸	9 ⁷⁹	10 ⁸⁰
Triage Date HSR →	1/10/08	1/8/08	1/29/08	1/28/08	1/15/08	11/7/07	not done	No form	1/24/08	1/19/08
Date NSC →	1/11/08	1/10/08	1/30/08	1/28/08	1/16/08 ⁸¹	11/7/07	Not done	10/23/07	1/24/08	1/25/08 ⁸²
Type of Complaint	URI	Ribs Hurt	Arm Pain	H/A, Abd pain	Severe dental pain	Left Ear Pain	Dental pain	Chest pain	Right Ear Pain	Dental pain
Screen # 1	1	1	1	1	0 ⁸³	1	0 ⁸⁴	N/A ⁸⁵	1	1
Screen # 2	1	0 ⁸⁶	0 ⁸⁷	0 ⁸⁸	0 ⁸⁹	1	0 ⁹⁰	N/A	1	0 ⁹¹
Screen # 3	0 ⁹²	N/A	0 ⁹³	0 ⁹⁴	N/A	0 ⁹⁵	N/A	0 ⁹⁶	1	N/A
Screen # 4	0 ⁹⁷	N/A	0 ⁹⁸	0 ⁹⁹	N/A	0 ¹⁰⁰	N/A	0 ¹⁰¹	0 ¹⁰²	N/A
Screen # 5	1	N/A	0 ¹⁰³	1	N/A	1 ¹⁰⁴	N/A	1	1 ¹⁰⁵	N/A
Screen # 6	N/A ¹⁰⁶	N/A	N/A	N/A ¹⁰⁷	N/A	N/A ¹⁰⁸	N/A	N/A	N/A ¹⁰⁹	N/A
Screen # 7	1	N/A	1	1	0 ¹¹⁰	1	0 ¹¹¹	1	1	0 ¹¹²
Screen # 8	1	1	1	1	1	1	N/E	0 ¹¹³	1	1
Screen # 9	1	N/A	1	1	1	1	0 ¹¹⁴	1	1	1 ¹¹⁵

- Screen # 1 The nurse performed same-day triage of the Health Services Request Form and documented an appropriate disposition.
- Screen # 2 The nurse saw youth with urgent complaints on the same day, or youth with routine complaints the following business day.
- Screen # 3 The nursing subjective history was appropriate to the patient’s complaint and included a description of onset of symptoms.
- Screen # 4 The nursing physical assessment and collection of objective data was appropriate to the complaint (e.g., vital signs, Snellen test, urine dipstick, etc.).
- Screen # 5 The nursing diagnosis/assessment was appropriate based on the clinical findings.
- Screen # 6 The plan of care and nursing intervention were consistent with case history, physical findings, and the applicable nursing protocol.
- Screen # 7 The nurse referred the patient to a clinician in accordance with the criteria for referral found in the nursing protocol, or accepted in accordance with good clinical judgment.
- Screen # 8 The nurse legibly dated, timed, and signed the form.
- Screen # 9 The referral visit to the clinician took place according to protocol: stat-immediate, urgent-same day, routine-within 5 business days.

Nursing Sick Call Summary:

	# of Records	#N/A	Final #Records	# of Compliant Records	COMMENTS
Screen #1	10	1	9	7	
Screen #2	10	1	9	3	
Screen #3	10	4	6	1	
Screen #4	10	4	6	0	
Screen #5	10	4	6	5	
Screen #6	10	10	0	0	
Screen #7	10	1	9	6	
Screen #8	10	1	9	8	
Screen #9	10	1	9	8	
Total	90	27	63	38	Plus 4 of 8 applicable Questions

Compliance = 60% (42 of 71 Applicable Questions + Screens)

Medical Care

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Did the clinician sign all medical encounters? If the signature was illegible, was a stamp with the clinician's name and credentials used?	1			

Select 10 to 20 records of youth seen by an MD, NP, or PA for medical encounters (return from hospitalization, infirmary, sick call referral, etc.) in the past 180 days.

State ID# →	1	2	3	4	5	6	7	8	9	10
Visit date:	1/9/08	1/17/08	1/15/08	12/5/07	12/21/07	12/19/07	12/13/07	1/3/07	1/4/07	1/3/08
Clinician name:	A	A	A	C	B	C	C	A	C	C
Nature of visit:	URI	Trauma to eye	Thigh pain	Earache, headache	headache	Back pain	Trauma to head and hand	Scrotal mass	GI upset	Penile burning, d/c
Screen # 1	1	1	1	0 ¹¹⁶	0	0 ¹¹⁷	1	1	0 ¹¹⁸	0 ¹¹⁹
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	0 ¹²⁰	1	0 ¹²¹	1	1	1	1	0 ¹²²	0 ¹²³
Screen # 4	1	N/A	0 ¹²⁴	N/A	N/A	1	1	1	N/A	N/A
Screen # 5	1	N/A	N/A	0 ¹²⁵	N/A	0 ¹²⁶	0 ¹²⁷	1	0 ¹²⁸	0 ¹²⁹
Screen # 6	1	1	1	1	N/A	0 ¹³⁰	1	1	N/A	N/A
Screen # 7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1

- Screen # 1 The clinician addressed the patient's current complaint by obtaining a history of the present illness and appropriate review of systems.
- Screen # 2 The nurse or clinician measured a full set of vital signs when clinically appropriate (including weight, if clinically indicated).
- Screen # 3 The clinician documented all pertinent physical findings, laboratory, and diagnostic results or other related objective data.
- Screen # 4 The clinician made an appropriate assessment based upon the patient's medical history, laboratory, and physical findings.
- Screen # 5 The clinician documented an appropriate treatment plan that included diagnostic and therapeutic measures, clinical monitoring, and follow-up.
- Screen # 6 The clinician documented appropriate patient education related to the diagnosis and treatment plan.
- Screen # 7 All aspects of the treatment plan occurred as ordered within a clinically appropriate time.

Medical Care Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	5	
Screen #2	10	0	10	10	
Screen #3	10	0	10	6	
Screen #4	10	5	5	4	
Screen #5	10	3	7	2	
Screen #6	10	3	7	6	
Screen #7	10	9	1	1	
Total	70	20	50	34	Plus 1 of 1 Questions

Compliance = 69% (35 of 51 Applicable Questions + Screens)

Chronic Disease Management

Number of patients enrolled in clinic 14 Percent of clinic health records reviewed 71 %

Select 10 to 20 health records or 10% of this clinic population. Avoid records of youth arriving within the past 90 days. Write the youth's ID number in top row below:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	0 ¹³¹	1	1	1	1	1	1	1	1
Screen # 2	0 ¹³²	0 ¹³³	0 ¹³⁴	0 ¹³⁵	0 ¹³⁶	0 ¹³⁷	0 ¹³⁸	1	1 ¹³⁹	0 ¹⁴⁰
Screen # 3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Screen # 4	N/A	N/A	N/A	N/A	1	N/A	1	N/A	0 ¹⁴¹	1
Screen # 5	N/A	N/A	N/A	N/A	0 ¹⁴²	N/A	0 ¹⁴³	N/A	0 ¹⁴⁴	0 ¹⁴⁵
Screen # 6	1	0	1	0	0	0 ¹⁴⁶	0	N/A	0	N/A
Screen # 7	N/A	0	N/A	0 ¹⁴⁷	0 ¹⁴⁸	N/A	0 ¹⁴⁹	1	N/A	0 ¹⁵⁰
Screen # 8	1	0	1	1	1	0 ¹⁵¹	1	1	1	1
Screen # 9	N/A	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Screen # 10	0 ¹⁵²	N/A	1	0 ¹⁵³	1	N/A	1	0 ¹⁵⁴	1	1

- Screen # 1 All chronic diseases are listed on the Problem List.
- Screen # 2 For the initial chronic care visit the clinician performed an appropriate medical history, physical examination pertinent to the management of the chronic disease.
- Screen # 3 Baseline and ongoing follow up laboratory/diagnostic data (HbA_{1c}, serum drug levels, if ordered, etc.) were completed prior to the scheduled clinic visit and the clinician addressed results during the clinic visit.
- Screen # 4 The clinician saw the patient quarterly or more frequently as clinically indicated (i.e., based on degree of disease control). Appropriate exceptions are documented in the UHR.
- Screen # 5 The clinician's evaluation of the youth was clinically appropriate (interval history, physical examination, laboratory tests, etc.).
- Screen # 6 The clinician accurately assessed degree of disease control (i.e., good, fair, poor).
- Screen # 7 The clinician's treatment plan documented appropriate diagnostic & therapeutic measures based upon disease control and indicates when the patient is to be seen for the next clinic follow up visit.
- Screen # 8 The clinician's or nurse's notes document appropriate patient education regarding disease process, diagnostic tests, treatment goals, medication purpose, and side effects, etc.
- Screen # 9 There were no lapses in medication continuity. The clinician's assessment of medication adherence is consistent with the MAR. If the patient was non-adherent, counseling is documented in the health record.
- Screen # 10 The clinician offered/ordered Pneumococcal and annual influenza immunizations as recommended. If accepted, the nurse documented the date of administration and initials on the Immunization and Communicable Disease Record. If refused, the clinician or nurse obtained refusal of treatment.

Chronic Disease Management Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	9	
Screen #2	10	0	10	2	
Screen #3	10	10	0	0	
Screen #4	10	6	4	3	
Screen #5	10	6	4	0	
Screen #6	10	2	8	2	
Screen #7	10	4	6	1	
Screen #8	10	0	10	8	
Screen #9	10	9	1	1	
Screen #10	10	2	8	5	
Total	100	39	61	31	

Compliance = 51% (31 of 61 Applicable Screens)

Infection Control

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question # 1	There is a Local Operating Procedure (LOP) describing the facility's infection control program that is consistent with statewide policy.	1			
Question # 2	There is a licensed health care provider who is designated as having public health/infection control duties and who has received appropriate orientation and training.	1			
Question # 3	There is a functional system for reporting diseases and laboratory test results, which are required by State and Federal Law (e.g., AIDS cases, positive HIV results, Hepatitis A, B, or C, syphilis, etc.).			0 ¹⁵⁵	
Question # 4	There are exposure control plans in place for airborne and blood borne pathogens that include: a) Documentation of new hire and annual training regarding exposure control plans not fully evaluated. b) A policy describing use of standard precautions to prevent contact with blood or other potentially infectious materials (OPIM) Yes c) A policy describing engineering (sharps disposal, specimen handling) and work practice controls intended to eliminate or minimize employee exposure Yes. d) A policy describing housekeeping procedures used to maintain a clean and sanitary environment, including a written schedule for cleaning and methods of decontamination Yes.	1			
Question # 5	Engineering Controls: a) Sharps containers are secure and easily accessible in areas where sharps are used. -Yes b) Hand wash facilities are in or near all work areas and antiseptic hand cleaner are available when needed. -Yes. c) An eyewash station is present and tested quarterly for functionality. The eyewash station functions properly. -No d) Specimen containers are used for transport of biological specimens (e.g., blood, urine). -Yes e) Biohazard storage bins are available. -Yes f) Blood and body fluid spills are cleaned appropriately per policy. N/E		0 ¹⁵⁶		
Question # 6	Compliance with work practice controls: a) Food and drink are not kept in refrigerators, freezers, shelves, cabinets, or counter tops where blood, laboratory specimens, or other potentially infectious materials are kept. Yes. b) Staff observes Standard Precautions. N/E c) Refrigerators are labeled appropriately (biohazard for specimens, food only, or medication only). Yes d) Personal Protective Equipment is immediately available in health care delivery areas. Yes. e) Staff performs hand-washing as required. N/E	1			

Infection Control Continued:

						SC	PC	NC	NA	
Question 7	Are Infection Control Meetings held quarterly (minimum 4 meetings per year)?					1				
Question 8	If Question 7 is SC or PC , do the minutes address the following areas? (Put Y if topics are present or N if topic is missing, for each quarter in space provided):						0 ¹⁵⁹			
		QTR 1	QTR 2	QTR 3 ¹⁵⁷	QTR 4 ¹⁵⁸					
	a) TB skin testing programs for staff and youth									
	b) Exposure control plans and training regarding airborne and blood borne pathogens									
	c) Hepatitis B training and vaccination programs (e.g., number of employees trained, number accepting vaccine, and number completing vaccination series)									
	d) Staff compliance with work practice controls									
	e) Reporting communicable diseases for the previous quarter, noting any trends present									
f) Sanitation reports (institutional and infection control) and any follow-up action taken										
Question 9	If respiratory isolation rooms are used for the purposes of respiratory isolation they are functional as evidenced by routine testing (at least monthly when not in use and daily when in use). Is staff fit-tested for N-95 respirators?								N/A	
For calculating score, only give credit for applicable questions in substantial compliance.						Totals:	5	2	1	1

Compliance = 63% (5 of 8 applicable Questions)

Pharmacy Services

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Is the pharmacy currently licensed?	1			
Question #2	Are the pharmacy and medication rooms adequately lit, organized, clean, and provide sufficient space to prepare medications?	1			
Question #3	Does the facility pharmacist or pharmacy tech conduct monthly inspections of the pharmacy, medications rooms, and all areas of the facility where medications are stored? Does the facility pharmacist or designee develop and implement a plan to correct identified deficiencies?	1			
Question #4	Does the pharmacy have computers and software programs to track medication usage, inventory, cost, drug-drug interactions, and clinical prescribing patterns?	1			
Question #5	Does the pharmacist dispense all prescriptions into appropriate containers labeled with the youth's name, ID number, and medication information as required by state law?	1			
Question #6	Is there strict accountability for all medications dispensed from the pharmacy, including medications administered from a night locker?	1			
Question #7	Is there a pharmacy system for monitoring patient adverse drug reactions?	1			
Question #8	Does the facility have a 24-hour prescription service or other mechanism to provide essential medications 24 hours per day (e.g., night locker)?	1			
Question #9	Are stock bottles of legend medications kept inside the pharmacy (except for biological agents such as insulin and vaccines under proper storage conditions)?	1			
Question #10	Is there a facility Pharmacy and Therapeutics Committee that meets quarterly? Do P & T meeting minutes reflect meaningful content and initiatives to improve pharmacy services?	1			
Question #11	Are youth with asthma permitted to keep inhalers in their possession (except for cause documented in the health record)? Are youth permitted to keep other medications in their possession as determined by the CMO?	1			
Question #12	The pharmacist provides a monthly report detailing pharmacy utilization costs, drug stop lists, monthly lists of drugs used by class, and physician prescribing lists.	1			
Question #13	When a youth paroles, is medication continuity provided in accordance with the policy?	1			
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	13			

Compliance = 100% (13 of 13 Questions)

Medication Administration Process

Observe all areas where medications are stored and administered. Observe the medication administration process.

Key: SC =Substantial Compliance, PC=Partial Compliance, NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Are medications administered from centralized medication rooms, except in specialized mental health units, SMP, TD, or BTP?	1			
Question #2	Is there a local policy for medication administration that is in compliance with the statewide policy and procedure?				N/E
Question #3	Are the medication storage and administration rooms secure, clean, organized, and have adequate space, storage, lighting, and a sink or alcohol-based hand sanitizer?		0 ¹⁶⁰		
Question #4	Are all medications in the Documed or night locker current and accounted for (from a sample of 5 medications)?	1			
Question #5	Are all narcotics and other controlled substances double-locked, counted at every shift, and all accounted for (from a sample of 5 medications)?		0 ¹⁶¹		
Question #6	Are all needles and syringes securely stored, counted at every shift, and all accounted for?	1			
Question #7	The medication room contains no medications that are discontinued or expired. (There is a 3-day window period to return these medications to the pharmacy.)	1			
Question #8	Are external medications stored separately from internal medications?	1			
Question #9	Does the nurse administer all legend medication from properly labeled containers and not from stock bottles?	1			
Question #10	Does custody staff provide continuous security during medication administration?			0 ¹⁶²	
Question #11	Medications that are to be administered at the hour of sleep are not administered before 2100 hours (one hour window permitted).	1			
Question #12	Is the medication refrigerator clean and used only to store medications (no food or specimens)? Does staff check and log the temperature daily?	1			
Question #13	Medications are not crushed except upon a physician order and for a valid reason (e.g., patient is known to hoard medication). Time-released medications are not crushed.	1			
Question #14	Observe the nurse administering medications to 5 to 10 youth, and answer the following elements.				N/E
		Y or N			
a.	The medication administration record (MAR) was available to the nurse during medication administration.	0			
b.	The nurse confirmed the identity of the youth per policy.	N/E			
c.	The nurse compared the medication container label to the MAR.	N/E			
d.	The nurse placed the medications into a cup prior to administration.	N/E			
e.	The nurse performed visual oral cavity checks for medications in accordance with medication administration policies.	N/E			
f.	The nurse documented on the MAR at the time the medication is administered.	N/E			
g.	If a medication was not available after hours, the nurse obtained the medication from the Documed or night locker and signed it out prior to administration.	N/E			

Compliance = 75% (9 of 12 Questions)

Medication Administration Health Record Review

Select 10 to 20 health records and corresponding MARs of patients receiving medications in the preceding 180 days to review. Write the youth's ID number in top row below:

State ID# →	1 ¹⁶³	2 ¹⁶⁴	3 ¹⁶⁵	4 ¹⁶⁶	5 ¹⁶⁷	6 ¹⁶⁸	7 ¹⁶⁹	8 ¹⁷⁰	9 ¹⁷¹	10 ¹⁷²
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	1	1	1	0 ¹⁷³	1
Screen # 3	1	1	1	1	1	1	1 ¹⁷⁴	1	0	1
Screen # 4	1	1	0 ¹⁷⁵	1	1	1	1	1	1	1
Screen # 5	1 ¹⁷⁶	1	1	1	1	1	1 ¹⁷⁷	1	1	1
Screen # 6	1	1	1	1	1	1	1	1	1	1
Screen # 7	1	1	1	1	0 ¹⁷⁸	1	1	1	1	1
Screen # 8	N/A	N/A	N/A	0 ¹⁷⁹	N/A	0 ¹⁸⁰	N/A	0 ¹⁸¹	N/A	N/A
Screen # 9	1	0 ¹⁸²	1	1	0 ¹⁸³	1 ¹⁸⁴	1 ¹⁸⁵	0 ¹⁸⁶	1	1 ¹⁸⁷

- Screen #1 The medication orders were complete (name of medication, strength, route of administration, frequency, duration, and number of refills).
- Screen #2 The clinician order was dated, timed, and legibly signed (if the signature is not legible, a signature stamp must also be used).
- Screen #3 The clinician documented an appropriate clinical note that corresponds with the initial medication order.
- Screen #4 The nurse dated and timed the medication order transcription (routine orders within 4 hours, urgent orders within 2 hours, and stat orders within 1 hour).
- Screen #5 The nurse and/or pharmacy accurately transcribed the physician order onto the MAR.
- Screen #6 The MAR reflected that all medications were initiated within 24 hours of the order being written or on the start date ordered.
- Screen #7 There is documentation of medication administration status (e.g., administered, refused, etc.) for every dose ordered for the youth.
- Screen #8 For discontinued medications, the nurse discontinued medications according to policy.
- Screen #9 The MAR is neat and legible, and contains legible initials, signatures, and credentials of nursing staff who have administered medications to youth.

MAR Review Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	10	
Screen #2	10	0	10	9	
Screen #3	10	0	10	9	
Screen #4	10	0	10	9	
Screen #5	10	0	10	10	
Screen #6	10	0	10	10	
Screen #7	10	0	10	9	
Screen #8	10	7	3	0	
Screen #9	10	0	10	7	
Total	90	8	83	73	

Compliance =88% (73 of 83 Applicable Screens)

Urgent/Emergent Care Services

Select 10 to 20 health records from the Urgent/Emergent Care Tracking Log in the previous 180 days. Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question # 1	There is an Urgent/Emergent Tracking Log that records all unscheduled health care encounters.		0 ¹⁸⁸		
Question # 2	Emergency equipment and supplies at the facility are consistent with the statewide policy and procedure. The facility has at least one automated external defibrillator (AED).	1			
Question # 3	The emergency equipment, medications, and supplies are in proper working order. An equipment checklist log shows that health care staff inspects equipment and supplies each shift.	1			
Question # 4	There is documentation that health care providers have been trained regarding emergency response. There is documentation of the last three emergency drills and one disaster drill, which delineates the events of the drill and identifies strengths and weaknesses.			0 ¹⁸⁹	
Question # 5	Interview nurses, physicians, nurse practitioners, physicians assistants, and dentists to ensure that all know how to properly operate the emergency equipment (O ₂ , Ambu bag, cardiac monitor, AED, etc.).				N/E
For calculating score, only give credit for applicable questions in substantial compliance.					
Totals:		2	1	1	1

Write the youth's ID number in the top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	0 ¹⁹⁰	1	1	1	1	1	1	1	1	1
Screen # 2	0 ¹⁹¹	1	0 ¹⁹²	1	0 ¹⁹³	1	1	1	1	1
Screen # 3	1	1	1	0 ¹⁹⁴	0 ¹⁹⁵	1	0 ¹⁹⁶	0 ¹⁹⁷	0 ¹⁹⁸	0 ¹⁹⁹
Screen # 4	1	1	1	1	1	1	1	0 ²⁰⁰	0 ²⁰¹	0 ²⁰²
Screen # 5	1	1	1	1	1	1	1	1	N/A ²⁰³	1
Screen # 6	N/A	N/A	1	N/A	N/A	0 ²⁰⁴	N/A	N/A	N/A	N/A
Screen # 7	N/A	N/A	1	N/A	N/A	0	N/A	N/A	N/A	N/A

Screen # 1 The entry in the Urgent/Emergent Log is complete, legible, and there is a corresponding progress note in the health care record.

Screen # 2 The nurse documented the date and time of the encounter and documented an assessment in SOAP format.

Screen # 3 The nurse's subjective and objective evaluation was appropriate given the nature of the complaint (e.g., vital signs, SOB = peak flow meter, abdominal pain =abdominal assessment)

Screen # 4 The nurse's assessment and plan were appropriate, including notification or referral to the clinician when clinically indicated.

Screen # 5 If the nurse referred the youth to a clinician, the follow-up visit was timely and clinically appropriate.

Screen # 6 For patients returning from the emergency room, nursing staff contacted the physician on-call to obtain follow-up orders.

Screen # 7 If the youth was sent to an outside facility, the physician saw the youth the following business day.

Urgent/Emergent Care Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	9	
Screen # 2	10	0	10	7	
Screen # 3	10	0	10	4	
Screen # 4	10	0	10	7	
Screen # 5	10	1	9	9	
Screen # 6	10	8	2	1	
Screen # 7	10	8	2	1	
Total	70	17	53	38	Plus 2 of 4 applicable questions

Compliance = 70% (40 of 57 Questions + Screens)

Outpatient Housing Unit

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy and procedure.			0	
Question #2	There is an Outpatient Housing Unit (OHU) log that lists all youth placed in the OHU in the past 180 days. The log contains youth name, I.D. number, reason for admission and admission and discharge dates.	1			
Question #3	There is a current, standardized nursing procedure manual in the OHU at all times.			0	
Question #4	There is in policy and actual practice a physician on call 24 hours per day, 7 days a week.	1			
Question #5	All youth placed in an OHU are within sight or sound of licensed health care staff at all times in accordance with policy			0	
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	2		3	

Select 10 to 20 health records of patients currently admitted or discharged from the OHU within the last 180 days Write the youth's ID number in the top row.

State ID# →	1	2	3	4	5	6	7	8
Placement date: →	9/30/07	11/9/07	1/14/08	12/26/07	8/11/07	10/21/07	1/19/08	1/4/08
Discharge date: →	10/1/07	11/11/07	1/15/08	12/27/07	8/13/07	10/23/07	1/22/08	1/8/08
Screen # 1	1	1	1	1	1	1	1	1
Screen # 2	1	1	0	1	0	0	0	1
Screen # 3	1	1	1	1	1	0 ²⁰⁵	1	1
Screen # 4	0 ²⁰⁶	0 ²⁰⁷	0 ²⁰⁸	0 ²⁰⁹	0 ²¹⁰	0 ²¹¹	0 ²¹²	0 ²¹³
Screen # 5	n/a	1	1	1	1	0 ²¹⁴	0	1
Screen # 6	1	1	1	1	1	0 ²¹⁵	1	1
Screen # 7	n/a	0 ²¹⁶	1	1	n/a	1	0 ²¹⁷	1
Screen # 8	1	1	1	1	n/a	0 ²¹⁸	1	1
Screen # 9	0 ²¹⁹	0 ²²⁰	0 ²²¹	0 ²²²	0 ²²³	1	1	1

- Screen #1 The clinician (MD, NP, PA, or psychologist) wrote or gave a verbal order to place the youth in the OHU.
- Screen #2 The clinician orders include the initial impression: diagnostic and therapeutic measures, the frequency of vital signs, and other monitoring (e.g., peak flow meter and capillary glucose measurements, etc.), and clinical criteria for notifying the physician (change in clinical status).
- Screen #3 The youth's clinical condition/reason for admission did not exceed the criteria for placement in the OHU.
- Screen #4 A nurse documented an appropriate initial assessment, plan of care, and patient education (including orientation to the OHU).
- Screen #5 The clinician performed and documented a clinical assessment on the next business day or sooner, if clinically indicated.
- Screen #6 Nursing assessments are documented at least once every shift, or more often if clinically indicated, and are pertinent to the admitting diagnosis (es).
- Screen #7 A clinician conducts clinically appropriate rounds that are documented in the UHR daily, Monday through Friday.

Screen #8 The UHR reflects that the clinical and nursing plan of care was implemented (e.g., vital signs recorded, lab tests performed, medications administered, etc.).
 Screen #9 A physician and nursing discharge note was completed at the time of release from the OHU.

Outpatient Housing Unit Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	8	0	8	8	
Screen # 2	8	0	8	4	
Screen # 3	8	0	8	7	
Screen # 4	8	0	8	0	
Screen # 5	8	1	7	5	
Screen # 6	8	0	8	7	
Screen # 7	8	2	6	4	
Screen # 8	8	1	7	6	
Screen # 9	8	0	8	3	
Total	72	4	68	44	Plus 2 of 5 Applicable Questions

Compliance = 63% (46 of 73 Applicable Questions + Screens)

Health Records

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question # 1	Local policies are consistent with statewide policies and procedures, and address all aspects of health record management. (See Audit Tool Instructions.)	1			
Question # 2	The Movement and Problem List is visible upon opening the UHR.	1			
Question # 3	There is a functional tracking system for laboratory, diagnostic, and consultation reports.	1			
Question # 4	The facility has a functional system for UHR accountability, filing, and retrieval.	1			
	Totals:	4			

Compliance = 100% (4 of 4 Applicable Questions)

Preventive Services

Select 10 to 20 health records of youth who have been in DJJ over one year.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question #1	There is a policy and procedure regarding preventive services that is consistent with the US Preventive Services Task Force (USPSTF) and American Medical Association Guidelines for Adolescent Preventive Services (GAPS) in areas that are applicable to DJJ youth.	1			

Write the youth's ID number in the top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	0	1	1	1	1
Screen # 2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Screen # 3	1	1	1	1	1	1	1	1	1	1
Screen # 4	1	1	1	0 ²²⁴	1	1	0 ²²⁵	0 ²²⁶	1	0 ²²⁷
Screen # 5	1	1	1	1	1	1	1	1	1	1
Screen # 6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

- Screen # 1 TB skin testing was performed annually. If previously positive, a nurse conducted a TB symptom screen.
- Screen # 2 Annual pap smears were performed (at a minimum) beginning 3 years after initiation of sexual intercourse and 2 consecutive years thereafter. If there are 3 consecutive normal annual pap smears, then they are performed every 3 years thereafter. Management of abnormal pap smears was appropriate, including referral.
- Screen # 3 A nurse measures the youth's blood pressure annually. The nurse refers youth with abnormal blood pressure to a clinician.
- Screen # 4 A nurse measures the youth weight annually. Obesity is addressed if clinically indicated (BMI >24 %).
- Screen # 5 Hepatitis A and B vaccinations are current, as applicable.
- Screen # 6 Youth are offered Tetanus-Diphtheria Booster if not received within ten years.

Preventive Services Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	9	
Screen # 2	10	10	0	0	
Screen # 3	10	0	10	10	
Screen # 4	10	0	10	6	
Screen # 5	10	0	10	10	
Screen # 6	10	10	0	0	
Total	60	20	40	35	Plus 1 of 1 Applicable Questions

Compliance = 88% (36 of 41 Questions + Screens)

Consultation and Specialty Services

Interview staff responsible for specialty service contracts and consultation tracking. Review the Consultation Tracking log. Select 10 health records from the facility of youth who received consultation services in the last 180 days.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local consultation policy and procedure that is consistent with the statewide policy.	1			
Question #2	The facility has implemented the outside specialty care log to include receipt of reports. Staff maintains it accurately and contemporaneously.	1			
Question #3	There is sufficient custody staffing and cooperation to transport youths to outside medical appointments.	1			
	For calculating score, only give credit for questions in substantial compliance.				
	Totals:	3			

Write the youth's ID number in top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	0 ²²⁸	1	1	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	1	1	1	1	1	1	1	1	1
Screen # 4	1	1	1	1	1	1	1	1	1	1
Screen # 5	1	1	1	1	1	1	1	1	1	1
Screen # 6	1	1	1	1	1	1	1	1	1	1
Screen # 7	1	1	1	1	1	1	1	1	1	1
Screen # 8	1	N/A	1	N/A	1	1	1	1	1	1
Screen # 9	N/A	N/A	1	0 ²²⁹	1	N/A	1	N/A	1	1

- Screen # 1 The health record contained a Consultation Request Form. The clinician legibly documented the service requested, urgency (routine or urgent), and dated and signed the form.
- Screen # 2 The clinician legibly documented the history of the present illness, physical findings, and lab data that supports the rationale for the service on the Consultation Request Form.
- Screen # 3 The clinician legibly documented the medical history, physical and laboratory findings, and an assessment that supports the need for the consult in the Progress Notes.
- Screen # 4 The record reflects that the youth was seen by the consultant within the required time frames (90 days for routine, 10 ten days for urgent unless indicated sooner).
- Screen # 5 Upon the patient's return from the consultation appointment, the nurse reviewed the consultant's recommendations and addressed any urgent recommendations.
- Screen # 6 The clinician reviewed, dated, and initialed the consultation report within 3 business days of the youth's return to the facility or receipt of the report.
- Screen # 7 The UHR shows that the clinician met with the youth 5 business days (sooner if clinically indicated) to review results of the consult with the youth and develop a treatment plan.
- Screen # 8 The health record reflected that the consultant's recommendations were ordered and implemented, or a valid reason for **not** implementing the recommendations was documented (i.e., patient is out to court, refused, etc.). If the physician disagrees with the consultant's recommendations, an appropriate alternate plan of care was ordered and implemented.
- Screen # 9 The health record reflected that the clinician monitored the youth to ensure that the treatment plan was implemented and the desired clinical outcome was achieved, or the treatment plan was amended.

Consultation and Specialty Services Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	9	
Screen # 2	10	0	10	10	
Screen # 3	10	0	10	10	
Screen # 4	10	0	10	10	
Screen # 5	10	0	10	10	
Screen # 6	10	0	10	10	
Screen # 7	10	0	10	10	
Screen # 8	10	2	8	8	
Screen # 9	10	4	6	5	
Total	90	6	84	82	Plus 3 of 3 Applicable Questions

Compliance =98% (85 of 87 Questions + Screens)

Peer Review

Review the local and statewide peer review policies and procedures, interview staff, inspect peer review file storage locations.

Review peer review files to ensure compliance with policy and the Health Care Remedial Plan.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question # 1	The local peer review policy and procedure, and actual practice are consistent with the statewide policy and procedure, NCCHC standards, and the Health Care Remedial Plan.			0	
Question # 2	The Statewide DJJ Medical Director, Health Care Director, or clinical service chief monitors the peer review process, which includes regular reporting from the facilities on peer review activities and regular quality management meetings at least annually.	1			
Question # 3	The CMO reviews sentinel events (unexpected hospitalizations, medical errors) and the Statewide Medical Director/Chief Psychiatrist reviews the reports of these investigations. The Statewide Medical Director/Chief Psychiatrist reviews all deaths.				N/A
Question # 4	There is biannual peer review for MDs, PAs, and NPs at each facility. These files are marked "Peer Review" and kept in a secure location. There is documentation that findings have been shared with applicable staff	1			
Question # 5	The peer review process includes a meaningful corrective and adverse action process up to, and including, suspending privileges for inappropriate care or unprofessional behavior.				N/A
	For calculating score, only give credit for questions in substantial compliance. Totals:	2		1	2

Compliance = 67% (2 of 3 applicable Questions)

Credentialing

Review the local and statewide credentialing policies and procedures, interview staff, and inspect storage locations of credential files.

Review credentials files to ensure compliance with policy and the Remedial Plan.

Key: SC =Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	N/A
Question # 1	The local credential policies and procedures, and actual practice are consistent with statewide policies and procedures, NCHC standards, and the Health Care Remedial Plan.				N/A
Question # 2	Credential files are stored in a locked cabinet with access limited to those with a legitimate need to know.	1			
Question # 3	Specific staff is assigned to maintain the credential files. Inspection shows that the files are current and well-maintained.	1			
Question # 4	Review all credential files. They contain the required elements of the Health Care Remedial Plan: a) Curriculum Vitae that includes relevant personal information; undergraduate, graduate, and postgraduate education b) Employment history and hospital appointments (including disciplinary action and loss of privileges) c) Academic appointments and society memberships, if applicable d) Copies of all current licenses, registrations, board certifications, and Drug Enforcement Agency (DEA) licenses e) Statement of physical and mental health f) Drug and alcohol dependence history, if any g) Results of National Practitioner Data Bank Inquiry h) Prior and current malpractice claims and judgments i) Prior professional liability coverage and current coverage for contractors, if not covered by State of California j) ECFMG certificate, if applicable k) Authorization for release of information for any information required to complete the application process, including confidential material l) Three references			0 ²³⁰	
Question # 5	Review of credentialing process listed in question #4 reveals no substantial problems or concerns regarding the clinician's mental fitness, clinical competence, or moral character.				N/A
Question # 6	Recredentialing occurs bi-annually. All files are current.	1			
Question # 7	Physicians, nurse practitioners, and physician assistants do not begin work until the credentialing process is completed. Under extenuating circumstances, temporary privileges may be granted until the credentialing process is completed, not to exceed 3 months.	1			
Question # 8	Physicians or nurse practitioners treating chronically ill youth are board certified or eligible in a primary care-related field.			0 ²³¹	
Question # 9	Physicians treating HIV infected youth are board certified in infectious diseases (ID) or have completed a primary care residency with additional HIV related training, and are experienced in the treatment of HIV patients. If no facility clinician meets this requirement, ID consultants are used.				N/A
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	4		2	3

Compliance = 67% (4 of 6 Applicable Questions)

Quality Management

Review the local and statewide Quality Management Program policy and procedure. Review the composition of the QM Committee and meeting minutes. Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question # 1	There is a local policy and procedure that is consistent with the statewide policy and procedure.	1			
Question # 2	The facility has a Quality Management (QM) Committee that meets quarterly or more often as needed, as determined by Statewide policy.	1			
Question # 3	The composition of the institutional QM Committee meetings meets policy requirements.	1			
Question # 4	Minutes of the QM Committee are available for review.	1			
Question # 5	QM studies for the previous 2 quarters from the date of the last audit are available for review.			0	
Question # 6	The reasons for the QM studies performed by the facility are specified on the tools or in meeting minutes, and are related to suspected problems identified by staff, Health Care Service audits, Superintendents, and youth, etc. (high risk, high volume, problem prone aspects of care).				N/A
Question # 7	The most recent Corrective Action Plan (CAP) developed as part of a QM study is reviewed for the following: Enter date of CAP reviewed: _____				N/A
	a) The CAP identified specific improvements needed.				
	b) The CAP identified specific staff members responsible for improvements.				
	c) The CAP had a targeted completion date.				
	d) There was documentation to indicate any recommended training was held.				
	e) Follow-up studies were done to determine whether or not corrective actions solved the problem or issue.				
Question # 8	Physician Chart Reviews: a) There will be quarterly review of nursing sick call records based upon criteria developed by the QM Committee (a minimum of 5 records per nurse performing sick call) b) Outpatient Housing Unit: 10% or 10 records/ quarter. Findings are addressed at QM meetings.			0	
Question # 9	The Supervising Nurse reviews 10 records monthly of each nurse who conducts nursing sick call, urgent care, or outpatient housing unit care. There is documentation that findings from chart reviews have been discussed with the applicable staff members. As performance improves, reviews may be performed quarterly.	1			
Question # 10	On at least an annual basis, the Chief Medical Officer develops a Quality Management report for the Statewide Medical Director that focuses on high risk, problem prone aspects of patient care; identifies deficiencies; makes recommendations for improvements; and provides direction for quality improvement activities.			0	
For calculating score, only give credit for applicable questions in substantial compliance.					
Totals:		5		3	2

Compliance = 63% (5 of 8 Questions)

Total Number of Questions and Screens Evaluated	= 693
Total Number of Questions and Screens in Substantial Compliance	= 500
Total Score	= 72%

Endnotes

¹ Review of system questions such as ‘chest pain’ or ‘shortness of breath’ do not have a yes/no response so it is unclear whether the clinician asked the question or not. The physical examination section has prompts for examinations that may not be relevant to the patient’s problems. For example, under the Neck examination section it prompts an examination of the thyroid only. This is not the relevant examination for a youth with possible neck cancer. At the end of the form, instead of a section devoted to listing the patient’s diagnoses and a medical treatment plan, the clinician is only to indicate whether the youth is “cleared for all activity” or has any medical restrictions. Thus the form suggests its primary purpose is a medical classification tool. We have some suggestions and will forward them to Dr. Morris under separate cover.

² J0731.

³ Buspirone 5 mg found in the drawer of Robert C. No documentation on the MAR for the morning dose. Amoxicillin 500 mg found in the drawer of Calvin W. No MAR found in the book. The administration status of all 8 am doses was not completed by 11 am.

⁴ The CMO is not board eligible or certified in primary care.

⁵ The facility is overstaffed with respect to clinician staffing.

⁶ Health record review shows that youth are not consistently brought up for medical appointments when they are in Temporary Detention and School.

⁷ The Institutions and Camps Manual has only 24 of 32 health care policies. The local operating procedures only have 24 of 32 essential policies. DON was not aware of all the new policies.

⁸ The facility does not have a complete set of health care policies and has not completed training of health care staff.

⁹ Medical reception screening is conducted at a desk in an area of high traffic with youth sitting just outside the open door that does not ensure auditory privacy. Youth must pass through this room to enter a clinical examination area that is simultaneously used.

¹⁰ The document provided to us as an orientation manual for youth was information more appropriate to staff than youth. The booklet stated that sick call would be held twice weekly in each housing unit and not five days a week. This is not in compliance with DJJ policies and procedures.

¹¹ Identity removed. DOA 12/3/07.

¹² Identity removed. 12/10/07.

¹³ Identity removed. DOA 12/10/07.

¹⁴ Identity removed. DOA 12/20/07.

¹⁵ Identity removed. DOA 12/26/07.

¹⁶ Identity removed. DOA 1/2/08.

¹⁷ Identity removed. DOA 1/3/08.

¹⁸ Identity removed. DOA 1/22/08.

¹⁹ Identity removed. DOA 1/17/08.

²⁰ Identity removed. DOA 12/24/07.

²¹ NP wrote order for Atenolol 50 mg twice daily and for the nurse’s to take BP and pulse prior to each dose and if systolic BP <110 or diastolic BP <60 or pulse <60 beats/minute to hold dose. Unusual order.

²² Patient with a history of acne on Benzoyl Peroxide. Not continued.

-
- ²³ Albuterol Inhaler not ordered. Patient reported weekly use of inhaler but clinician note states to “see the nurse for use of Albuterol inhaler”.
- ²⁴ The patient arrived on 12/20/07. The nurse measured the patient’s height and weight and vital signs but not visual acuity. This information was documented in the progress notes. On 12/26/07 another nurse recopied the 12/20/07 vital signs, height and weight onto the history and physical form and included visual acuity. However there is no signature of the nurse adding this information. When clinical information collected on one date is recopied onto another form on another date, the nurse should indicate this, and if new measurements are obtained (e.g., visual acuity) the nurse who obtained the measurements should sign his/her signature.
- ²⁵ Visual acuity not performed.
- ²⁶ Visual acuity not performed.
- ²⁷ The usual medical reception tests were performed, however the patient had a history of a heart condition (under the care of a cardiologist) and recent hypokalemia that was noted at the probation department. The clinician did not order a repeat potassium level.
- ²⁸ No documentation of counseling regarding test results.
- ²⁹ There is no documentation that the youth was counseled regarding his lab results.
- ³⁰ HIV counseling does not include what the patient was specifically told about his test result (that is was negative or positive), only that it was done.
- ³¹ No documented HIV counseling.
- ³² The patient had a history of asthma since age 12 with emergency department visit. The clinician did not describe the patient’s asthma history including frequency of symptoms and inhaler use, whether the patient had been treated with steroids or hospitalizations with or without intubation. The psychiatrist noted that the patient reported that he lost consciousness once during an asthma attack and remembers regaining consciousness in the ambulance and that he was hospitalized overnight. The patient also gave a history of head injury with loss of consciousness, but no additional history was provided such as date the event occurred or inquiring about residual such as memory loss, behavior changes, etc. However the psychiatrist reported that the patient exhibited symptoms such as difficulty sustaining attention, forgetful and easily distracted that was diagnosed as ADHD.
- ³³ According to medical information received from the Santa Barbara Probation Department, this 17 year old has a history of a heart murmur, irregular heartbeat, atypical chest pain, hypertension and dyslipidemia, recent hypokalemia (K+ =3.7 in October 2007) and had been under the care of a cardiologist. He was taking Atenolol 50 mg twice daily. The clinician’s documented history consisted of noting that the patient had a history of hypertension and a heart murmur for 5 years. The clinician’s review of symptoms indicated that the patient had a murmur, palpitations and hypertension but there was no further elaboration such as the onset, frequency, duration of symptoms. The clinician did not document an assessment or plan of care. We incidentally note that on the day of his arrival, the cardiologist’s 3-month follow-up note confirming the above (except heart murmur) was faxed to the facility and filed in the record. There is no documentation that any clinician has reviewed the cardiologist’s note and previous medical records (the original workup has not been requested). Although placed on an antihypertensive medication, the patient was not referred into the chronic disease program for evaluation and treatment of his hypertension.
- ³⁴ Patient has a BMI of 25. At risk for obesity.
- ³⁵ The patient has a history of asthma and is being treated with an inhaled steroid and short-acting beta agonist. Although the clinician stated that the patient was well-controlled with use of the inhaled steroid, the clinician did not document the frequency of symptoms, including night time awakening and frequency of use of the short-acting inhaler.
- ³⁶ Patient gave a history of left-side neck mass being removed at the age of 10. The clinician noted questionable cancer, but the psychologist note stated the mass was malignant. The clinician did not examine the neck for masses, only that the thyroid was not palpable. The history and physical examination form is problematic in that clinicians tend to only describe what is on the form. Also in the progress notes the patient complained of right lower abdominal pain associated with exercising and weight lifting. The clinician did not examine the patient for an inguinal hernia. The patient has a history of TB infection in 2003, but this was not noted by the clinician. He has an extensive history of drug use with daily use of PCP, crystal methamphetamine, marijuana and alcohol use from age 11.
- ³⁷ The clinician did not address the patient’s admission blood pressure of 149/96 mm/hg or BMI of 28.
- ³⁸ Clinician noted last inhaler use but did not inquire about night time symptoms. Did not note a history of wheezing on review of symptoms.

-
- ³⁹ History of head injury with loss of consciousness not listed.
- ⁴⁰ The clinician documented that the patient had a history of a heart murmur and “dehydrogenic oils (chest pains)”. There is no documentation of his diagnosis of hypertension, dyslipidemia, premature ventricular contractions, etc. The cardiologist’s note states he did not hear a murmur. We discussed this problem list with the nurse practitioner who advised that the patient said that he got chest pains when he ate “dehydrogenic oils”. We suspect that the patient had been told to avoid partially hydrogenated oils or “Trans” fat which has been associated with an increased risk of heart disease. However this is not a valid problem to be placed on the Problem List.
- ⁴¹ Grade II acne and 2005 non-displaced sternal fracture secondary to sports injury.
- ⁴² The clinician did not document the history of left sided neck mass, fracture of right elbow and fracture of right knee due to sports injuries. Also this patient has been diagnosed with bipolar disorder with psychotic features, paranoid schizophrenia and PTSD. None of these problems are documented on the Problem List.
- ⁴³ The clinician did not note the patient’s history of asthma, fracture of the lower jaw and abdominal stabbing.
- ⁴⁴ The clinician did not note the patient’s grade III acne or dyshidrosis.
- ⁴⁵ The clinician did not document a treatment plan for the patient’s asthma.
- ⁴⁶ The clinician did not document a plan on the intake history form but did document a progress note. The plan does not address the patient’s previous evaluation by a cardiologist and need to obtain medical records. The clinician did not auscultate a murmur but documented a murmur in the assessment and placed the patient on SBE precautions (it’s unclear whether the patient was previously on SBE precautions and for what diagnosis).
- ⁴⁷ Patient has a BMI of 25. Should be counseled.
- ⁴⁸ The clinician did not appropriately evaluate the patient for an inguinal hernia.
- ⁴⁹ The clinician did not order an inhaler on a prn basis, rather instructing the patient to see the nurse for inhaler use. The nurse cannot give an inhaler without an order.
- ⁵⁰ The clinician ordered LFTs on 1/7/08 but they were not done.
- ⁵¹ The clinician ordered a chest x-ray for a history of a positive TB skin test on 1/22/08. The x-ray was taken the same day but the results are not in the chart.
- ⁵² Patient with hypertension, hyperlipidemia not enrolled into chronic disease clinic.
- ⁵³ The clinician did not enroll the patient into the asthma clinic.
- ⁵⁴ The local policy does not contain all elements of the statewide policy. It has numerous typographical errors.
- ⁵⁵ Identity removed. Transferred on 1/2/08 for history of major depression with psychotic features.
- ⁵⁶ Identity removed. Transferred on 8/16/07.
- ⁵⁷ Identity removed. Transferred 10/3/07.
- ⁵⁸ Identity removed. Transferred 10/5/07.
- ⁵⁹ Nurse did not complete intrasystem transfer form but made a direct referral to NP.
- ⁶⁰ The nurse did not note that the patient had asthma and should be referred to the chronic disease program.
- ⁶¹ The youth did not have an acute condition, but the nurse referred the patient on the day of arrival.
- ⁶² Form is unsigned and undated by a clinician.
- ⁶³ Form is unsigned and undated by a clinician.

⁶⁴ Form is unsigned and undated by a clinician.

⁶⁵ The NP saw the patient on the day of arrival but did not sign the intrasystem transfer form.

⁶⁶ The youth had a normal CBC upon intake in December 2006 (H/H =13.7/42.1%). An 11/7/07 H/H was 12.8/37.5%. This lab test should be repeated and if still low, causes of anemia pursued. On 1/28/07 the patient complained of headache and abdominal pain.

⁶⁷ Youth had an abnormally low potassium (3.4) and elevated glucose (119) and SGOT (46) in July 2007. These tests should be repeated fasting to rule out lab error.

⁶⁸ There was no local policy on nursing sick call in the LOP manual.

⁶⁹ In the room where nursing sick call is conducted, there is no examination table or oto/ophthalmoscopes.

⁷⁰ This program has not yet been developed by central office.

⁷¹ The clinic room in which nurses conduct sick call does not provide adequate visual or auditory privacy.

⁷² Identity removed.

⁷³ Identity removed. 1/8/08.

⁷⁴ Identity removed.

⁷⁵ Identity removed.

⁷⁶ 1/15/08.

⁷⁷ Identity removed. 1/8/08. This 18 year old patient complained of dental pain related to partially erupting wisdom teeth. In November 2007 the dentist recommended extraction of #16 and 17 that the youth initially refused. However due to continued discomfort on 12/26/07 the youth agreed and he obtained a signed parental consent. However, following this the procedure was not done and on 1/8/08 the youth submitted another request which the dentist documented that the extraction would be done. On 1/22 the youth submitted another request but on 1/23/08 the youth was in TD and not brought to the clinic for sick call. On 1/24/08 the youth was transferred to CIM. Despite the fact that there is a Chief Dentist and 2 dentists here, there does not seem to be any urgency to perform dental work involving pain.

⁷⁸ . Identity removed 10/23/07.

⁷⁹ , Identity removed. 1/23/08.

⁸⁰ 1/18/08.

⁸¹ Triage and seen by dentist on 1/16/08. Dentist requested follow-up in two days but it did not happen. The next entry in the dental record was 1/23/08 youth not brought up because he was in detention. No follow-up since.

⁸² Screening conducted by dentist on 1/26/08.

⁸³ The nurse collected the form at 1/15/08 at 0400 but did not document a disposition related to a routine or urgent assessment.

⁸⁴ This patient was not triaged by a nurse.

⁸⁵ No assessment form. Progress note only.

⁸⁶ On 1/8/07 a HSR form was triaged by the nurse for a complaint of "My ribs hurt". On 1/8/08, the youth was listed as a "No Show". The nurse did not pursue the reason for the No Show. Since the complaint might have been injury related, this should have been done. On 1/9/08 the nurse documented on the same form that the YCO stated that the youth was on TD. The youth was not escorted to the clinic. On 1/10/08 the youth was brought to the clinic and refused to be seen. Further investigation revealed that on 1/3/08 the youth

was involved in an altercation that resulted in significant injury to another youth. He was still on TD until just recently. There was no documentation in the record to show that the youth was assessed by health care staff following the altercation. A Behavior Report documented that the three youths who attacked the other youth were brought up to the OHU.

⁸⁷ On 1/29/08 the youth who complained that his arm was hurting badly was listed as a No show for sick call with a plan to reschedule. This should have been pursued to determine the reason for the No Show. Further investigation revealed that he was in school. We inquired regarding this and the youth was brought up on 1/30/07. We reviewed the record following the encounter.

⁸⁸ A LPT, rather than an RN saw the patient.

⁸⁹ This patient complained of severe dental pain that made him cry at night. A nurse did not triage the patient.

⁹⁰ A nurse did not document the date the form was received or triaged. It is not possible to evaluate the timeliness of evaluation.

⁹¹ The nurse did not see the patient. This form was referred to the dentist who did not triage the form or see the youth until 1/25/08.

⁹² The nurse obtained a history of youth having symptoms of a cold for one week with cough and congestion. Did not inquire about sore throat, ear pain, chills, whether cough was productive, etc.

⁹³ The nurse did not obtain an appropriate history of the patient's ear pain such as precipitating event or describe the onset of symptoms, etc.

⁹⁴ The nurse did not obtain an appropriate history such as onset, duration, severity, etc.

⁹⁵ The nurse did not obtain an appropriate history of the ear pain such as onset, quality, discharge, URI symptoms, etc.

⁹⁶ The nurse did not obtain an appropriate history of the chest pain such as onset, quality, severity, duration, etc.

⁹⁷ The nurse obtained vital signs but did not examine the patient. BP 141/80 mm/hg.

⁹⁸ The nurse did not describe the patient's arm.

⁹⁹ The LPT took vital signs but did not perform an examination of the patient.

¹⁰⁰ The nurse did not examine ear, nose, throat, and neck.

¹⁰¹ The nurse took vital signs and oxygen saturation but did not auscultate the lungs or heart. This may have been deferred due to the patient's agitation but this was not documented.

¹⁰² The nurse did not examine the ears.

¹⁰³ The nurse's assessment of right arm injury was not consistent with the documentation.

¹⁰⁴ Repetition of symptoms "left ear pain".

¹⁰⁵ Repetition of symptoms of "right ear pain".

¹⁰⁶ The nurse did not document a treatment plan, but did refer the patient.

¹⁰⁷ The nurse did not document a treatment plan, but did refer the patient.

¹⁰⁸ The nurse did not document a treatment plan, but did refer the patient.

¹⁰⁹ The nurse did not document a treatment plan, but did refer the patient.

¹¹⁰ The nurse did not refer the patient in accordance with protocol. The nurse should have referred the patient to the dentist on 1/15/08.

¹¹¹ Unable to evaluate.

-
- ¹¹² Nurse did not see patient to determine urgency of the complaint.
- ¹¹³ After discussions with the supervising nurse, it was concluded that the nurse misdated the entry.
- ¹¹⁴ The dentist saw the patient and scheduled him for follow-up in 2 days. However, the patient was not seen in two days. The dentist made a note on 1/23/08 that he patient was not seen because he was in TD. He has had no follow-up since then.
- ¹¹⁵ Dentist saw patient and told to stop eating sweets. Patient arrived on 1/8/08 with numerous caries. No dental plan documented as to when treatment will begin.
- ¹¹⁶ No history related to headache.
- ¹¹⁷ Inadequate history for back pain, i.e., no history related to radiation, injury, exacerbating/alleviating factors, date of onset
- ¹¹⁸ No history related to GI upset except “no nausea”, i.e., pain, diarrhea, etc
- ¹¹⁹ Did not obtain history of sexual relations
- ¹²⁰ Youth was hit in eye. Did not check vision and did not palpate for possible orbital fracture.
- ¹²¹ No physical examination related to headache
- ¹²² No exam for tenderness, etc
- ¹²³ Should get GC, Chlamydia test in patient treated for urethritis
- ¹²⁴ Blood pressure was 154/88. This was not noted by MD.
- ¹²⁵ No follow-up
- ¹²⁶ No follow-up
- ¹²⁷ No follow-up
- ¹²⁸ No follow-up
- ¹²⁹ Treated for Chlamydia, should also treat for gonorrhea
- ¹³⁰ Did not provide education re stretching, back exercises
- ¹³¹ Hypertension, hyperlipidemia not listed
- ¹³² Did not obtain appropriate history, i.e., age of onset, ER visits, hospitalizations, prednisone use, etc
- ¹³³ Inadequate history; did not note heart murmur in physical exam, but put in assessment and on problem list
- ¹³⁴ No history related to ER visits, hospitalization, nighttime symptoms
- ¹³⁵ No history related to ER visits, hospitalization, nighttime symptoms
- ¹³⁶ No history related to ER visits, hospitalization, nighttime symptoms
- ¹³⁷ No history related to ER visits, hospitalization, nighttime symptoms
- ¹³⁸ No history related to ER visits, hospitalization, nighttime symptoms
- ¹³⁹ No initial history

-
- ¹⁴⁰ No history related to ER visits, hospitalization, nighttime symptoms
- ¹⁴¹ Not seen quarterly
- ¹⁴² No history of nighttime symptoms
- ¹⁴³ No history related to exacerbations or nighttime symptoms
- ¹⁴⁴ No history related to exacerbations, nighttime symptoms
- ¹⁴⁵ No history related to nighttime symptoms, recent exacerbations
- ¹⁴⁶ Noted moderate on problem list, but only occasional wheezing
- ¹⁴⁷ States uses inhaler generally every day. If this is so, should be prescribed inhaled steroid. MD note on 10/25 also states patient uses inhaler daily
- ¹⁴⁸ Patient uses inhaler multiple times per day, has had nebulizer treatment multiple times over last few months and is not prescribed inhaled steroid
- ¹⁴⁹ States patient uses inhaler 2x/day, should be prescribed inhaled steroids
- ¹⁵⁰ States patient uses inhaler 1-2x/day, should be prescribed inhaled steroids
- ¹⁵¹ Did not refer to chronic care clinic and not on chronic disease list
- ¹⁵² No flu vaccine
- ¹⁵³ No flu vaccine
- ¹⁵⁴ No flu vaccine
- ¹⁵⁵ Staff indicated that they do not currently forward reportable communicable diseases as required by local, state and federal law.
- ¹⁵⁶ The eyewash station in the main clinic area is not functional.
- ¹⁵⁷ October 18, 2007.
- ¹⁵⁸ January 10, 2008.
- ¹⁵⁹ Infection Control Minutes do not address key communicable disease/infection control surveillance activities.
- ¹⁶⁰ Storage drawers and cabinets are broken, difficult to open and some are unable to lock. This area needs secure cabinets and both upper and lower cabinets should be replaced.
- ¹⁶¹ Narcotics were in a locked cabinet and accounted for, but keys to the narcotic box were kept in an unlocked drawer.
- ¹⁶² There was no security staff presents for morning medication administration. Staff report inconsistency with custody presence during medication administration.
- ¹⁶³ Identity removed. This 17 y.o. arrived in DJJ on 5/4/07. He had a history of hypothyroidism and asthma. He was taking Levothyroid 50 mcg daily. Order 12/31/07.
- ¹⁶⁴ Identity removed. Physician order dated 1/7/08.
- ¹⁶⁵ Identity removed. Physician order dated 1/8/08.
- ¹⁶⁶ Identity removed. Physician order dated 1/11/08..
- ¹⁶⁷ Identity removed. Physician order dated 1/9/08.
- ¹⁶⁸ Identity removed. Physician order dated 1/14/08.

-
- ¹⁶⁹ [] Identity removed. Physician order dated 1/8/08.
- ¹⁷⁰ [] Identity removed. Physician order dated 12/18/07.
- ¹⁷¹ [] Identity removed. Physician order dated 11/30/07.
- ¹⁷² [] Identity removed. Physician order dated 11/9/07.
- ¹⁷³ No time.
- ¹⁷⁴ Unsigned by psychiatrist.
- ¹⁷⁵ Order written at 0900 and transcribed at 1400.
- ¹⁷⁶ The NP wrote the order as 50mg Levothyroxine po qd x 6 weeks. The nurse transcribed the order as Levothyroxine tab ½ tab po at noon by 6 weeks. NP ordered repeat thyroid labs in one month. Not done as of 1/31/08. Scheduled for 2/5/08. Not enrolled in the chronic disease program.
- ¹⁷⁷ The nurses' handwriting was not fully legible.
- ¹⁷⁸ No documentation status of 1/11/08 in pm.
- ¹⁷⁹ Nurse did not write D/C on 1/11/08 MAR order.
- ¹⁸⁰ The nurse did not document D/C with date and initials of discontinuation of order.
- ¹⁸¹ Order was rewritten on 1/15/08 but original order not discontinued on same date. Order expired on 1/17/08.
- ¹⁸² The MAR is defaced with yellow magic markers and crossing out over dosing boxes. Not in compliance with policy.
- ¹⁸³ The MAR is defaced with yellow magic markers and crossing out over dosing boxes. Not in compliance with policy.
- ¹⁸⁴ The nurses have crossed out the original order to signify the order is no longer active. This should not be done.
- ¹⁸⁵ The nurses have crossed out the original order to signify the order is no longer active. This should not be done.
- ¹⁸⁶ The nurses have crossed out the original order to signify the order is no longer active. This should not be done.
- ¹⁸⁷ The nurses have crossed out the original order to signify the order is no longer active. This should not be done.
- ¹⁸⁸ There are multiple urgent/emergent care logs.
- ¹⁸⁹ No emergency drills have been conducted.
- ¹⁹⁰ There no entry in the urgent/emergent log
- ¹⁹¹ Incorrect SOAP format, subjective info in objective section
- ¹⁹² Incorrect SOAP format, subjective info in objective section
- ¹⁹³ Not in SOAP format
- ¹⁹⁴ Youth involved in altercation, hit in head with resulting bump on forehead, no review of symptoms related to head injury
- ¹⁹⁵ Youth involved in altercation, hit in head, no review of symptoms related to head injury
- ¹⁹⁶ Inadequate history.

-
- ¹⁹⁷ Inadequate history. No history related to accompanying symptoms, duration of symptoms, use of inhaler, etc
- ¹⁹⁸ Inadequate history related to headache.
- ¹⁹⁹ Inadequate history and no physical exam
- ²⁰⁰ Did not document assessment
- ²⁰¹ Complaining of severe headache (8:50 am). Referred to MD for evaluation. Note 5 hours later that youth refused. Should have been seen right away for severe headache.
- ²⁰² Did not document assessment
- ²⁰³ Already addressed in Screen 4.
- ²⁰⁴ Youth was sent to emergency room, there is are no notes upon return and no records from ER
- ²⁰⁵ Patient with asthma. Presented at 7:30 pm with acute exacerbation, temperature 101.2 F oxygen saturation =91%. Should have been sent to ED.
- ²⁰⁶ Inadequate patient education
- ²⁰⁷ Inadequate patient education
- ²⁰⁸ Inadequate patient education
- ²⁰⁹ Inadequate education
- ²¹⁰ Inadequate history, physical and education
- ²¹¹ Inadequate education, history (no history of cough, fever, chills, etc)
- ²¹² Inadequate history, physical exam, and education
- ²¹³ No history or physical exam
- ²¹⁴ Should have been sent to ED that night
- ²¹⁵ No repeat vital signs, oxygen saturation that night after 2220 hours (temperature 101.4 and pulse ox 93% at that time)
- ²¹⁶ No clinician evaluation while in OHU
- ²¹⁷ Not seen 1/21
- ²¹⁸ Should have been monitored more frequently
- ²¹⁹ No nursing or MD note
- ²²⁰ No MD note
- ²²¹ No nursing note
- ²²² No nursing note
- ²²³ No nursing note
- ²²⁴ BMI 32.3, weight not addressed
- ²²⁵ BMI 29.8, weight not addressed

²²⁶ BMI 25.2, weight not addressed

²²⁷ BMI 24.5, weight not addressed

²²⁸ Seen in neurology clinic 12/11. Had been approved in ED during prior visit. No history given on consult request.

²²⁹ Patient stated hip pain not improving when seen by physician for follow-up of ortho visit. Physician did not order subsequent follow-up.

²³⁰ Some files are missing DEA licenses, C-V, data bank searches, medical license and/or EDFMG certificate

²³¹ Dr. Do has been seeing some chronic care patients and he is not board certified or eligible.

**CALIFORNIA DEPARTMENT OF
CORRECTIONS
AND REHABILITATION
DIVISION OF JUVENILE JUSTICE**

**Ventura Youth Correctional Facility
Health Care Audit
December 4-6, 2007**

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Introduction

The Health Care Remedial Plan (HCRP) requires the Division of Juvenile Justice (DJJ) to make a number of specific changes in the medical, mental health, and dental care programs. To measure DJJ compliance with the requirements of the Health Care Remedial Plan, the Medical Experts developed this audit instrument with clearly defined standards, criteria, and thresholds of compliance. The audit instrument is comprised of indicators selected from:

- The Health Care Remedial Plan
- DJJ policies and procedures developed in consultation with the Medical Experts
- National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Juvenile Detention and Confinement Facilities, 2004 Edition
- The American Medical Association's Guidelines for Adolescent Preventive Services (GAPS)
- US Preventive Services Task Force (USPSTF)
- Guidelines for the evaluation and treatment of other disease such as those published by the Centers for Disease Control and Prevention (CDC)

Regarding those areas related to nursing and medical care practice, the Medical Experts will use their professional judgment to assess compliance.

NOTE: This audit instrument does not address mental health. The Mental Health Experts will develop the Mental Health Audit Instrument.

Audit Instrument and Compliance Thresholds

The audit instrument will be used by the Medical Experts to evaluate compliance with the HCRP. It is also intended for use by the DJJ Office of Health Services Quality Management Team and by the local facility Quality Management Team to evaluate progress consistent with the HCRP. The audit instrument includes indicators from sources cited above, which the Medical Experts judge to be critical in establishing an adequate health care system. Some indicators allow for partial compliance if the facility is close to, but has not yet achieved substantial compliance.

The Medical Experts have developed a companion document to the audit instrument entitled ***Health Care Audit Instrument Instructions***. Its purpose is to clarify interpretations and scoring of the audit instrument. This document is available on request.

A facility is in substantial compliance when all of the following conditions are satisfied:

- a. The facility receives a score of 85% or higher during an audit conducted by the Court experts. When determining overall compliance, areas that are determined to be in partial compliance will be considered non-compliant. The experts shall have the discretion to find a facility providing adequate medical care in compliance if it achieves a score of no less than 75%.

- b. Medical assessments and treatment plans provided to youth comply with the policies and procedures, as determined by the medical experts. The medical assessment and treatment plans provided to the youth shall be deemed adequate and appropriate under these policies and procedures, only under any one of the following conditions:
 - (1) The assessment or treatment plan is consistent with guidelines specifically adopted in the policies and procedures; or
 - (2) The practitioner documents in the medical notes that he/she is deviating from adopted policies and procedures, and that such deviation is consistent with the community standard; or
 - (3) Where no treatment guidelines are specifically adopted in these policies and procedures, the assessment or plan is consistent with the community standard.
- c. The facility is conducting minimally adequate death reviews and quality management proceedings.
- d. The facility has tracking, scheduling, and medication administration systems adequately in place.
- e. Both experts have concluded that there is not a pattern or practice that is likely to result in serious violations of wards' rights that is not being adequately addressed.

We are available to answer questions as well as provide training to staff regarding the audit instrument.

Ventura Youth Correctional Facility

Executive Summary

Overall, the facility scored 76%. The facility population at the time of our visit was 125 females and 76 males in the camp. There are currently five living units, plus the camp.

The facility has made significant progress in improving health care services. Clinic sanitation is excellent; clinics are clean and well organized. We note however, that local policies have not yet been developed or implemented.

Summary of Health Care Areas Reviewed

- Facility, Leadership, Budget, Staffing, Orientation and Training scored 63%.

Areas to be addressed include the establishment of a health care budget that is managed by the Chief Medical Officer. We note that the facility has not been provided an institutional or health care budget for the fiscal year, which is almost half over. The facility spends money as they deem necessary, without being able to determine whether they are over or under their budget.

Nurses continue to report lack of pay parity for selected classifications. We were unable to verify this during our visit and this should be explored further by Health Care Services.

We did not evaluate staffing during this visit. We did note however that there were 7 nursing vacancies for 21 budgeted positions. We toured the special counseling units Alvarado and BV. We interviewed the unit manager regarding daily activities of the youth and staff in the unit. He indicated that the youth are in school from 8:00 am-3:30 pm, Monday through Friday. A registered nurse and two psych techs provides coverage for the two units for days and evenings. As of the week prior to our visit, it was decided that the registered nurse will not conduct sick call in the housing unit because the room does not have an exam table and youths are not permitted to be in the room unescorted for security reasons. Thus the sole duties of the registered nurse are to administer medications for a total of 30 wards. On the day of our tour, there were no psych techs in the unit and we inquired as to their whereabouts. The unit manager reported that he didn't know.

Although there has been improved cooperation between medical and custody staff, there is a need for further cooperation and coordination of activities. One area is that staff reported that officers do not consistently permit youth to be escorted to the medical clinic when medication administration is occurring. This is primarily because there is only one officer posted in the medical section who must be present during medication administration. If any other youth are brought to the medical section, another officer must be present and this does not consistently occur. Scheduled and unscheduled visits, as well as medication administration are to be anticipated on a daily basis and custody posts should be established to provide supervision of these dual activities. During our review we observed that a youth in emotional crisis was left

alone and unsupervised in the medical clinic while the nurse called a physician to report the patient's condition. There must be adequate custody posts to provide health care services 24 hours per day. Another area requiring improved cooperation is that when youth are scheduled for medications or clinical appointments and want to refuse these services, medical policies require that the youth refuse in person. However, we were advised that officers do not uniformly enforce the requirement to have youth report to the medical clinic to do so. Although youth have a right to refuse care, they do not have the right to refuse direction from a correctional officer.

- Medical Reception scored 69%. Medical reception is generally occurring in a timely manner with exceptions. Areas requiring improvement include performing accurate and complete reviews of current symptoms; identification of active problems with a corresponding treatment plan for each problem, including known risk factors (obesity, tobacco, and substance abuse); and documentation of laboratory test result counseling. We recommend that clinicians review initial progress notes carefully to ensure awareness of problems not initially identified on the day of arrival.
- Intrasystem Transfer scored 83%. The intrasystem transfer process is occurring in a timely manner. There is staff confusion regarding when to use the Intrasystem transfer versus medical reception logs. Areas requiring improvement include the development and implementation of a local policy, and to ensure that clinicians review, date and sign the intrasystem transfer form in a timely manner.
- Nursing Sick Call scored 62%. Youth requests are being collected and triaged in a timely manner, however sick call is not being uniformly performed in clinical areas providing privacy and, not unexpectedly, nursing assessments are poor. Nurses have not received training in health assessment and nursing protocols. Areas requiring improvement include development of local policy, performance of nursing sick call in clinical areas with privacy, training of nursing staff regarding health assessment skills and nursing protocols, and a system for ongoing peer review and feedback to assist nurses in improving their assessment skills.
- Medical Care scored 81%. Areas requiring improvement included the history of the presenting complaint, clinical assessment, and treatment plan.
- Chronic Disease Management scored 77%. Areas requiring improvement included the initial history and frequency of chronic care visits.
- Infection Control scored 50%. The infection control program is in development. Areas requiring improvement include provision of training to the infection control nurse, conducting infection control meetings a minimum of quarterly, and addressing key infection control indicators. As the program develops, staff should focus on data showing trends that health care staff should address (e.g. positive culture reports, % of TB skin test conversions, % of youth completing hepatitis vaccinations, etc.)
- Pharmacy Services scored 92%. Congratulations. While the facility met the goal of 85%, an area that could be improved is that the computer software does not have the capability to identify drug-drug interactions.
- Medication Administration Process scored 77%. Nurses administering medications to youth adhered to accepted nursing practices. The medication room was neat and

organized and all narcotics were accounted for. Areas requiring improvement include the development of a local policy, compliance with time requirements for administration of hour of sleep medications, and improved cooperation between nursing and custody staff during medication administration (e.g. staff reported feeling rushed by custody because of scheduling issues which nurses perceived did not permit them to follow proper medication administration procedures and increasing risk of medication errors).

- Medication Administration Health Record review scored 84%. Although this area did generally well, there should be increased attention to accurate and timely transcription of orders, proper documentation of discontinuation of medications, and signatures on the MAR.
- Urgent/Emergent Care scored 75%. Areas requiring improvement included the use of the SOAP format by nursing staff, nursing evaluations, checking emergency equipment and performance of emergency training and drills.
- Outpatient Housing Unit was not assessed during this visit.
- Health Records scored 25%. Areas requiring improvement included development of a local policy, need for a tracking system for laboratory and x-ray reports, and need for an accountability system for the UHRs.
- Preventive Services scored 88%. While the facility met the goal of 85%, an area that could be improved is clinician identification and development of a treatment plan for youth who are obese.
- Consultations scored 84%. Areas requiring improvement included follow-up after the consultation.
- Peer Review scored 40%. Areas requiring improvement included development of a local policy, monitoring by statewide Medical Director, and biannual reviews.
- Credentialing scored 88%. Congratulations. While the facility met the goal of 85%, an area that could be improved is the development of a local policy.
- Quality Management scored 38%. Areas requiring improvement include development of a local policy, conducting of CQI studies, physician review of nursing sick call, SRN review of nursing sick call and annual Quality Management Report to the Statewide Medical Director.

Recognizing that there are areas requiring improvement, we wish to congratulate staff on their progress to date.

The following section of this report shows the specific results of the audit during this visit. Each of the remaining sections shows the individual audit tool, and the results of each question and screen. Where a score of zero (0) was given, we inserted an endnote to describe the reasons for partial or noncompliance. Placing the cursor over the endnote will show the reviewers comment or the reviewer may click on the endnote to find the text at the end of the document that describes the reason for the finding. In the cases where non-compliance is self-explanatory, an endnote is not added.

Facility Leadership, Budget, Staffing, Orientation and Training

Interview facility leadership. Review staffing and vacancy reports, facility health care budget, staff credentials and licensure, and orientation and training documentation. Key: SC =Substantial Compliance, PC=Partial Compliance, NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Key facility health care leadership positions (Chief Medical Officer [CMO], Supervising Registered Nurse [SRN], Pharmacist, etc.) are filled or are being effectively recruited. Pay parity exists with CDCR.		0 ¹		
Question #2	Each facility has a full-time CMO who is board-certified or eligible in a primary care field. The NCYCC shall have one full-time CMO responsible for all complex facilities. The CMO's duties are consistent with the HCSR (see page 14).	1			
Question #3	In both policy and actual practice, the facility is assigned a health care budget that is under the control of the CMO.			0 ²	
Question #4	Budgeted and actual physician staffing hours are sufficient to meet policy and procedures requirements, and to provide quality medical services.	1			
Question #5	Budgeted and actual registered nurse staffing hours are sufficient to meet policy and procedures requirements and to provide quality nursing services.	1			
Question #6	Medical Technical Assistant's (MTA) primary responsibilities will be the performance of health care duties.				N/A
Question #7	Escort staffing and cooperation are sufficient to assure that youth attend on-site health care appointments		0 ³		
Question #8	The CMO ensures that an accurate and complete system exists for tracking professional and DEA licensure; and that CPR certification is in place. All licensed staff has a current and valid license.	1			
Question #9	Newly hired staff receives a structured orientation program within 30 days of arrival. Documentation of orientation is kept in personnel files.	1			
Question #10	Existing staff is trained regarding changes in new policies and procedure within 60 days of distribution.				N/E
	Totals:				

Compliance = 63% (5 of 8 applicable Questions)

Medical Reception

Select 10 to 20 health records of youth completing medical reception within the past 60-90 days. Include youth with known Latent TB infection and other health problems. Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	The medical reception process is conducted in a confidential and private manner. Signage (in English and Spanish) regarding confidentiality is in the medical area.	1			
Question #2	There is a comprehensive verbal and written orientation program (minimum English and Spanish) for youth in a language they understand.		0 ⁴		
	For calculating score, only give credit for applicable questions in substantial compliance.	Totals:			

Write the youth's ID number in top row:

State ID# →	1 ⁵	2 ⁶	3 ⁷	4 ⁸	5 ⁹	6 ¹⁰	7 ¹¹	8 ¹²	9 ¹³	10 ¹⁴
Screen # 1	1	1	1	1	0 ¹⁵	1 ¹⁶	1	1	1	1
Screen # 2	N/A	1	1	N/A	1	0 ¹⁷	N/A	1	N/A	1
Screen # 3	1	1	1	1	1	1	1 ¹⁸	1	1	1
Screen # 4	1	1	0 ¹⁹	1	1	0 ²⁰	1	1	1	1
Screen # 5	0 ²¹	1	0	0 ²²	0 ²³	1	1	1	1	1
Screen # 6	0 ²⁴	1	0 ²⁵	0 ²⁶	0	0 ²⁷	0 ²⁸	0 ²⁹	1	0 ³⁰
Screen # 7	0 ³¹	1	1	0 ³²	1	0 ³³	1	1	1	1
Screen # 8	1	0 ³⁴	N/A	0 ³⁵	0 ³⁶	0 ³⁷	0 ³⁸	0	N/A	1
Screen # 9	N/A	1	1	1	1	1	1	1	1	1
Screen # 10	N/A	0 ³⁹	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

- Screen # 1 A nurse completed the Receiving Health Screening form on the day of arrival. The nurse referred to, or contacted a clinician for all youth with acute medical, mental health, or dental conditions; with symptoms of TB; or on essential medications.
- Screen # 2 A clinician ordered essential medications (e.g., chronic disease, mental health) on the day of arrival. Medications were administered within 24 hours. No insulin, TB, or HIV doses were missed.
- Screen # 3 A nurse measured the youth's height and weight, vital signs, visual acuity, initiated the immunization history, and planted a PPD (unless previously positive) within 24 hours of arrival. The TB test was read and documented within 72 hours.
- Screen # 4 A nurse obtained routine laboratory tests (RPR, GC, and Chlamydia, voluntary HIV antibody test, pregnancy screen, disease specific tests) within 72 hours and results were communicated to youth either at the time the physical exam was performed or when the youth was brought back for counseling. The clinician appropriately addressed abnormal laboratory findings, including counseling the youth as appropriate.
- Screen # 5 A nurse or clinician documented HIV Post-Test notification and counseling.
- Screen # 6 A clinician performed a history and physical including a testicular exam for males and pelvic examination for females (if clinically indicated) within seven calendar days of arrival. The clinician integrated information from the health screening examination, laboratory tests, and medical history into the physical exam process.
- Screen # 7 A clinician (MD, NP, or PA) initiated a Problem List noting all significant medical, dental, and mental health diagnoses.
- Screen # 8 A clinician documented an appropriate treatment plan on the History and Physical Exam Form or in the Progress Notes. The plan included appropriate diagnostic, therapeutic measures, patient education, and clinical monitoring (if indicated).
- Screen # 9 The UHR reflects that all medical reception physician orders were implemented as ordered.

Screen # 10 Youth with chronic diseases (e.g., asthma, diabetes) were enrolled in the chronic disease management program and clinically evaluated by a clinician for their chronic disease within 30 days of arrival.

Medical Reception Summary:

Screen #	# Records Reviewed	#N/A	Final # of Records	# of Compliant Records	COMMENTS
1	10	0	10	9	
2	10	4	6	5	
3	10	0	10	10	
4	10	0	10	8	
5	10	0	10	6	
6	10	0	10	2	
7	10	0	10	7	
8	10	2	8	2	
9	10	1	9	9	
10	10	9	1	0	
Total	100	16	84	58	Plus 1 of 2 Questions

Compliance = 69% (59 of 86 Screens and Questions)

Intrasystem Transfer

Select 10 to 20 health records from the Intrasystem Transfer Log and corresponding Medical Administration Records (MARs) of youth transferred to the facility in the previous 120 days. Review pertinent scheduling logs (consultation, chronic illness clinic, etc.).

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy and procedure. The statewide Transfer Form is in use.			0	
Question #2	There is a process whereby health care staff is notified of pending transfers from the facility one business day in advance of transfer.	1			
	For calculating score, only give credit for applicable questions in substantial compliance.	Totals:			

Write the youth's ID number in top row.

State ID# →	1 ⁴⁰	2 ⁴¹	3 ⁴²	4 ⁴³	5 ⁴⁴	6 ⁴⁵	7 ⁴⁶	8 ⁴⁷
Date of arrival	3/17/07	9/12/07	6/22/07	5/24/07	8/16/07	10/17/07	10/17/07	11/7/07
Screen # 1	1	1	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	0 ⁴⁸	1	1
Screen # 3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Screen # 4	0 ⁴⁹	1	1	1	0	1 ⁵⁰	1	1
Screen # 5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Screen # 6	N/A	0 ⁵¹	N/A	1	1	N/A	N/A	N/A
Screen # 7	N/A	N/A	N/A	N/A	N/A	N/A	1	N/A

- Screen # 1 A sending facility nurse reviewed the youth's record prior to transfer and documented required health information on the statewide transfer form. If the sending facility nurse did not complete the transfer form, the receiving nurse documented that she notified the facility of this (minimum information is the sending facility and who the nurse spoke to).
- Screen # 2 Upon arrival, a nurse interviewed the youth and reviewed the UHR. The nurse completed the form noting any additional information related to acute and chronic medical or mental health conditions, current medications, pending or recently completed consultations, and any other health condition requiring follow-up or special housing on the transfer form.
- Screen # 3 The receiving nurse referred youth with acute medical, dental, or mental health conditions on the day of arrival.
- Screen # 4 The receiving physician reviewed the health record of each youth within one business day of arrival and legibly signed and dated the Intrasystem form. The clinician addressed any significant medical problems.
- Screen # 5 A clinician evaluated youth with chronic diseases within 3 business days and enrolled the youth into the chronic disease program.
- Screen # 6 The MAR showed that continuity of essential medications (e.g., chronic disease, mental health, antibiotics, etc.) was provided.
- Screen # 7 The UHR shows that medical care ordered at the previous facility (e.g., vaccinations, consultations, laboratory tests) was carried out following arrival, or a clinical progress note provided an appropriate rationale for doing otherwise.

Intrasystem Transfer Summary:

Screen #	# Records Reviewed	# N/A	Final # of Records	# of Compliant Records	COMMENTS
1	8	0	8	8	
2	8	0	8	7	
3	8	8	0	N/A	
4	8	0	8	6	
5	8	8	0	N/A	
6	8	5	3	2	
7	8	7	1	1	
Total	56	28	28	24	Plus 1 of 2 Questions

Compliance = 83% (25 of 30 Questions + Screens)

Nursing Sick Call

Select 10 to 20 health records from general population nursing sick call encounters during the last 120 days. Key: SC =Substantial Compliance, PC=Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy. The statewide health services request form is in use.			0 ⁵²	
Question #2	Youth can confidentially submit Health Services Request forms (HSRF) daily into a locked box accessed only by health care staff. Health care staff collects and triages the forms daily.	1			
Question #3	Upon youth request, custody or health care staff assists youth with completion of the HSRFs. Sign language and translation services are available.	1			
Question #4	Nursing sick call is conducted in clean, adequately equipped, and supplied rooms with access to a sink for hand-washing or alcohol-based sanitizer.			0 ⁵³	
Question #5	Nursing sick call is conducted 5 days a week for each housing unit, excluding weekends and holidays.	1			
Question #6	All registered nurses conducting sick call have been trained and demonstrate competency in health assessment and use of nursing protocols.			0 ⁵⁴	
Question #7	The UHR is available and present for sick call encounters including in specialized housing units and during lockdowns.	1			
Question #8	Nurses conduct sick call with, at a minimum, auditory privacy, and also with visual privacy if a physical examination is performed.			0 ⁵⁵	
Question #9	There is signage in all health care delivery areas stating that staff shall maintain the confidentiality of medical information.	1			
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:				

State ID# →	1 ⁵⁶	2 ⁵⁷	3 ⁵⁸	4 ⁵⁹	5 ⁶⁰	6 ⁶¹	7 ⁶²	8 ⁶³	9 ⁶⁴	10 ⁶⁵
Triage Date HSR →	11/27/07	11/5/07	11/28/07	10/3/07	10/11/07	10/18/07	11/30/07	10/27/07	11/11/07	11/14/07
Date NSC →	11/27/07	11/5/07	11/29/07	10/3/07	10/11/07	10/18/07	11/30/07	10/27/07	11/11/07	11/14/07
Complaint	Right knee pain	Multiple complaints	Chest Pain	Ear pain	H/A, coughing blood	Anxiety, increased HR	Left ear pain	UTI	Abdominal pain	Neck pain
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	0 ⁶⁶	0 ⁶⁷	1	0 ⁶⁸	0 ⁶⁹	0 ⁷⁰	0 ⁷¹	0 ⁷²	1	0 ⁷³
Screen # 4	0 ⁷⁴	0 ⁷⁵	0 ⁷⁶	0 ⁷⁷	0 ⁷⁸	0 ⁷⁹	0 ⁸⁰	0 ⁸¹	1	0 ⁸²
Screen # 5	0 ⁸³	1	0 ⁸⁴	0 ⁸⁵	0 ⁸⁶	0 ⁸⁷	1	0 ⁸⁸	0 ⁸⁹	0 ⁹⁰
Screen # 6	1	1	1	1	1	1	1	0 ⁹¹	0 ⁹²	1
Screen # 7	1	1	0 ⁹³	1	0 ⁹⁴	1	1	0 ⁹⁵	0	0 ⁹⁶
Screen # 8	1	1	1	1	1	1	1	0 ⁹⁷	1	1

Screen # 9	1	1	1	1	1 ⁹⁸	1	1	N/A ⁹⁹	N/A	1
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- Screen # 1 The nurse performed same-day triage of the Health Services Request Form and documented an appropriate disposition.
- Screen # 2 The nurse saw youth with urgent complaints on the same day, or youth with routine complaints the following business day.
- Screen # 3 The nursing subjective history was appropriate to the patient's complaint and included a description of onset of symptoms.
- Screen # 4 The nursing physical assessment and collection of objective data was appropriate to the complaint (e.g., vital signs, Snellen test, urine dipstick, etc.).
- Screen # 5 The nursing diagnosis/assessment was appropriate based on the clinical findings.
- Screen # 6 The plan of care and nursing intervention were consistent with case history, physical findings, and the applicable nursing protocol.
- Screen # 7 The nurse referred the patient to a clinician in accordance with the criteria for referral found in the nursing protocol, or accepted in accordance with good clinical judgment.
- Screen # 8 The nurse legibly dated, timed, and signed the form.
- Screen # 9 The referral visit to the clinician took place according to protocol: stat-immediate, urgent-same day, routine-within 5 business days.

Nursing Sick Call Summary:

	# of Records	#N/A	Final #Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	10	
Screen #2	10	0	10	10	
Screen #3	10	0	10	2	
Screen #4	10	0	10	1	
Screen #5	10	0	10	2	
Screen #6	10	0	10	8	
Screen #7	10	0	10	5	
Screen #8	10	0	10	9	
Screen #9	10	2	8	8	
Total	90	2	88	55	Plus 5 of 9 questions

Compliance = 62% (60 of 97 Questions + Screens)

Medical Care

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Did the clinician sign all medical encounters? If the signature was illegible, was a stamp with the clinician's name and credentials used?	1			

Select 10 to 20 records of youth seen by an MD, NP, or PA for medical encounters (return from hospitalization, infirmary, sick call referral, etc.) in the past 180 days.

State ID# →	1	2	3	4	5	6	7	8	9	10
Visit date:	11/30/07	9/5/07	11/7/07	11/14/07	11/4/07	12/3/07	9/13/07	11/7/07	10/18	10/19
Clinician name:	Dr. A	Dr. A	Dr. A	Dr. A	Dr. A	Dr. B	Dr. B	Dr. A	Dr. B	Dr. A
Nature of visit:	Shortness of breath	Left leg lesion	Hand pain	Ear discharge	Toe pain	Abdominal pain	Chest pain	Headache	Abdominal burning	rash
Screen # 1	1	1	1	0 ¹⁰⁰	1	0 ¹⁰¹	1	1	1	1
Screen # 2	1	0 ¹⁰²	1	1	1	1	1	1	0 ¹⁰³	1
Screen # 3	1	1	1	0 ¹⁰⁴	1	1	1	1	1	1
Screen # 4	1	1	1	1	1	0 ¹⁰⁵	1	1	N/A	1
Screen # 5	1	0 ¹⁰⁶	1	1	1	0 ¹⁰⁷	1	1	0 ¹⁰⁸	0 ¹⁰⁹
Screen # 6	1	1	1	1	1 ¹¹⁰	1	1	1	N/A	1
Screen # 7	1	1	0 ¹¹¹	1	0	N/A	N/A	N/A	N/A	N/A

- Screen # 1 The clinician addressed the patient's current complaint by obtaining a history of the present illness and appropriate review of systems.
- Screen # 2 The nurse or clinician measured a full set of vital signs when clinically appropriate (including weight, if clinically indicated).
- Screen # 3 The clinician documented all pertinent physical findings, laboratory, and diagnostic results or other related objective data.
- Screen # 4 The clinician made an appropriate assessment based upon the patient's medical history, laboratory, and physical findings.
- Screen # 5 The clinician documented an appropriate treatment plan that included diagnostic and therapeutic measures, clinical monitoring, and follow-up.
- Screen # 6 The clinician documented appropriate patient education related to the diagnosis and treatment plan.
- Screen # 7 All aspects of the treatment plan occurred as ordered within a clinically appropriate time.

Medical Care Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	8	
Screen #2	10	0	10	8	
Screen #3	10	0	10	9	
Screen #4	10	1	9	8	
Screen #5	10	0	10	6	
Screen #6	10	1	9	9	
Screen #7	10	5	5	3	
Total	70	7	63	51	Plus 1 of 1 Question

Compliance = 81% (52 of 64 Screens +Questions)

Chronic Disease Management

Number of patients enrolled in clinic = 28

Percent of clinic health records reviewed =36%

Select 10 to 20 health records or 10% of this clinic population. Avoid records of youth arriving within the past 90 days. Write the youth's ID number in top row below:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	0	1	1	1	1	1	1
Screen # 2	1	0 ¹¹²	0 ¹¹³	0 ¹¹⁴	0 ¹¹⁵	0 ¹¹⁶	0 ¹¹⁷	0 ¹¹⁸	0 ¹¹⁹	0 ¹²⁰
Screen # 3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1
Screen # 4	0	0	0 ¹²¹	0 ¹²²	1	1	0 ¹²³	1	1	1
Screen # 5	1	N/A	N/A	1	1	0 ¹²⁴	N/A	1	1	1
Screen # 6	1	0	N/A	1	1	1	1	1	1	1
Screen # 7	1	1	N/A	1	1	1	1	1	0 ¹²⁵	1
Screen # 8	1	1	N/A	1	1	1	1	1	1	1
Screen # 9	1	1	1	1	1	1	0 ¹²⁶	1	1	1
Screen # 10	N/A	1	1	1	1	1	N/A	1	1	N/A

- Screen # 1 All chronic diseases are listed on the Problem List.
- Screen # 2 For the initial chronic care visit the clinician performed an appropriate medical history, physical examination pertinent to the management of the chronic disease.
- Screen # 3 Baseline and ongoing follow up laboratory/diagnostic data (HbA_{1c}, serum drug levels, if ordered, etc.) were completed prior to the scheduled clinic visit and the clinician addressed results during the clinic visit.
- Screen # 4 The clinician saw the patient quarterly or more frequently as clinically indicated (i.e., based on degree of disease control). Appropriate exceptions are documented in the UHR.
- Screen # 5 The clinician's evaluation of the youth was clinically appropriate (interval history, physical examination, laboratory tests, etc.).
- Screen # 6 The clinician accurately assessed degree of disease control (i.e., good, fair, poor).
- Screen # 7 The clinician's treatment plan documented appropriate diagnostic & therapeutic measures based upon disease control and indicates when the patient is to be seen for the next clinic follow up visit.
- Screen # 8 The clinician's or nurse's notes document appropriate patient education regarding disease process, diagnostic tests, treatment goals, medication purpose, and side effects, etc.
- Screen # 9 There were no lapses in medication continuity. The clinician's assessment of medication adherence is consistent with the MAR. If the patient was non-adherent, counseling is documented in the health record.
- Screen # 10 The clinician offered/ordered Pneumococcal and annual influenza immunizations as recommended. If accepted, the nurse documented the date of administration and initials on the Immunization and Communicable Disease Record. If refused, the clinician or nurse obtained refusal of treatment.

Chronic Disease Management Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	9	
Screen #2	10	0	10	1	
Screen #3	10	9	1	1	
Screen #4	10	0	10	5	
Screen #5	10	3	7	6	
Screen #6	10	1	9	8	
Screen #7	10	1	9	8	
Screen #8	10	1	9	9	
Screen #9	10	0	10	9	
Screen #10	10	3	7	7	
Total	100	18	82	63	

Compliance = 77% (63 of 82 Screens)

Infection Control

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question # 1	There is a Local Operating Procedure (LOP) describing the facility's infection control program that is consistent with statewide policy.			0	
Question # 2	There is a licensed health care provider who is designated as having public health/infection control duties and who has received appropriate orientation and training.		0 ¹²⁷		
Question # 3	There is a functional system for reporting diseases and laboratory test results, which are required by State and Federal Law (e.g., AIDS cases, positive HIV results, Hepatitis A, B, or C, syphilis, etc.).	1			
Question # 4	There are exposure control plans in place for airborne and blood borne pathogens that include: a) Documentation of new hire and annual training regarding exposure control plans (yes) b) A policy describing use of standard precautions to prevent contact with blood or other potentially infectious materials (OPIM) (yes) c) A policy describing engineering (sharps disposal, specimen handling) and work practice controls intended to eliminate or minimize employee exposure (yes) d) A policy describing housekeeping procedures used to maintain a clean and sanitary environment, including a written schedule for cleaning and methods of decontamination (yes)	1			
Question # 5	Engineering Controls: a) Sharps containers are secure and easily accessible in areas where sharps are used. (yes) b) Hand wash facilities are in or near all work areas and antiseptic hand cleaner are available when needed. (yes) c) An eyewash station is present and tested quarterly for functionality. The eyewash station functions properly. (yes) d) Specimen containers are used for transport of biological specimens (e.g., blood, urine). e) Biohazard storage bins are available. (yes) f) Blood and body fluid spills are cleaned appropriately per policy. (N/E)	1			
Question # 6	Compliance with work practice controls: a) Food and drink are not kept in refrigerators, freezers, shelves, cabinets, or counter tops where blood, laboratory specimens, or other potentially infectious materials are kept. (yes) b) Staff observes Standard Precautions. (N/E) c) Refrigerators are labeled appropriately (biohazard for specimens, food only, or medication only). (yes) d) Personal Protective Equipment is immediately available in health care delivery areas. (yes) e) Staff performs hand-washing as required. (N/E)	1			

Infection Control Continued:

Infection Control Continued:						SC	PC	NC	NA
Question 7	Are Infection Control Meetings held quarterly (minimum 4 meetings per year)?						0 ¹²⁸		
Question 8	If Question 7 is SC or PC , do the minutes address the following areas? (Put Y if topics are present or N if topic is missing, for each quarter in space provided):	QTR 1	QTR 2¹²⁹	QTR 3	QTR 4¹³⁰		0		
	a) TB skin testing programs for staff and youth	0	0	0	0				
	b) Exposure control plans and training regarding airborne and blood borne pathogens	1	1	0	1				
	c) Hepatitis B training and vaccination programs (e.g., number of employees trained, number accepting vaccine, and number completing vaccination series)	0	1	0	1				
	d) Staff compliance with work practice controls	1	0	0	1				
	e) Reporting communicable diseases for the previous quarter, noting any trends present	0	0	0	0				
	f) Sanitation reports (institutional and infection control) and any follow-up action taken	0	1	0	0				
Question 9	If respiratory isolation rooms are used for the purposes of respiratory isolation they are functional as evidenced by routine testing (at least monthly when not in use and daily when in use). Is staff fit-tested for N-95 respirators?								N/A
For calculating score, only give credit for applicable questions in substantial compliance.									
Totals:									

Compliance = 50% (4 of 8 Questions)

Pharmacy Services

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Is the pharmacy currently licensed?	1			
Question #2	Are the pharmacy and medication rooms adequately lit, organized, clean, and provide sufficient space to prepare medications?	1			
Question #3	Does the facility pharmacist or pharmacy tech conduct monthly inspections of the pharmacy, medications rooms, and all areas of the facility where medications are stored? Does the facility pharmacist or designee develop and implement a plan to correct identified deficiencies?	1			
Question #4	Does the pharmacy have computers and software programs to track medication usage, inventory, cost, drug-drug interactions, and clinical prescribing patterns?		0 ¹³¹		
Question #5	Does the pharmacist dispense all prescriptions into appropriate containers labeled with the youth's name, ID number, and medication information as required by state law?	1			
Question #6	Is there strict accountability for all medications dispensed from the pharmacy, including medications administered from a night locker?	1			
Question #7	Is there a pharmacy system for monitoring patient adverse drug reactions?	1			
Question #8	Does the facility have a 24-hour prescription service or other mechanism to provide essential medications 24 hours per day (e.g., night locker)?	1			
Question #9	Are stock bottles of legend medications kept inside the pharmacy (except for biological agents such as insulin and vaccines under proper storage conditions)?	1			
Question #10	Is there a facility Pharmacy and Therapeutics Committee that meets quarterly? Do P & T meeting minutes reflect meaningful content and initiatives to improve pharmacy services?	1			
Question #11	Are youth with asthma permitted to keep inhalers in their possession (except for cause documented in the health record)? Are youth permitted to keep other medications in their possession as determined by the CMO?	1			
Question #12	The pharmacist provides a monthly report detailing pharmacy utilization costs, drug stop lists, monthly lists of drugs used by class, and physician prescribing lists.	1			
Question #13	When a youth paroles, is medication continuity provided in accordance with the policy?	1			
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	12			

Compliance = 92% (12 of 13 Questions)

Medication Administration Process

Observe all areas where medications are stored and administered. Observe the medication administration process.

Key: SC =Substantial Compliance, PC=Partial Compliance, NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	Are medications administered from centralized medication rooms, except in specialized mental health units, SMP, TD, or BTP?	1			
Question #2	Is there a local policy for medication administration that is in compliance with the statewide policy and procedure?			0 ¹³²	
Question #3	Are the medication storage and administration rooms secure, clean, organized, and have adequate space, storage, lighting, and a sink or alcohol-based hand sanitizer?	1			
Question #4	Are all medications in the Documed or night locker current and accounted for (from a sample of 5 medications)?	1			
Question #5	Are all narcotics and other controlled substances double-locked, counted at every shift, and all accounted for (from a sample of 5 medications)?	1			
Question #6	Are all needles and syringes securely stored, counted at every shift, and all accounted for?	1			
Question #7	The medication room contains no medications that are discontinued or expired. (There is a 3-day window period to return these medications to the pharmacy.)	1			
Question #8	Are external medications stored separately from internal medications?	1			
Question #9	Does the nurse administer all legend medication from properly labeled containers and not from stock bottles?	1			
Question #10	Does custody staff provide continuous security during medication administration?		0 ¹³³		
Question #11	Medications that are to be administered at the hour of sleep are not administered before 2100 hours (one hour window permitted).			0 ¹³⁴	
Question #12	Is the medication refrigerator clean and used only to store medications (no food or specimens)? Does staff check and log the temperature daily?	1			
Question #13	Medications are not crushed except upon a physician order and for a valid reason (e.g., patient is known to hoard medication). Time-released medications are not crushed.				N/E
Question #14	Observe the nurse administering medications to 5 to 10 youth, and answer the following elements.	1			
					Y or N
a.	The medication administration record (MAR) was available to the nurse during medication administration.				Y
b.	The nurse confirmed the identity of the youth per policy.				Y
c.	The nurse compared the medication container label to the MAR.				Y
d.	The nurse placed the medications into a cup prior to administration.				Y
e.	The nurse performed visual oral cavity checks for medications in accordance with medication administration policies.				Y
f.	The nurse documented on the MAR at the time the medication is administered.				Y
g.	If a medication was not available after hours, the nurse obtained the medication from the Documed or night locker and signed it out prior to administration.				N/A

Medication Administration Process:

Compliance =77 % (10 of 13 Questions)

Medication Administration Health Record Review

Select 10 to 20 health records and corresponding MARs of patients receiving medications in the preceding 180 days to review. Write the youth's ID number in top row below:

State ID# →	1 ¹³⁵	2 ¹³⁶	3 ¹³⁷	4 ¹³⁸	5 ¹³⁹	6 ¹⁴⁰	7 ¹⁴¹	8 ¹⁴²	9 ¹⁴³	10 ¹⁴⁴
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	0 ¹⁴⁵	1	1	1	N/A ¹⁴⁶	1	1	1	1
Screen # 4	1	1	1	1	0 ¹⁴⁷	0 ¹⁴⁸	1	1	0 ¹⁴⁹	1
Screen # 5	1	1	1	1	1	1	1	1	0 ¹⁵⁰	1
Screen # 6	1	1	1	0 ¹⁵¹	1	1	1	1	0 ¹⁵²	1
Screen # 7	1	1	1	0	1	1	1	1	N/A	1
Screen # 8	0 ¹⁵³	0 ¹⁵⁴	N/A	N/A	1	1	N/A	0	N/A	0
Screen # 9	1	1	1	1 ¹⁵⁵	1	1	1	0 ¹⁵⁶	1	1

- Screen #1 The medication orders were complete (name of medication, strength, route of administration, frequency, duration, and number of refills).
- Screen #2 The clinician order was dated, timed, and legibly signed (if the signature is not legible, a signature stamp must also be used).
- Screen #3 The clinician documented an appropriate clinical note that corresponds with the initial medication order.
- Screen #4 The nurse dated and timed the medication order transcription (routine orders within 4 hours, urgent orders within 2 hours, and stat orders within 1 hour).
- Screen #5 The nurse and/or pharmacy accurately transcribed the physician order onto the MAR.
- Screen #6 The MAR reflected that all medications were initiated within 24 hours of the order being written or on the start date ordered.
- Screen #7 There is documentation of medication administration status (e.g., administered, refused, etc.) for every dose ordered for the youth.
- Screen #8 For discontinued medications, the nurse discontinued medications according to policy.
- Screen #9 The MAR is neat and legible, and contains legible initials, signatures, and credentials of nursing staff who have administered medications to youth.

MAR Review Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen #1	10	0	10	10	
Screen #2	10	0	10	10	
Screen #3	10	1	9	8	
Screen #4	10	0	10	7	
Screen #5	10	0	10	9	
Screen #6	10	0	10	8	
Screen #7	10	1	9	8	
Screen #8	10	4	6	2	
Screen #9	10	0	10	9	
Total	90	6	84	71	

Compliance = 85% (71 of 84 Screens)

Urgent/Emergent Care Services

Select 10 to 20 health records from the Urgent/Emergent Care Tracking Log in the previous 180 days. Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question # 1	There is an Urgent/Emergent Tracking Log that records all unscheduled health care encounters.	1			
Question # 2	Emergency equipment and supplies at the facility are consistent with the statewide policy and procedure. The facility has at least one automated external defibrillator (AED).	1			
Question # 3	The emergency equipment, medications, and supplies are in proper working order. An equipment checklist log shows that health care staff inspects equipment and supplies each shift.		0 ¹⁵⁷		
Question # 4	There is documentation that health care providers have been trained regarding emergency response. There is documentation of the last three emergency drills and one disaster drill, which delineates the events of the drill and identifies strengths and weaknesses.			0 ¹⁵⁸	
Question # 5	Interview nurses, physicians, nurse practitioners, physicians assistants, and dentists to ensure that all know how to properly operate the emergency equipment (O ₂ , Ambu bag, cardiac monitor, AED, etc.).				N/E
	For calculating score, only give credit for applicable questions in substantial compliance.	Totals:			

Write the youth's ID number in the top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	0 ¹⁵⁹	0 ¹⁶⁰	1	1
Screen # 2	0	1	1	N/A	1	0 ¹⁶¹	0 ¹⁶²	0	0 ¹⁶³	0 ¹⁶⁴
Screen # 3	0 ¹⁶⁵	1	1	N/A	0 ¹⁶⁶	1	1	1	1	1
Screen # 4	N/A	1	1	N/A	N/A	1	1	1	1	1
Screen # 5	N/A	N/A	1	0 ¹⁶⁷	N/A	N/A	N/A	N/A	1	1
Screen # 6	N/A	N/A	1	N/A	N/A	1	1	1	N/A	N/A
Screen # 7	N/A	N/A	1	N/A	N/A	1	1	1	N/A	N/A

- Screen # 1 The entry in the Urgent/Emergent Log is complete, legible, and there is a corresponding progress note in the health care record.
- Screen # 2 The nurse documented the date and time of the encounter and documented an assessment in SOAP format.
- Screen # 3 The nurse's subjective and objective evaluation was appropriate given the nature of the complaint (e.g., vital signs, SOB = peak flow meter, abdominal pain =abdominal assessment)
- Screen # 4 The nurse's assessment and plan were appropriate, including notification or referral to the clinician when clinically indicated.
- Screen # 5 If the nurse referred the youth to a clinician, the follow-up visit was timely and clinically appropriate.
- Screen # 6 For patients returning from the emergency room, nursing staff contacted the physician on-call to obtain follow-up orders.
- Screen # 7 If the youth was sent to an outside facility, the physician saw the youth the following business day.

Urgent/Emergent Care Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	8	
Screen # 2	10	1	9	3	
Screen # 3	10	1	9	7	
Screen # 4	10	3	7	7	
Screen # 5	10	6	4	3	
Screen # 6	10	6	4	4	
Screen # 7	10	6	4	4	
Total	70	23	47	36	Plus 2 of 4 applicable Questions

Compliance = 75% (38 of 51 applicable Questions and Screens)

Outpatient Housing Unit

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local policy and procedure that is consistent with the statewide policy and procedure.				
Question #2	There is an Outpatient Housing Unit (OHU) log that lists all youth placed in the OHU in the past 180 days. The log contains youth name, I.D. number, reason for admission and admission and discharge dates.				
Question #3	There is a current, standardized nursing procedure manual in the OHU at all times.				
Question #4	There is in policy and actual practice a physician on call 24 hours per day, 7 days a week.				
Question #5	All youth placed in an OHU are within sight or sound of licensed health care staff at all times in accordance with policy				
	Totals:				

Select 10 to 20 health records of patients currently admitted or discharged from the OHU within the last 180 days Write the youth's ID number in the top row.

State ID# →	1	2	3	4	5	6	7	8	9	10
Placement date: →										
Discharge date: →										
Screen # 1										
Screen # 2										
Screen # 3										
Screen # 4										
Screen # 5										
Screen # 6										
Screen # 7										
Screen # 8										
Screen # 9										

- Screen #1 The clinician (MD, NP, PA, or psychologist) wrote or gave a verbal order to place the youth in the OHU.
- Screen #2 The clinician orders include the initial impression: diagnostic and therapeutic measures, the frequency of vital signs, and other monitoring (e.g., peak flow meter and capillary glucose measurements, etc.), and clinical criteria for notifying the physician (change in clinical status).
- Screen #3 The youth's clinical condition/reason for admission did not exceed the criteria for placement in the OHU.
- Screen #4 A nurse documented an appropriate initial assessment, plan of care, and patient education (including orientation to the OHU).

- Screen #5 The clinician performed and documented a clinical assessment on the next business day or sooner, if clinically indicated.
- Screen #6 Nursing assessments are documented at least once every shift, or more often if clinically indicated, and are pertinent to the admitting diagnosis (es).
- Screen #7 A clinician conducts clinically appropriate rounds that are documented in the UHR daily, Monday through Friday.
- Screen #8 The UHR reflects that the clinical and nursing plan of care was implemented (e.g., vital signs recorded, lab tests performed, medications administered, etc.).
- Screen #9 A physician and nursing discharge note was completed at the time of release from the OHU.

Outpatient Housing Unit Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1					
Screen # 2					
Screen # 3					
Screen # 4					
Screen # 5					
Screen # 6					
Screen # 7					
Screen # 8					
Screen # 9					
Total					

Compliance _____ % Questions + Screens

Outpatient Housing Unit was not reviewed during this visit.

Health Records

Key: SC =Substantial Compliance, PC=Partial Compliance , NC =Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	NA
Question # 1	Local policies are consistent with statewide policies and procedures, and address all aspects of health record management. (See Audit Tool Instructions.)			0	
Question # 2	The Movement and Problem List is visible upon opening the UHR.	1			
Question # 3	There is a functional tracking system for laboratory, diagnostic, and consultation reports.			0	
Question # 4	The facility has a functional system for UHR accountability, filing, and retrieval.			0	
	Totals:	1		3	

Compliance = 25% (1 of 4 Questions)

Preventive Services

Select 10 to 20 health records of youth who have been in DJJ over one year.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question #1	There is a policy and procedure regarding preventive services that is consistent with the US Preventive Services Task Force (USPSTF) and American Medical Association Guidelines for Adolescent Preventive Services (GAPS) in areas that are applicable to DJJ youth.	1			

Write the youth's ID number in the top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	N/A	N/A	1	1	1	1	1	1	1	1
Screen # 3	1	1	1	1	1	1	1	1	1	1
Screen # 4	1	0 ¹⁶⁸	0 ¹⁶⁹	0 ¹⁷⁰	1	0 ¹⁷¹	0 ¹⁷²	1	1	0 ¹⁷³
Screen # 5	1	1	1	1	1	1	1	1	1	1
Screen # 6	N/A	N/A	N/A	1	N/A	N/A	N/A	N/A	N/A	N/A

- Screen # 1 TB skin testing was performed annually. If previously positive, a nurse conducted a TB symptom screen.
- Screen # 2 Annual pap smears were performed (at a minimum) beginning 3 years after initiation of sexual intercourse and 2 consecutive years thereafter. If there are 3 consecutive normal annual pap smears, then they are performed every 3 years thereafter. Management of abnormal pap smears was appropriate, including referral.
- Screen # 3 A nurse measures the youth's blood pressure annually. The nurse refers youth with abnormal blood pressure to a clinician.
- Screen # 4 A nurse measures the youth weight annually. Obesity is addressed if clinically indicated (BMI >24 %).
- Screen # 5 Hepatitis A and B vaccinations are current, as applicable.
- Screen # 6 Youth are offered Tetanus-Diphtheria Booster if not received within ten years.

Preventive Services Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	10	
Screen # 2	10	2	8	8	
Screen # 3	10	0	10	10	
Screen # 4	10	0	10	4	
Screen # 5	10	0	10	10	
Screen # 6	10	9	1	1	
Total	60	11	49	43	Plus 1 of 1 Question

Compliance = 88% (44 of 50 applicable Questions + Screens)

Consultation and Specialty Services

Interview staff responsible for specialty service contracts and consultation tracking. Review the Consultation Tracking log. Select 10 health records from the facility of youth who received consultation services in the last 180 days.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question #1	There is a local consultation policy and procedure that is consistent with the statewide policy.	1			
Question #2	The facility has implemented the outside specialty care log to include receipt of reports. Staff maintains it accurately and contemporaneously.		0 ¹⁷⁴		
Question #3	There is sufficient custody staffing and cooperation to transport youths to outside medical appointments.	1			
	For calculating score, only give credit for questions in substantial compliance.				
	Totals:	2	1		

Write the youth's ID number in top row:

State ID# →	1	2	3	4	5	6	7	8	9	10
Screen # 1	1	1	1	1	1	1	0	1	1	1
Screen # 2	1	1	1	1	1	1	N/A	1	1	1
Screen # 3	1	1	1	0	1	1	1	1	1	0
Screen # 4	1	1	1	1	1	1	1	1	1	1
Screen # 5	N/A	1	1	1	1	1	1	1	1	1
Screen # 6	1	1	1	1	1	1	1	1	1	1
Screen # 7	0 ¹⁷⁵	1	0	0	1	1	1	1	0	0
Screen # 8	0 ¹⁷⁶	1	1	1	1	1	0	1	1	0 ¹⁷⁷
Screen # 9	0	1	1	1	0	1	N/A	1	N/A	N/A

- Screen # 1 The health record contained a Consultation Request Form. The clinician legibly documented the service requested, urgency (routine or urgent), and dated and signed the form.
- Screen # 2 The clinician legibly documented the history of the present illness, physical findings, and lab data that supports the rationale for the service on the Consultation Request Form.
- Screen # 3 The clinician legibly documented the medical history, physical and laboratory findings, and an assessment that supports the need for the consult in the Progress Notes.
- Screen # 4 The record reflects that the youth was seen by the consultant within the required time frames (90 days for routine, 10 ten days for urgent unless indicated sooner).
- Screen # 5 Upon the patient's return from the consultation appointment, the nurse reviewed the consultant's recommendations and addressed any urgent recommendations.
- Screen # 6 The clinician reviewed, dated, and initialed the consultation report within 3 business days of the youth's return to the facility or receipt of the report.
- Screen # 7 The UHR shows that the clinician met with the youth 5 business days (sooner if clinically indicated) to review results of the consult with the youth and develop a treatment plan.
- Screen # 8 The health record reflected that the consultant's recommendations were ordered and implemented, or a valid reason for **not** implementing the recommendations was documented (i.e., patient is out to court, refused, etc.). If the physician disagrees with the consultant's recommendations, an appropriate alternate plan of care was ordered and implemented.

Screen # 9 The health record reflected that the clinician monitored the youth to ensure that the treatment plan was implemented and the desired clinical outcome was achieved, or the treatment plan was amended.

Consultation and Specialty Services Summary:

	# of Records	#N/A	Final # of Records	# of Compliant Records	COMMENTS
Screen # 1	10	0	10	9	
Screen # 2	10	1	9	9	
Screen # 3	10	0	10	8	
Screen # 4	10	0	10	10	
Screen # 5	10	1	9	9	
Screen # 6	10	0	10	10	
Screen # 7	10	0	10	5	
Screen # 8	10	0	10	7	
Screen # 9	10	3	7	5	
Total	90	5	85	72	Plus 2 of 3 Questions

Compliance = 84% (74 of 88 Questions + Screens)

Peer Review

Review the local and statewide peer review policies and procedures, interview staff, inspect peer review file storage locations.

Review peer review files to ensure compliance with policy and the Health Care Remedial Plan.

Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

		SC	PC	NC	NA
Question # 1	The local peer review policy and procedure, and actual practice are consistent with the statewide policy and procedure, NCCHC standards, and the Health Care Remedial Plan.			0	
Question # 2	The Statewide DJJ Medical Director, Health Care Director, or clinical service chief monitors the peer review process, which includes regular reporting from the facilities on peer review activities and regular quality management meetings at least annually.			0	
Question # 3	The CMO reviews sentinel events (unexpected hospitalizations, medical errors) and the Statewide Medical Director/Chief Psychiatrist reviews the reports of these investigations. The Statewide Medical Director/Chief Psychiatrist reviews all deaths.	1			
Question # 4	There is biannual peer review for MDs, PAs, and NPs at each facility. These files are marked "Peer Review" and kept in a secure location. There is documentation that findings have been shared with applicable staff		1		
Question # 5	The peer review process includes a meaningful corrective and adverse action process up to, and including, suspending privileges for inappropriate care or unprofessional behavior.	1			
	For calculating score, only give credit for questions in substantial compliance. Totals:	2	1	2	

Compliance = 40% (2 of 5 Questions)

Credentialing

Review the local and statewide credentialing policies and procedures, interview staff, and inspect storage locations of credential files.

Review credentials files to ensure compliance with policy and the Remedial Plan.

Key: SC =Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE =Not Evaluated

		SC	PC	NC	N/A
Question # 1	The local credential policies and procedures, and actual practice are consistent with statewide policies and procedures, NCCHC standards, and the Health Care Remedial Plan.			0	
Question # 2	Credential files are stored in a locked cabinet with access limited to those with a legitimate need to know.	1			
Question # 3	Specific staff is assigned to maintain the credential files. Inspection shows that the files are current and well-maintained.	1			
Question # 4	Review all credential files. They contain the required elements of the Health Care Remedial Plan: a) Curriculum Vitae that includes relevant personal information; undergraduate, graduate, and postgraduate education b) Employment history and hospital appointments (including disciplinary action and loss of privileges) c) Academic appointments and society memberships, if applicable d) Copies of all current licenses, registrations, board certifications, and Drug Enforcement Agency (DEA) licenses e) Statement of physical and mental health f) Drug and alcohol dependence history, if any g) Results of National Practitioner Data Bank Inquiry h) Prior and current malpractice claims and judgments i) Prior professional liability coverage and current coverage for contractors, if not covered by State of California j) ECFMG certificate, if applicable k) Authorization for release of information for any information required to complete the application process, including confidential material l) Three references	1			
Question # 5	Review of credentialing process listed in question #4 reveals no substantial problems or concerns regarding the clinician's mental fitness, clinical competence, or moral character.	1			
Question # 6	Recredentialing occurs bi-annually. All files are current.				N/A
Question # 7	Physicians, nurse practitioners, and physician assistants do not begin work until the credentialing process is completed. Under extenuating circumstances, temporary privileges may be granted until the credentialing process is completed, not to exceed 3 months.	1			
Question # 8	Physicians or nurse practitioners treating chronically ill youth are board certified or eligible in a primary care-related field.	1			
Question # 9	Physicians treating HIV infected youth are board certified in infectious diseases (ID) or have completed a primary care residency with additional HIV related training, and are experienced in the treatment of HIV patients. If no facility clinician meets this requirement, ID consultants are used.	1			
	For calculating score, only give credit for applicable questions in substantial compliance.				
	Totals:	7		1	1

Compliance = 88 % (7 of 8 applicable Questions)

Quality Management

Review the local and statewide Quality Management Program policy and procedure. Review the composition of the QM Committee and meeting minutes. Key: SC = Substantial Compliance, PC = Partial Compliance, NC = Noncompliance, NA = Not Applicable, NE = Not Evaluated

					SC	PC	NC	NA
Question # 1	There is a local policy and procedure that is consistent with the statewide policy and procedure.						0	
Question # 2	The facility has a Quality Management (QM) Committee that meets quarterly or more often as needed, as determined by Statewide policy.				1			
Question # 3	The composition of the institutional QM Committee meetings meets policy requirements.				1			
Question # 4	Minutes of the QM Committee are available for review.				1			
Question # 5	QM studies for the previous 2 quarters from the date of the last audit are available for review.						0 ¹⁷⁸	
Question # 6	The reasons for the QM studies performed by the facility are specified on the tools or in meeting minutes, and are related to suspected problems identified by staff, Health Care Service audits, Superintendents, and youth, etc. (high risk, high volume, problem prone aspects of care).							N/A
Question # 7	The most recent Corrective Action Plan (CAP) developed as part of a QM study is reviewed for the following: Enter date of CAP reviewed: _____	Y	N	NA				N/A
	a) The CAP identified specific improvements needed.							
	b) The CAP identified specific staff members responsible for improvements.							
	c) The CAP had a targeted completion date.							
	d) There was documentation to indicate any recommended training was held.							
	e) Follow-up studies were done to determine whether or not corrective actions solved the problem or issue.							
Question # 8	Physician Chart Reviews: a) There will be quarterly review of nursing sick call records based upon criteria developed by the QM Committee (a minimum of 5 records per nurse performing sick call) b) Outpatient Housing Unit: 10% or 10 records/ quarter. Findings are addressed at QM meetings.						0	
Question # 9	The Supervising Nurse reviews 10 records monthly of each nurse who conducts nursing sick call, urgent care, or outpatient housing unit care. There is documentation that findings from chart reviews have been discussed with the applicable staff members. As performance improves, reviews may be performed quarterly.						0	
Question # 10	On at least an annual basis, the Chief Medical Officer develops a Quality Management report for the Statewide Medical Director that focuses on high risk, problem prone aspects of patient care; identifies deficiencies; makes recommendations for improvements; and provides direction for quality improvement activities.						0	
For calculating score, only give credit for applicable questions in substantial compliance.								
Totals:					3		5	2

Compliance =38% (3 of 8 applicable Questions)

Total Number of Applicable Questions and Screens Evaluated = 699

Total Number of Questions and Screens in Substantial Compliance = 530

Total Score **530 ÷ 699** = 76 %

Respectfully Submitted,

Joe Goldenson MD

Date

Madie LaMarre MN, APRN, BC

Date

Endnotes:

¹ Staff report that there is not pay parity among nursing staff, e.g. SRN IIIs.

² There is no health care budget.

³ There is not consistent escort support across all shifts. There is not a posted officer in the health care unit on the weekends, although the facility had two officers originally allocated to the health care unit because it was slated to be a CTC. It never became a CTC and the Warden reported that he lost the positions. On 11/30/07, the psychiatrist planned to see five patients, but because medication administration was being conducted the com center sergeant officer refused to allow the girls to come for their appointments. This required the SRN II to go to the lieutenant to enable the girls to be seen.

⁴ No handout in Spanish.

⁵ []Identity removed. 24 years old. Admitted 8/21/07.

⁶ []Identity removed -Arrived 5/14/07

⁷ []Identity removed -Admitted 4/26/07

⁸ []Identity removed Admitted 4/19/07

⁹ []Identity removed.

¹⁰ []Identity removed Arrived 8/8/07.

¹¹ []Identity removed. Arrived 5/23//07. This 20 year old transferred from NAC to VYCF on 5/23/07. ON 5/22/07 at NAC the patient reported poor vision in her left eye. The nurse at Chad did not measure the patient's visual acuity. Upon intake a nurse performed an initial screening measured the patient's VA as OD 20/25 and OS 20/15. On 5/24/07 at 2030 a nurse saw the patient who complained of a visual problem. The nurse referenced the admission VA testing but did not repeat it. She did not refer the patient to a clinician but put the patient on the optometrists June 2007 eye appointment schedule. A second note by the same nurse at the same time states that the patient stated that she only saw "black" out of the right eye. The nurse noted she had a history of recent head trauma prior to admission. The nurse also noted that the patient was scheduled for her PE on 5/29/07 and referred the patient to the clinic the following day for repeat VA. On 5/26/07 a nurse attempted to repeat the Snellen test but the patient refused saying that she could "see alright". On 5/29/07 the NP saw the patient for her history and physical. The patient refused to answer ROS questions. The NP documented the visual acuity readings by the screening nurse and answered 'No' to physical examination questions about strabismus and blindness. The NP could not see the optic disk of the right eye however and made no further comment. The NP did not document lack of visualization of the optic disc as a concern and did not document a treatment plan addressing this. On 6/2/07 a psychiatrist note documents that the patient is probably schizophrenic but refuses to talk with the psychiatrist and he planned no medications. The plan was to monitor the patient. On 6/7/07 the optometrist saw the patient and documented that the patient could not see out of the right eye and had a retinal detachment. His recommendation was to refer the patient to the ophthalmologist ASAP. The appointment was made for 6/14/07 but rescheduled due to patient refusal (not documented in the record). On 6/18/07 the ophthalmologist saw the patient. She had bare light perception out of the right eye and a dense cataract. His diagnosis was total retinal detachment with giant retinal tear from 9 to 3 and the retina appeared folded onto itself. There was massive proliferative vitreoretinopathy (PVR). The ophthalmologist recommended surgery but explained to the patient that the prognosis was poor. On 6/25/07 ophthalmologist saw the patient again and urged surgery despite the poor prognosis but the patient again refused. On 6/25/07, NP discussed the patient's refusal with the ward. On 6/28/07 psychiatry saw the patient to evaluate for competency to refuse the retinal surgery and determined that she had features of schizophrenia and was unmedicated, but since her condition was not life-threatening that medication could not be forced. On 7/19/07 a second psychiatric opinion concluded that the patient was paranoid schizophrenic in need of involuntary antipsychotic medication to help with a more rationale assessment to the need for surgical repair of right retinal detachment. She is currently gravely disabled from her psychotic condition she cannot make the correct decision. She was medicated and later refused treatment.

¹² []Identity removed. Arrived 7/31/07.

¹³ []Identity removed Arrived 4/25/07

¹⁴ []Identity removed Arrived 10/10/07

¹⁵ The patient is a 23 year pregnant female who gave a history of loss of appetite and weight loss upon arrival. The nurse did not refer the patient to a physician for evaluation, but instead made a disposition of routine processing. A late entry by the NP documents that the patient was seen, however, there is no clinical evaluation documented related to the patient's lack of appetite and weight loss.

¹⁶ Patient had a urinalysis positive for leukocytes and nitrites. The physician was notified.

¹⁷ Medications were not ordered until 8/9/07

¹⁸ Visual acuity was documented as of 20/25 and was 20/15 however patient is almost blind in due to retinal detachment and a day later the youth only saw black in the left eye.

¹⁹ Pap smear showed ASCUS findings. No documentation that patient was notified in a timely manner.

²⁰ The NP saw the patient the day following the abnormal urinalysis but did not perform a clinical examination.

²¹ No documentation of notification of HIV test results or trichomonas infection on pap smear.

²² Unable to locate documentation of HIV post-test counseling.

²³ HIV post-test counseling not done. Labs are not filed in the correct place, but under the database.

²⁴ This 24 year old complained of a vaginal discharge upon arrival. A pelvic exam was performed but no wet prep was performed. The pap smear showed Trichomonas and she was treated on 9/6/07. The patient tested positive for hepatitis C antibody and was informed on 8/24/07. She denied a history of injection drug use. On 8/31/07 her HCV RNA viral load was undetectable and liver function tests were normal. On 10/9/07, the patient was sent to an infectious disease specialist who suspected a false positive hepatitis C antibody test and recommended repeat testing. On 10/19/07 repeat tests for hepatitis C antibody and viral load are negative. I find no documentation that the patient was told of this result. No documentation of HIV antibody negative test result. The patient was anemic, but this was not fully explored and she was simply placed on iron.

²⁵ Physical examination was performed on 5/10/07, 14 days after arrival..

²⁶ The NP did not elaborate on the patient's complaints/history of headache, chest pain, scoliosis and backache.

²⁷ The clinician did not address the patient's diagnosis of UTI.

²⁸ The NP did not identify lack of visualization of the optic disc as a problem, when progress notes clearly described inability to see from the right eye.

²⁹ PE performed 9 days after arrival.

³⁰ Patient gave a history of hospitalization for chest pain, SOB and anxiety that was not explored. No date, location, outcome.

³¹ Anemia not listed on Problem list

³² Second abnormal pap smear (CIN 1) not listed.

³³ The UTI was not documented on the Problem List.

³⁴ The NP did not document a treatment plan for the patient's asthma.

³⁵ The patient has perineal condyloma. A treatment plan was not documented.

³⁶ The NP did not document any treatment plan related to the patient's pregnancy or refer to recent treatment upon arrival for a UTI.

³⁷ The clinician did not develop a plan for follow-up of UTI.

³⁸ NP did not develop a plan for the patient's visual problem.

³⁹ Patient was not seen for asthma intake evaluation for 4 months (9/28/07)

⁴⁰ []Identity removed. 19 year old.

⁴¹ []Identity removed

⁴² []Identity removed

⁴³ []Identity removed Transferred 5/24/07

⁴⁴ []Identity removed

⁴⁵ []Identity removed. Arrived 10/17/07

⁴⁶ []Identity removed Arrived 10/17/07

⁴⁷ []Identity removed. Arrived 11/7/07

⁴⁸ Nurse used Receiving health screening form and did not complete the lower portion of ITF

⁴⁹ The Nurse Practitioner saw the youth one day following his arrival, but did not sign the intrasystem transfer form within one day of arrival. It was signed by the MD on 6/17/07.

⁵⁰ Progress note entry.

⁵¹ Doxycycline, Retin-A and Lamisil cream not renewed until the following day. Cleocin T not renewed without progress note to explain rationale. 9/12/07 evening dose of Doxycycline not administered.

⁵² The staff have not yet completed the local policies and procedures to be compliant with the statewide.

⁵³ Nurses have not been conducting sick call in the mental health units in clinical areas, but in day room or at the door. Staff plan to now bring all patients up to the main clinic.

⁵⁴ Statewide protocols and training have not been conducted.

⁵⁵ Nurses have been conducting sick call in the mental health units without adequate privacy.

⁵⁶ []Identity removed

⁵⁷ []Identity removed

⁵⁸ []Identity removed

⁵⁹ []Identity removed

⁶⁰ []Identity removed -In December 2005, this 19 year old had a history of leukopenia (2.2) and neutropenia (557) and has continued to be leukopenic (2/3, 794) as of 6/17/07. On 10/11/07 complained of constant headache, coughing up blood and weakness. He has been worked up and followed by hematology.

⁶¹ []Identity removed

⁶² []Identity removed

⁶³ []Identity removed

⁶⁴ []Identity removed

⁶⁵ []Identity removed

⁶⁶ Did not describe onset of right knee pain (gradual or injury related)

⁶⁷ The nurse did not describe presence or absence of urinary tract symptoms with complaints of vaginal discharge and abdominal and back pain.

⁶⁸ The nurse did not describe the onset of ear pain, and associated symptoms such as discharge, upper respiratory symptoms, allergies, etc.

⁶⁹ The nurse did not explore the patient's statement that he coughed up blood, consider previous TB skin test status (tested 0 mm in April 2007) or evaluate for night sweats or weight loss. The nurse did not note his history of chronic leukopenia.

⁷⁰ Nurse did not obtain a history of onset of increased heart rate, associated symptoms such as shortness of breath, dizziness, history of heart problems

⁷¹ Nurse did not evaluate the onset, severity, or associated symptoms.

⁷² Patient complained of painful urination. Nurse did not inquire about onset of symptoms, presence of fever, chills, vaginal discharge, and history of sexually transmitted infections including herpes.

⁷³ The nurse inquired about history of injury or trauma but did not take a history of onset, character, radiation. Severity ranked as 8 of 10.

⁷⁴ The knees were not examined for swelling, erythema, tenderness etc.

⁷⁵ No physical examination documented.

⁷⁶ Nurse did not auscultate chest or heart sounds

⁷⁷ The nurse did not examine the patient's head, ears, eyes, nose and throat.

⁷⁸ The nurse did not auscultate the patient's lungs or weigh the patient.

⁷⁹ The nurse did not auscultate the patient's heart or lungs

⁸⁰ Nurse examined the patient's left ear, not the right, throat or neck for swollen lymph nodes.

⁸¹ The nurse did not obtain vital signs or examine the patient.

⁸² The nurse did not examine the patient.

⁸³ The nurse did not document a nursing diagnosis/assessment.

⁸⁴ The nurse did not document a nursing diagnosis or assessment.

⁸⁵ The nurse did not document a nursing diagnosis or assessment

⁸⁶ The nurse did not document a nursing diagnosis or assessment.

⁸⁷ The nurse did not document a nursing diagnosis or assessment.

⁸⁸ The nurse did not document a nursing diagnosis or assessment.

⁸⁹ The nurse did not document a nursing diagnosis or assessment

-
- ⁹⁰ The nurse did not document a nursing diagnosis or assessment
- ⁹¹ The nurse's plan was to increase fluids without an accurate assessment of the problem.
- ⁹² The patient described the abdominal pain as a 7 out of 10, warranting a referral to a physician.
- ⁹³ The nurse did not document the urgency of the referral.
- ⁹⁴ The nurse documented a routine referral, but this should have been referred urgently.
- ⁹⁵ The patient should have been referred urgently for painful urination.
- ⁹⁶ Pain severity of 8 of 10 warrants and urgent referral
- ⁹⁷ The nurse did not sign or date the evaluation.
- ⁹⁸ The patient was seen the same day.
- ⁹⁹ The patient refused the appointment.
- ¹⁰⁰ Physician noted ear discharge for 3 days. No history related to pain or decreased hearing.. Noted TM perforation, but no history related to trauma.
- ¹⁰¹ No history related to quality, intensity, radiation, etc. No history related to urinary symptoms.
- ¹⁰² Physician noted that vital signs were on sick call slip, but that was from 9/2.
- ¹⁰³ No history of nausea, vomiting, location, etc.
- ¹⁰⁴ Did not check for pain or tenderness
- ¹⁰⁵ Diagnosed and treated for UTI without symptoms of UTI and with equivocal urinalysis
- ¹⁰⁶ Physician treated patient's infected lesion with both Keflex and Bactrim. It is not clinically appropriate to use 2 antibiotics.
- ¹⁰⁷ Did not order urine culture
- ¹⁰⁸ Did not order follow-up
- ¹⁰⁹ No follow-up ordered
- ¹¹⁰ Noted would re-check the next day, but no specific education documented
- ¹¹¹ Physician told patient to return in 5 days if not better. Patient submitted health care requests on 11/13 & 11/14 stating that hand still hurt. Physician saw patient on 11/14 but did not address hand pain..
- ¹¹² Patient with asthma. Physician noted history of multiple hospitalizations but did not obtain history re: most recent hospitalization, most recent exacerbation, ER visits, systemic steroid use, hx of intubation, nighttime symptoms
- ¹¹³ Patient with asthma. Physician noted history of 2 hospitalizations but did not obtain history re: most recent hospitalization, ER visits, intubations
- ¹¹⁴ Patient with asthma. Physician noted history of 4 hospitalizations but did not obtain history re: most recent hospitalization, ER visits, intubations
- ¹¹⁵ Patient with moderate asthma. No history of emergency room visits or use of systemic steroids.

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- ¹¹⁶ No chronic care intake visit.
- ¹¹⁷ No chronic care intake visit found.
- ¹¹⁸ Patient with asthma. Physician noted history of multiple hospitalizations but did not obtain history re: most recent hospitalization, most recent exacerbation, ER visits, systemic steroid use, hx of intubation,
- ¹¹⁹ Patient with asthma. No history related to emergency room visits or systemic steroid use.
- ¹²⁰ Patient with seizure disorder. No history related to frequency, most recent, etiology, etc
- ¹²¹ Physician saw patient with asthma on 6/3/07. Noted fair control and ordered f/u in 30 days. Not seen again for asthma until 10/19/07.
- ¹²² Physician saw patient on 8/9/07 and noted fair control. Ordered follow-up in one month. Not seen again until 10/12/07
- ¹²³ Patient not seen in chronic care for hypertension since 3/22/07. (Has been in and out of CTC for psych problem. Has been back since 10/16/07.)
- ¹²⁴ Most recent visit on 11/19/07. No history of # of attacks, inhaler use, ETA visits, nighttime symptoms
- ¹²⁵ Seen in chronic care for asthma 9/28/07. Degree of control had been good and was only fair at time of visit due to nighttime symptoms. Physician ordered follow-up in 3 months. Should have been sooner.
- ¹²⁶ Medication expired and was not renewed.
- ¹²⁷ The nurse has been recently appointed and has not had formal training but is being oriented to the position.
- ¹²⁸ Meetings were held in the first quarter (January, March), third quarter (July) and fourth quarter (November).
- ¹²⁹ July 19, 2007
- ¹³⁰ November 28, 2007.
- ¹³¹ No drug-drug interaction capability.
- ¹³² No local policies.
- ¹³³ Correctional officers are present for administration but staff reports are not consistently supportive to the nurses need to take sufficient time do administer and document medications. Sometimes youth misbehave and correctional officers do not intervene.
- ¹³⁴ Currently medications are administered at 1945 for general population. We understand this will be changed to 2030.
- ¹³⁵ []Identity removed
- ¹³⁶ []Identity removed -Order 9/5/07
- ¹³⁷ []Identity removed Order 6/22/07
- ¹³⁸ []Identity removed Order 8/14/07
- ¹³⁹ []Identity removed. Order 8/16/07
- ¹⁴⁰ []Identity removed. Order 11/19/07
- ¹⁴¹ []Identity removed Order 10/3/07.

¹⁴² []Identity removed Order 9/11/07

¹⁴³ []Identity removed. Order 11/19/07

¹⁴⁴ []Identity removed. Order 10/4/07

¹⁴⁵ Patient had 3 day leg lesion that increased in size. No vital signs. Culture performed showed staph aureus sensitive to both oxacillin and Bactrim. Physician treated the patient with both Keflex and Bactrim x 10 days.

¹⁴⁶ Medication Renewal from return to court.

¹⁴⁷ Nurse dated, but did not time transcription.

¹⁴⁸ The nurse transcribed the order as 11/19/07 at 1130, however the clinician wrote the order at 11/19/07 at 1400.

¹⁴⁹ The 11/19/07 order for Aldactone was not transcribed onto the MAR and the patient did not receive it until the order was rewritten on 11/26/07.

¹⁵⁰ See above note.

¹⁵¹ MAR says first dose was given in the clinic however there is no documentation of this.

¹⁵² See above note.

¹⁵³ The nurse who discontinued the medications did not sign the note indicating discontinuation.

¹⁵⁴ Nurses are crossing out medication names and instructions with a highlighter.

¹⁵⁵ Nurses are using yellow magic markers to cross out medication orders.

¹⁵⁶ Only one nurse signed the MAR on the back. More than one initial on the front.

¹⁵⁷ Staff checked emergency equipment weekly until 11/24/07. Implemented daily checks the week prior to the audit.

¹⁵⁸ Staff have not implemented emergency drills.

¹⁵⁹ Log did not reflect that patient was sent to the emergency room.

¹⁶⁰ Log did not reflect that patient was sent to the emergency room.

¹⁶¹ Subjective and objective information was under Assessment.

¹⁶² Subjective information was under objective.

¹⁶³ Subjective and objective information in wrong sections.

¹⁶⁴ Subjective and objective information in wrong sections.

¹⁶⁵ Patient complaining of abdominal pain. Nurse did not obtain history related to intensity, quality, location, radiation, etc. Did not examine abdomen.

¹⁶⁶ Youth seen after hitting head on bed frame. Nurse did not obtain any further history, i.e., headache, visual changes, loss of consciousness

¹⁶⁷ Patient hit in eye with branch. Complaining of pain, and photophobia. NP did not obtain a history related to change in vision and did not check visual acuity.

¹⁶⁸ Weight on 11/16/07 was 207. Height is 69 inches. BMI 30. Weight not addressed.

¹⁶⁹ Weight on 12/4/07 was 145. Height is 64 inches. BMI is 24.7. Weight not addressed.
¹⁷⁰ Weight on 12/3/07 was 179. Height is 69 inches. BMI is 26.4. Weight not addressed.
¹⁷¹ Weight on 11/2/07 was 240. Height is 68 inches. BMI is 36.5. Weight not addressed.
¹⁷² Weight on 1/6/07 was 207. Height is 69 inches. BMI is 30.6. Weight not addressed.
¹⁷³ Weight on 11/13/07 was 268.7. Height is 68 inches. BMI is 40.9. Weight not addressed.

¹⁷⁴ There is a log but it does not track the receipt of the reports.

¹⁷⁵ No treatment plan

¹⁷⁶ Seen by consultant 7/05. Ordered follow-up in 6 months. Follow-up has not been ordered or scheduled as of 12/4/07.

¹⁷⁷ Specialist recommended mild muscle relaxant and anti-inflammatory medication. This recommendation was not addressed.

¹⁷⁸ There were no QM studies to review