SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

MARGARET FARRELL, Plaintiff, vs. MATTHEW CATE, Defendant.	)	CASE NO. RG03079344

FIFTEENTH REPORT OF SPECIAL MASTER

Nancy M. Campbell, Special Master
Aubra Fletcher, Monitor
Zack Schwartz, Monitor
56 East Road
Tacoma, WA 98406
253-503-0684
nancy@nmcampbell.com

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APPENDICES

I. INTRODUCTION

This report reviews the first comprehensive report of the *Farrell* Dental Services Expert and the third comprehensive report of the Medical Care Experts. The reviews are based on audits occurring in 2008 and 2009 and may not reflect DJJ's most recent progress in these areas. The report also discusses recent population, staffing, and budget changes affecting California's Division of Juvenile Justice (DJJ) and the youth in its care. Special Master, Donna Brorby, and Monitors, Aubra Fletcher and Zack Schwartz, conducted careful review and provide thoughtful summary in this report. The Special Master has made very few substantive changes. The Office of the Special Master (OSM) and the Medical and Dental Services Experts submit these final reports after consideration of the parties' comments.

II. DENTAL SERVICES

The *Farrell* Dental Expert, Dr. Don Sauter, conducted his first formal audit round between August 2008 and August 2009.[1] His comprehensive report is attached as Appendix A. He has reviewed and approved this section of the Special Master's report.[2]

Dr. Sauter found DJJ facilities substantially compliant with most *Farrell* requirements. He reports, however, that planned reductions in staff may present a new challenge to DJJ's ability to provide acceptable dental treatment to youth.[3] During the time of Dr. Sauter's audits, DJJ's dental staffing was excessive.[4] DJJ implemented its new staffing model on March 2, 2010,[5] and Dr. Sauter has timed his second audit round such that he may observe the effect of

[1] Appendix A, Don Sauter, Dental Comprehensive Report: Summary of First Round of Dental Site Visits, January 31, 2010, p. 5 [Sauter Comprehensive Report].
[2] *See* e-mail of Don Sauter to Aubra Fletcher, March 15, 2010.
[3] *See generally* Sauter Comprehensive Report.
[4] *Id.*, p. 2.
[5] *See, e.g.*, statements of Sharie Wise to Aubra Fletcher, February 17, 2010.

staff reductions on dental services.[6] The Special Master will file Dr. Sauter's individual site reports as they become available.

Dr. Sauter's report also stresses the need for a single chief dentist who reports directly to the DJJ Medical Director to oversee services statewide and to represent dental interests at DJJ's Central Office.[7] During Dr. Sauter's audit round, DJJ employed three Chief Dentists who did not report directly to DJJ's Medical Director.[8] Under DJJ's new staffing model it now employs only one Chief Dentist.[9] DJJ has not yet provided an updated organizational chart depicting a reporting relationship between the Chief Dentist and DJJ's Medical Director.[10]

III. MEDICAL CARE

The Medical Experts conducted their second round of audits from August 2008 to October 2009.[11] Their comprehensive report was completed in March 2010 and is attached as Appendix B. The Experts' executive summary and the recommendation section at the close of the report are brief and cogently summarize the Experts' findings and recommendations for the current fiscal year.[12] The Medical Experts have reviewed and approve this section of this report.[13]

A. Compliance Ratings Are High and Substantially Improved From Fiscal Year 2007-2008 to Fiscal Year 2008-2009

[6] *See* e-mail of Don Sauter to Doug Ugarkovich, et al., January 6, 2010.
[7] *See* Sauter Comprehensive Report, p. 5.
[8] *Id.*
[9] *See id.*; e-mail of Don Sauter to Aubra Fletcher, et al., March 15, 2010.
[10] E-mail of Don Sauter to Aubra Fletcher, March 15, 2010.
[11] Appendix B, Goldenson and LaMarre, *Farrell v. Cate*, Third Report of Consent Decree by the Medical Experts (April 2010), p. 3 (hereinafter "Goldenson and LaMarre Third Comprehensive Report"). The Experts completed their facility monitoring during fiscal year 2008-2009; their Central Office audit was conducted in October 2009. *Id.*
[12] Goldenson and LaMarre Third Comprehensive Report, pp. 3-5 and 54.
[13] Statements of Madeleine LaMarre and Joe Goldenson to Donna Brorby, during teleconference April 25, 2010.

As they did for their first round of audits, the Medical Experts have assigned compliance scores to each facility for 18 aspects of medical care:

Table I: Average Facility Compliance Scores (%)

Aspect of Care	2007-2008[14]	2008-2009[15]	Change
Peer Review	41	97	56
Facility Leadership, etc.	52	90	38
Quality Management	50	88	38
Health Records	38	75	37
Nursing Sick Call	45	72	27
Chronic Disease Management	68	93	25
Intrasystem Transfer	65	89	24
Infection Control	62	83	21
Credentialing	79	98	19
Consultations	78	92	14
Medical Care	78	92	14
Medication Administration: Process	77	89	12
Outpatient Housing Unit	70	81	11
Medical Reception	58	67	9
Pharmacy Services	92	100	8
Urgent/Emergent Care	71	74	3
Medication Administration: Records	82	84	2
Preventive Services	85	87	2

The Special Master gives more weight to these scores than on the compliance percentages in other subject areas,[16] for several reasons. Most important, the medical standards and criteria for

[14] The source for this column is Ninth Report of the Special Master (June 2009), pp. 2-4, based on the Medical Experts' second report. The Experts piloted and modified their audit tool during their first round of monitoring compliance with the Health Care Services Remedial Plan, so this column represents DJJ's first formal compliance scores.

[15] This column depicts the average of facility compliance scores from Goldenson and LaMarre Third Comprehensive Report, pp. 18-38. The average is calculated by adding the scores for all facilities for an area and dividing by the number of facilities scored on the area.

facility audits requires the Experts to apply many of the compliance standards to individual health care records, so many of the compliance ratings depict the proportion of individual cases meeting applicable criteria, rather than the percentage of items with which compliance has been achieved.[17] The Medical Experts methodically designed and tested their compliance audit tools to measure the presence of necessary components of a service delivery system and the quality of services; they were not the only Experts who designed their own audit instruments, but theirs and the Dental Expert's standards and criteria are more precise and cogent than any of the others.[18] The Medical and Dental audit tools make numerical audit scores an important part of the measure of compliance.[19]

There has been major improvement in compliance ratings since the Experts' second round. Of 101 individual facility audit items that the Experts rated in both years, 84 (83%) had improved.[20] Preston increased its proportion of substantial compliance ratings from 77% to

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[16] *Compare e.g.*, Eleventh Report of the Special Master (June 2009), p. 9 (discussing significance of cumulative Expert compliance ratings in the various subject areas, by percentage of substantial compliance, partial compliance, and non-compliance ratings).

[17] For 10 of the 18 aspects of care rated, the Experts review a sample of youth health care records against objective standards they developed and the parties accepted as audit criteria. *See,* Health Care Audit Instrument, filed December 6, 2007. By contrast, scores in other subject areas represent the percentage of items with which compliance has been achieved. As the Special Master has already noted, there are vast differences in the scope and importance of individual remedial plan requirements. *See* Eleventh Report of the Special Master (June 2009), p. 9.

[18] The "audit tools" in each area are the "standards and criteria" for each remedial plan. *See* Consent Decree ¶ 9.

[19] *See,* Health Care Audit Instrument, pp. 3-4 (facility is in substantial compliance if it achieves an overall audit score of 85% and meets a few other criteria; Medical Experts have discretion to find compliance with an overall audit score of 75%, if the other criteria are met) and Sauter Comprehensive Report.

[20] Compare Goldenson and LaMarre Third Comprehensive Report, pp. 22-53 with Tenth Report of the Special Master (September 2009), Appendix G, Goldenson and LaMarre, Farrell v. Hickman, Second Report of Consent Decree by the Medical Experts (July 18, 2009) (hereinafter "Goldenson and LaMarre Second Comprehensive report"), pp. 18-38. This is the source for the remainder of the paragraph.

86% from fiscal year 2007-2008 to fiscal year 2008-2009, Stark from 64% to 84%, Ventura from 76% to 79%, SYCRCC from 72% to 88%, Chaderjian from 61% to 81%, and OH Close from 81% to 88%. For fiscal year 2008-2009, 66 of 104 individual audit ratings (63%) were above the 85% benchmark for compliance, compared to only 23 of 102 ratings (23%) in the prior year.

While the overall picture is one of progress from one year to the next, there was slippage in a few facility compliance ratings. Three of six facilities had decreased compliance scores for urgent/emergent care, which had one of the lower cumulative compliance ratings for the year, at 74%.[21] Preston had significantly lower scores in medication administration records and preventive services as well as in urgent/emergent care.[22]

Table II: Areas w/ Decreased Scores at One or More Facility From FY '07-'08 to FY '08-'09 (% Change)

Aspect of Care	Chaderjian	Close	Preston	Stark	SYCRCC	Ventura
Medical Reception	15	NA	(1)	9	31	(9)
Medication Administration: Process	25	(23)	8	34	17	9
Medication Administration: Records	7	3	(6)	9	0	1
Urgent/Emergent Care	23	18	(10)	3	(6)	(14)
Preventive Services	2	9	(8)	0	7	0
Consultations	42	20	7	18	(8)	7

The slippage in the ratings for urgent/emergent care relates to record-keeping practices, primarily, rather than the quality of care.[23] Based on their recent audits at Preston and Ventura,

[21] *See* Table I, above.

[22] See Table II, above. Preston's score medical reception dropped by one point; this is numerically small, but appears to indicate real problems, given that the Medical Experts observed poor performance by the physician performing admission history and physical examinations. *See* Goldenson and LaMarre Third Comprehensive Report, pp. 22, 25.

[23] Statements of Medical Experts to Zack Schwartz during teleconference, March 26, 2010. See also, Goldenson and LaMarre Third Comprehensive Report, p. 26 (Preston 78%, documentation issues), 31 (Stark 84%, documentation and emergency drills), 38 (Ventura 61%, clinical issues as well as documentation issues), 42 (SYCRCC 64% clinical issues), 47 (Chaderjian 83%

the Experts report that DJJ is addressing these issues.[24] Further, the Experts' draft report found Preston to be in substantial compliance with the Health Care Services Remedial Plan in February 2010, with an audit score of 92% and no serious or systemic problems resulting in inadequate care for youth.[25]

In addition to rating facilities, the Medical Experts rate Central Office on twenty "questions" or topics under two categories: (1) organization, budget, leadership and staffing (thirteen topics) and (2) statewide pharmacy services (seven topics). Like the Medical Experts themselves, the Special Master gives more weight to the qualitative explanations for the findings than the cumulative compliance percentages.[26] The findings are based on general assessments of compliance rather than chart reviews. Also, most of the questions are compound, such that noncompliance with one sub-part results in a noncompliance rating for the item as a whole. For example, although the Medical Experts have accepted the concept of dual administrative and clinical supervision for some clinical staff, DJJ has not accurately depicted the arrangement on its organizational chart, leaving it out of compliance with one of the items on the Central Office audit tool.[27]

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documentation issues), 51 (Close 72%, documentation, maintenance emergency equipment, emergency drills).

[24] Statements of Medical Experts to Zack Schwartz during teleconference, March 26, 2010 (re Ventura); statements of DJJ staff during court compliance task force meeting, March 25, 2010 (re Ventura); Goldenson and LaMarre, Preston Youth Correctional Facility Health Care Audit February 23-25, 2010 [draft report]. The Preston report rates urgent and emergent care at 86% compliance, noting deficiencies in the documentation in the urgent/emergent care log. *Id.* p. 7.

[25] *Id.*

[26] The cumulative compliance percentages are the percentage of the thirteen and seven questions or topics that the Experts find in substantial compliance.

[27] *See*, Goldenson and LaMarre Third Comprehensive Report, p. 8. The Medical Experts found DJJ in substantial compliance with only five of the thirteen Central Office organization, budget, leadership and staffing questions, yielding a compliance score of 38%. At the same time, they explain that this 38% score is misleading because "several indicators are very close to substantial

With the support of the Medical Experts, DJJ is reducing health care staff during this fiscal year.[28] If DJJ maintains high facility compliance ratings with the reduced staff, then it will be in a position to achieve full compliance with the health care services plan within two years.[29]

B. Areas of Achievement

Pharmacy Services. The Experts rate statewide pharmacy services in seven areas. From the Experts' second monitoring round to this one, DJJ moved from being in substantial compliance in one of the seven areas to being in substantial compliance with six of them.[30] This was achieved under the leadership of Statewide Pharmacy Manager Kenneth Lungren, Pharm.D., who has recently retired consistent with the commitment he made when he joined DJJ.[31] All facilities achieved a 100% score for compliance in pharmacy services.[32]

Medical Care. For this area, Dr. Goldenson reviews the quality of care provided to a sample of youth against accepted standards of care. In the most recent report, for fiscal year 2008-2009, Dr. Goldenson's rating for medical care was 92%, up from 78% in the previous

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compliance, and we expect that these areas would be in substantial compliance at our next review." Goldenson and LaMarre Third Comprehensive Report, p. 7.

[28] *See*, Goldenson and LaMarre Third Comprehensive Report, p. 4.

[29] *See*, Consent Decree, ¶ 23.

[30] The seventh area, which the Experts found partially compliant, involves cost-effectiveness issues to be considered after implementation of the 2009 staffing "business rules." Goldenson and LaMarre Third Comprehensive Report, pp. 18-19, 54.

[31] *See*, Goldenson and LaMarre Third Comprehensive Report, p. 4 (Mr. Lundgren retired, statewide pharmacy manager position vacant); Goldenson and LaMarre Second Comprehensive report, pp. 16 (Medical Experts positively impressed by the statewide pharmacy manager); Fifth Report of the Special Master, Appendix C, First Report of Consent Decree by the Medical Experts (September 2007) p. 10 (statewide pharmacy manager position filled between February and September 2007). As the Medical Experts note: "[Mr. Lundgren] is to be commended for the work he has done." Goldenson and LaMarre Third Comprehensive Report, p. 20.

[32] See also, Goldenson and LaMarre Third Comprehensive Report, p. 26 (Preston), 31 (Stark), 38 (Ventura), 42 (SYCRCC), 47 (Chaderjian), 51 (Close).

comprehensive report. [33] Medical care in DJJ is greatly improved since fiscal year 2006-2007, when Dr. Goldenson found that youth in DJJ who required health care services for serious medical problems faced an unacceptable risk of receiving substandard care.[34]

Peer Review. By the end of the 2007-2008 monitoring round, DJJ had put its peer review policy in place, but it had only begun to implement it.[35] Implementation of the policy was completed during fiscal year 2008-2009, which is the basis for the improved compliance scores.[36] The next important step with respect to peer review is for DJJ to require that peer reviewers select charts for review that are most likely to reflect care of serious medical care problems, *e.g.*, charts of youth with chronic, urgent and serious conditions.[37] Because the DJJ population is young and, therefore, relatively healthy, the current random selection practice results in the review of the care of minor conditions that do not necessarily require a physician's attention instead of conditions that test clinical practice. This might explain the failure of peer review to detect serious deficiencies in the practice of a physician at the Preston facility.[38] The

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[33] *See*, Table I, above. *See also*, Goldenson and LaMarre Third Comprehensive Report, pp. 26 (Preston 89% on medical care), 30 (Stark, 92%), 35-36 (Ventura, one problematic case noted involving pulmonary disease that might have been tuberculosis, despite 89% rating), 41 (SYCRCC, 95%), 46 (Chaderjian 87%), 50 (O.H. Close 99%).

[34] *See*, Fifth Report of the Special Master (October 2007), pp. 23-24.

[35] *See*, Ninth Report of the Special Master (June 2009), p. 4 and Goldenson and LaMarre Second Comprehensive Report, pp. 20 (Preston), 23 (Stark), 26 (Ventura), 29 (SYCRCC), 34 and 37 (Chaderjian and O.H. Close).

[36] *Compare* pages cited in previous footnote to Goldenson and LaMarre Third Comprehensive Report, pp. 27 (Preston), 32 (Stark), 39 (Ventura), 43 (SYCRCC), 48 (Chaderjian), 53 (O.H. Close).

[37] *See*, Goldenson and LaMarre Third Comprehensive Report, p. 5; statements of Medical Experts to Zack Schwartz, March 26, 2010. These are the sources for the rest of this paragraph except as otherwise noted.

[38] In addition to the sources cited in the previous footnote, see Goldenson and LaMarre Third Comprehensive Report, pp. 22-23. The physician left DJJ as a result of reductions in staff. Email LaMarre to Nancy Campbell, et al., April 5, 2010 (comments on draft report attached to the email).

Medical Experts have not yet audited "the accuracy/validity of individual clinician peer review,"[39] which the Special Master will ask them to do once DJJ selects records involving more complicated medical conditions for peer review.

Quality Management. DJJ had developed and implemented a Quality Management ("QM") Plan by the time of some the Experts' audits during fiscal year 2007-2008. It scored higher in Quality Management during fiscal year 2008-2009 because all facilities had implemented the plan during last year's audits, as compared to some the year before, and because facilities had a track record for QM minutes, studies and corrective action plans by last year but not the year before.[40] The Experts make the same recommendations in their current report as they did a year ago, *i.e.*, that: (1) review should be required of all health care areas annually, not just two aspects per quarter; (2) facilities should be encouraged to identify and study problems unique to their facilities as part of QM and (3) Central Office should perform QM reviews of facilities' systems and care ("external review").[41]

The Experts encourage DJJ to continue to strengthen and improve its QM processes to ensure compliance with the standards and criteria of the Health Care Services Remedial Plan. The Experts designed the medical standards and criteria for their own use and for the use of DJJ's Health Care Services Division to monitor the quality of medical services and the functioning of DJJ's health care services system.[42] It is critical that all QM activities be integral

[39] Goldenson and LaMarre Third Comprehensive Report, p. 27.
[40] *See*, e.g., site visit reports for Chaderjian, O.H. Close and Ventura that are a part of Appendix G to the Tenth Report of the Special Master and those attached to Appendix B, *infra*.
[41] *See*, Goldenson and LaMarre Third Comprehensive Report, pp. 4-5; *cf*., Ninth Report of the Special Master (June 2009), pp. 5-6 and Goldenson and LaMarre Second Comprehensive Report, pp. 4.
[42] Statements of Madeleine LaMarre and Joe Goldenson to Donna Brorby, during teleconference April 25, 2010. This is the source for the remainder of this paragraph.

to the health care services system, under the direction of DJJ's Medical Director. The Medical Experts believe that the court compliance unit has very limited utility in health care due to the clinical nature of the issues being monitored. To be cost-effective, Health Care Services Division Central Office staff needs to oversee and monitor these activities.

Facility Leadership and Resources. The gains in facility leadership and resources between the second and third rounds of medical monitoring reflect system-wide improvements in the medical budgeting processes and stability in facility medical management and staffing.[43] During the third monitoring round, DJJ is reducing medical staffing, which the Medical Experts have recommended.[44] DJJ will need to be attentive to institutional needs as it determines how to accomplish the reduction.[45] The Medical Experts challenged managers at O.H. Close to solve the serious inadequacy of clinic space there.[46]

Health Care Records. Since they were retained in spring 2008, DJJ's contract Registered Health Information Administrator and staff Health Program Specialist have developed unified health system and health care information policies.[47] This explains DJJ's improved compliance ratings in the area of health records. Next, DJJ needs a health records manual.[48] The Medical Experts have advised DJJ that it needs a *credentialed* Health Program Specialist II on staff, and that its *uncredentialed* HPS I is insufficient for a substantial compliance score with respect to

[43] *See*, Goldenson and LaMarre Third Comprehensive Report, pp. 4 (system), 24 (Preston), 29 (Stark), 34 (Ventura), 40 (SYCRCC), 44-45 (Chaderjian), 49-50 (O.H. Close).
[44] *See*, Goldenson and LaMarre Second Comprehensive Report, p. 4 and Goldenson and LaMarre Third Comprehensive Report, p. 4.
[45] *See*, Goldenson and LaMarre Third Comprehensive Report, p.49 (in mid-2009, O.H. Close advised the Experts that 20 medical staff received lay-off notices based only on length of service, without respect to institutional needs).
[46] *See*, *id*., pp. 49-50.
[47] *See*, *id*., pp. 15-16.
[48] *Id*.

Central Office management staffing.[49] DJJ's staff health records manager is not credentialed as a health records manager, which the Medical Experts find to be a violation of the remedial plan.[50]

Chronic Disease Management. The Experts found that "[c]hronic disease management has improved as shown by timely evaluation of youth as well as improvement in the quality of clinician evaluations."[51] DJJ's system-wide compliance rating in this area rose from 68% to 93% from fiscal year 2007-2008 to fiscal year 2008-2009, due to improved compliance with policies and procedures as documented in individual charts the Experts reviewed.[52] Much of this improvement can be attributed to the fact that Dr. Morris met with facility staff on an individual basis and provided training related to the management of youth with chronic medical problems.[53]

Other. The Medical Experts were pleased to see that DJJ has established the LVN position to replace the MTA position.[54] They also found a substantial improvement in the sanitation of health care units and sick call areas.[55]

C. Areas Requiring Attention

Central Office Oversight. DJJ's centralized health care system requires Central Office oversight of health care services at the facilities. Due to application of restrictions on travel, Central Office health services managers are not visiting facilities on a regular basis. The Experts

[49] *Id*., pp. 9-10.
[50] *See*, *id*., p. 10.
[51] *Id*., p. 5.
[52] Compare facility reports for 2007-2008 attached to Goldenson and LaMarre Second Comprehensive Report to facility reports to Goldenson and LaMarre Third Comprehensive Report.
[53] E-mail Goldenson to Brorby, April 20, 2010.
[54] Statements of Madeleine LaMarre and Joe Goldenson to Donna Brorby, during teleconference April 25, 2010.
[55] *See*, Goldenson and LaMarre Third Comprehensive Report, p. 5.

support cost-cutting measures and understand the necessity to restrict unnecessary travel, but DJJ health services leadership should seek necessary waivers of the travel ban to continue oversight of staff and programs at the facilities.[56]

Health Services Organization. The first two "questions" or topics that the Medical Experts evaluate with respect to DJJ's Central Office health care services division concern DJJ's Central Office and facility tables of organization. DJJ is very close to compliance in these two areas, but did not correct problems that the Experts identified last year.[57]

Reception. The compliance rating in 2008-2009 of 68% for medical reception is DJJ's lowest compliance score under the Health Care Services Remedial Plan.[58] By facility, Preston scored 71%, Stark 52%, Ventura 60%, SYCRCC 94% and Chaderjian 57%.[59] The Experts noted that O.H. Close failed to complete reception processes for a youth who was transferred from Preston before completing reception there, but did not give O.H. Close a compliance rating for reception.

Nursing Sick Call. Since 2007, the Experts have advised DJJ to prioritize the development and implementation of nursing protocols, in order to improve the quality of nursing

[56] Statements of Madeleine LaMarre and Joe Goldenson to Donna Brorby, during teleconference April 25, 2010.

[57] In their current report and their previous report, the Medical Experts found that DJJ's Central Office chart failed to depict one chief dental authority, and that facility charts fail to depict appropriate administrative and clinical supervision of clinical staff. *See*, Goldenson and LaMarre, Second Comprehensive Report pp. 7-9 and Goldenson and LaMarre Third Comprehensive Report, pp. 7-9. They also note that DJJ needs either to have its Medical Director report to DJJ's Chief Deputy Secretary, or seek modification of the remedial plan to permit the Medical Director to report to the Program Director, an arrangement that the Experts find acceptable. *Id*.

[58] *See*, Table 1, above.

[59] Goldenson and LaMarre Third Comprehensive Report, pp. 25 (Preston), 29 (Stark), 34 (Ventura), 40 (SYCRCC), and 45 (Chaderjian).

sick call, utilize skilled nursing staff fully and use physicians efficiently.[60] Finally, in October 2009, DJJ's Director of Nursing reported to them that development of nursing protocols was "well underway." He and the Experts have arranged for the Experts to assist DJJ with the protocols. Though protocols were not developed and implemented in fiscal year 2008-2009, there were improvements in nursing sick call. The compliance rating rose to 72% from 45% the prior year, largely due to improved compliance with sick call policies and procedures as documented in individual charts that the Experts reviewed.[61] The 72% compliance rating still is one of the lowest for areas under the Healthcare Services Remedial Plan.[62]

Utilization Data. DJJ has agreed to collect and analyze medical resource utilization data, as the Medical Experts have urged.[63] DJJ has just reduced health services staffing and "need[s] to monitor health resource utilization to assess whether the number and type of health care personnel and services is adequate to fulfill its mission."[64] The Experts recommended staffing reductions[65] and believe that DJJ will be able to provide adequate health care services following layoffs, but neither they nor DJJ had the benefit of utilization data as they determined current staff levels. The Experts believe that utilization data is essential to DJJ's meeting its mission of providing adequate and cost-effective health care for youth.

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[60] *See*, Ninth Report of the Special Master, p. 7; Goldenson and LaMarre Third Comprehensive Report, p. 5. See also, Fifth Report of the Special Master, Appendix C, Goldenson and LaMarre, Farrell v. Hickman, First Report of Consent Decree by the Medical Experts (September 2007).
[61] Compare facility reports for 2007-2008 attached to Appendix G to the Tenth Report of the Special Master to facility reports to Appendix B to this report.
[62] See Table 1, above.
[63] Goldenson and LaMarre Third Comprehensive Report, p. 4. Except as otherwise noted, this is the source for the rest of the paragraph.
[64] Goldenson and LaMarre Third Comprehensive Report, p. 4.
[65] See, Ninth Report of the Special Master (June 2009), p. 7.

Medical Contracting. The Medical Experts recommend that DJJ's Central Office continue to monitor facilities' success in keeping necessary medical contracts in place.[66] Given that they only encountered a few contracting problems during the third auditing round, the Experts believe that CDCR has resolved the serious systemic issues that once affected medical contracting.[67] The Experts still find problems at individual facilities, however, related to the lead time necessary to conclude a contract and the impediments to concluding a contract for routine as opposed to emergency services.[68] The Experts commend defendant for assigning medical contracting to staff specializing in that function, and note the importance of ensuring continuity through times of staff turnover.[69] DJJ's Central Office staff responsible for facilitating medical contracts should consider whether they can do more to prevent lapses in facility contracts.

Interdisciplinary Collaboration and Dispute Resolution Protocol. The Medical Experts report improved cooperation between health care and custody staff.[70] This is based largely on the absence of reports of any problems, compared to the early years of this case[71] but consistent

[66] Statements of Medical Experts to Zack Schwartz during teleconference, March 26, 2010. Except as otherwise noted, this is the source for the rest of this paragraph. After the Experts finished their appended comprehensive report, they found that one or more contracts lapsed at Ventura. *Id*. As a result, they recommend continued Central Office attention to facility medical contracts issues. *Id*.

[67] As a result, the Experts did not carry over their recommendation that Central Office work with the CDCR contracts office to improve the process for establishing and executing contracts from their previous comprehensive report.

[68] *See* Goldenson and LaMarre Third Comprehensive Report, pp. 24-25 (Preston staff noted difficulties with routine contracts required to provide follow-up care after emergency care provided under emergency contract; routine contracting takes six to nine months), 34 (Ventura has necessary contracts in place, though routine process takes six to nine months).

[69] A skillful staff member who was very experienced with medical contracting and who worked in Central Office facilitating medical contracts recently left that position. Statement of Madeleine LaMarre to Donna Brorby, April 25, 2010.

[70] Goldenson and LaMarre Third Comprehensive Report, p. 5.

[71] Statements of Madeleine LaMarre to Donna Brorby during teleconference, April 20, 2010.

with the mental health recent report of improved collaboration at Chaderjian.[72] DJJ has provided the Experts with a new draft protocol to guide staff in the resolution of issues when there is a potential conflict of needs and interests.[73] This is the proposed "dispute resolution protocol" required by the Safety and Welfare and Mental Health remedial plans.[74] The new draft represents progress since the Special Master's last report on this issue earlier this year.[75] It will be important for DJJ, in consultation with the medical and other Experts, to finally put an adequate protocol in place.

D. Revisions to Individual Site Reports

The Experts have made minor revisions to five individual site reports from their second round of audits based on comments provided by Defendant. Revised reports (Attachments 1 through 5) include: (1) "Heman G. Stark YCF Health Care Audit, January 13-15, 2009;" (2) "N.A. Chaderjian Youth Correctional Facility Health Care Audit, February 17-19, 2009;" (3) "Southern Youth Correctional Reception Center and Clinic Health Care Audit, March 2009;" (4) "Preston Youth Correctional Facility Health Care Audit, August 25-28, 2008," (5) "Ventura Youth Correctional Facility Health Care Audit, December 4-6, 2008."

IV. POPULATION, STAFFING, AND BUDGET CHANGES

DJJ has faced multiple external pressures in the last few months. Most significant among these is the fiscal crisis the state is confronting. A hiring freeze, lay-off plans, and travel bans are some of the direct impacts of the fiscal crisis. In addition, DJJ has created a new system-

[72] Statements of mental health Experts during "exit" conference after Chaderjian site visit, March 29, 2010, as recorded by Aubra Fletcher of OSM.
[73] E-mail Doug Ugarkovich to Trupin *et al*., March 10, 2010, attaching PoP #620 Dispute Resolution Protocol.
[74] Safety and Welfare Remedial Plan, pp. 14; Mental Health Remedial Plan, pp. 9, 12.

wide staffing model and has closed the Heman G. Stark facility. The Stark closure was initially scheduled to occur slowly over an 18-month period, however, a CDCR mandate required DJJ to complete the closure in just four months. Of the five facilities, Ventura has experienced the most difficulties related to Stark's closure. The remaining facilities have seen significantly fewer problems. Facility closures are always complex and despite considerable obstacles, DJJ demonstrated thoughtful planning, made significant efforts to ensure the safety of youth, and made admirable attempts to keep youth in close proximity to their families. There remain areas where DJJ could improve its processes. The Special Master reports on these issues to illuminate the pressures facing DJJ and to discuss possible solutions as DJJ faces such circumstances in the future.

A. Transfer of Youth and Staff Following Closure of Heman G. Stark Youth Correctional Facility

DJJ announced the planned closure of Stark in late August 2009.[76] DJJ gradually transferred the youth at Stark to other facilities between November 2009 and February 25, 2010.[77] Most of Stark's core program population was transferred to Ventura and most of its mental health caseload and SBTP units to SYCRCC.[78] To create space, SYCRCC transferred its core program units to Ventura. Northern facilities received some youth from Stark's core program living units, and Chaderjian received one of Stark's two SBTP living units.

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[75] See Fourteenth Report of the Special Master (February 2010), pp. 3-4.
[76] *See* statements of Bernard Warner during teleconference, August 27, 2009.
[77] *See* DJJ, "Status of Heman G. Stark Transition Timeline," undated (received December 3, 2009); statements of Sharie Wise to Aubra Fletcher, February 17, 2010. Stark's Correctional Treatment Center (CTC) will remain a juvenile treatment center. Fourteenth Report of the Special Master (February 2010), pp. 20-23 (discussing short- and long-term viability of this arrangement).

DJJ involved the Experts, the OSM, and plaintiff's counsel in the early stages of this planning.[79] DJJ planners prioritized space in southern facilities for youth with mental health needs, in order to house them near their families.[80] To minimize the number of youth who would be transferred away from their families to northern facilities, DJJ sent youth nearing their parole consideration dates to the Board early.[81] Some of these youth paroled.[82]

Staff at sending facilities shared information about youth transferees with receiving staff prior to transfers, to ease the transition for youth and staff.[83] Staff from receiving facilities visited and interacted with youth prior to their transfers, to discuss programs, expectations, and goals. To address youth and staff apprehension about the influx of southern gang-affiliated youth into northern facilities, many facilities have used their impressive conflict resolution teams to prevent and address gang and race tensions.[84] Also, SYCRCC creatively involved youth

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[78] *See* DJJ, "Status of Heman G. Stark Transition Timeline," undated (received December 3, 2009). The remainder of this paragraph is based on this source.

[79] DJJ provided planning documents and convened conference calls on September 3, 2009, September 16, 2009, and November 24, 2009.

[80] *See* statements of Bernard Warner and Sandra Youngen during teleconference, September 16, 2009; DJJ, "Status of Heman G. Stark Transition Timeline," undated (received December 3, 2009).

[81] Statements of Sandra Youngen during teleconference, September 16, 2009; statements of Mike Brady and Dorene Nylund during teleconference, November 24, 2009.

[82] Statements of Mike Brady and Dorene Nylund during teleconference, November 24, 2009.

[83] *See, e.g.*, statements of Sandra Youngen during teleconference, November 24, 2009; statements of Ventura superintendent during site visit, November 16, 2009; Aubra Fletcher and Zack Schwartz, Compliance with Safety and Welfare Requirements: SYCRCC Site Visit Report, January 25, 2010, p. 5; Zack Schwartz and Aubra Fletcher, Compliance with Safety and Welfare Requirements: Chaderjian Site Visit Report, December 14, 2009, p. 5.

[84] *See, e.g.*, statements of Ventura superintendent during site visit, November 16, 2009; Aubra Fletcher and Zack Schwartz, Compliance with Safety and Welfare Requirements: SYCRCC Site Visit Report, January 25, 2010, p. 5; Zack Schwartz and Aubra Fletcher, Compliance with Safety and Welfare Requirements: Chaderjian Site Visit Report, December 14, 2009, p. 5.

families in the transition, by holding family information sessions and farewell events for youth transferees.[85]

DJJ was not as effective at coordinating staffing changes with youth transfers. Staff reassignments and lay-offs in the wake of Stark's closure coincided, though not exactly, with the implementation of DJJ's new statewide staffing model. Stark closed on February 24, 2010.[86] The new staffing model was to take effect in January 2010, but a clerical error related to a labor agreement process delayed its implementation until early March 2010.

The most significant staffing problem has arisen at Ventura. Ventura did not receive adequate custody staffing for the large numbers of new youth transfers.[87] As of February 4, 2010, the facility had opened three new living units and was about to open a fourth, but DJJ still had not finalized which new custody staff would operate these units.[88] By mid-February, some Stark staff were voluntarily reporting to Ventura, and DJJ "involuntarily" transferred some custody staff early, as well.[89] The majority of Ventura's new custody staff would not report until early and mid-March, due largely to training schedules.[90] Overtime and early reports from Stark

[85] *See* statements of SYCRCC superintendent during DJJ Court Compliance Task Force meetings, October 22, 2009 and October 29, 2009.
[86] Statements of Sharie Wise to Aubra Fletcher, February 17, 2010. The following sentence is also based on this source.
[87] *See, e.g.*, DJJ, "Status of Heman G. Stark Transition Timeline," undated (received December 3, 2009).
[88] *See* statements of Ventura Superintendent David Finley during DJJ Court Compliance Task Force meeting, February 4, 2010.
[89] Statements of Sharie Wise to Aubra Fletcher, February 17, 2010; e-mail of Sharie Wise to Aubra Fletcher, March 18, 2010.
[90] Statements of Sharie Wise to Aubra Fletcher, February 17, 2010; e-mail of Sharie Wise to Aubra Fletcher, March 18, 2010. Approximately 300 Stark staff attended transitional academies held between December 2009 and February 2010, and other Stark staff were needed to cover their positions at Stark. E-mail of Sharie Wise to Aubra Fletcher, March 18, 2010.

covered the minimum complement of custody shifts in the meantime.[91] In the future, DJJ should ensure adequate living unit staff are in place prior to youth transfers, with minimal use of overtime.

Mental health staffing has also been a challenge at Ventura. In mid-November 2009, the facility had opened one new unit and was soon to open another, yet the Chief Psychologist could not begin the hiring process for needed clinicians because personnel displaced by Stark's closure and the new staffing model had not finalized their placement decisions.[92] In early February 2010, Ventura still had mental health vacancies, and Central Office had only approved one of the Chief Psychologist's four hiring freeze exemption requests.[93] Mental health staffing issues were not resolved until early March 2010.[94]

Ventura's education staffing difficulties have been the most concerning, and they continue unresolved as of this writing. Sixty-four of Ventura's new youth are high school students, which represents an approximately 23% increase.[95] DJJ's Education Services branch was originally told that new, permanent staff and teachers would transfer to Ventura in time for the arrival of new students from Stark.[96] Ventura's high school Principal had the foresight to

[91] Statements of DJJ Deputy Director of Facilities Steve Kruse during teleconference, February 18, 2010.
[92] Statements of chief psychologist during Ventura site visit, November 16, 2009.
[93] Statements of Ventura Chief Psychologist during DJJ Court Compliance Task Force meeting, February 4, 2010.
[94] *See* e-mail of Ventura Chief Psychologist to Aubra Fletcher, March 15, 2010; e-mail of Sharie Wise to Aubra Fletcher, March 18, 2010.
[95] Robert Gordon and Tom O'Rourke, "Mary B. Perry High School," undated (provided March 1, 2010).
[96] E-mail of Superintendent of Education Dr. David Murphy to Aubra Fletcher, April 8, 2010. According to Dr. Murphy, the new teachers would come from Stark and from CDCR's adult facilities, who were also laying off education staff at the same time. The state expected to supply those staff and teachers in January. However, the state layoff and placement processes were

recruit extra substitute teachers in case the transfers did not proceed as expected.[97] He recruited 20 substitutes in October and November 2009, though 10 subsequently chose not to remain in their substitute positions.[98]

DJJ transferred the majority of the new high school students to Ventura in January and February,[99] though by then Central Office was aware that staff transfers would not take effect until late February and early March 2010. At the same time, CDCR required the planned demotion of certain Ventura teachers—to non-teacher positions—to occur prior to the replacement teachers' completion of training.[100] Personnel rules required that on March 2, 2010, demoted teachers report to their new assignments and replacement teachers report to begin orientation and training. Ten of the 20 extra substitutes had in the meantime chosen to leave their positions.[101] Ventura's substitute pool, though larger than usual, was insufficient to cover

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delayed until late February and early March. The new students began arriving at Ventura in November, but the majority arrived in January and February.

[97] *Id.*; statements of Mary B. Perry High School principal during DJJ Court Compliance Task Force meeting, October 22, 2009; statements of DJJ Superintendent of Education Dr. David Murphy during DJJ Court Compliance Task Force meeting, February 25, 2010. The principal recruited substitutes instead of new permanent teachers because CDCR had stated that a sufficient number of permanent teachers were on the way. E-mail of DJJ Superintendent of Education Dr. David Murphy to Aubra Fletcher, April 8, 2010.

[98] E-mail of Superintendent of Education David Murphy to Aubra Fletcher, April 8, 2010. Ventura normally employs six substitute teachers. *Id.*

[99] *See id.*

[100] *Id.* The state's layoff and placement processes demoted a few of the existing teachers who had lesser seniority and/or placement rights than the new permanent teachers. *Id.*

[101] E-mail of Superintendent of Education Dr. David Murphy to Aubra Fletcher, April 8, 2010. Some of the 10 substitutes left because of rumors of lay-offs. *See, e.g.*, statements of Mary B. Perry High School principal during DJJ Court Compliance Task Force meeting, February 4, 2010; statements of DJJ Superintendent of Education David Murphy during DJJ Court Compliance Task Force meeting, February 25, 2010.

classes for the growing student body.[102] By early February, the lack of teaching staff was causing cancelations and was affecting instruction quality.[103]

Ventura's Principal informed DJJ's Chief Deputy Secretary of the class cancelations and quality of instruction problem, and the Chief Deputy Secretary responded by saying that his information reflected no true vacancies at Ventura since Stark and other staff had been assigned to report there.[104] However, these staff would not report for another three weeks. DJJ management's approach appears to have been to wait out the problem. By contrast, Ventura's Principal had identified job candidates willing to begin immediately if he could assure them a full-time position, but because of ongoing uncertainty about new staff assignments he could not provide such assurances.[105] He could not ascertain the number and type of "true" vacancies until the new staff placements took effect.[106]

The Education Experts arrived to audit Ventura on February 22, 2010 and concluded that the ongoing difficulties prevented an objective audit.[107] They provided OSM and the parties with an informal summary of their observations while on-site. They found that the transfer of new students occurred before adequate credentialed teaching staff were in place to provide educational services. They also found that Ventura had too few classrooms to accommodate its

[102] E-mail of DJJ Superintendent of Education Dr. David Murphy to Aubra Fletcher, April 8, 2010; statements of Mary B. Perry High School Principal during DJJ Court Compliance Task Force meeting, February 4, 2010.
[103] *See* statements of Mary B. Perry High School principal during DJJ Court Compliance Task Force meeting, February 4, 2010.
[104] *See* statements of Bernard Warner during DJJ Court Compliance Task Force meeting, February 4, 2010.
[105] *See* statements of Mary B. Perry High School Principal during DJJ Court Compliance Task Force meeting, February 4, 2010.
[106] E-mail of DJJ Superintendent of Education Dr. David Murphy to Aubra Fletcher, April 8, 2010.

increased student body. They reported that the reliance on substitute teachers that resulted from delayed staff transfers resulted in a breakdown of educational advisor assignments; issuance of course credits; high school graduation plan monitoring; School Consultation Team referrals and follow up; special education identification, interventions, and provision of compensatory services; and other records management issues. The Experts will conduct a formal audit of Ventura's education services in late May 2010.

On February 24, 2010, when reassigned staff were to report for their new assignments, only seven of twelve expected education staff arrived.[108] In early March, another teacher retired.[109] The state's initial assurance that new staff transfers would be sufficient for Ventura's needs proved to be incorrect.[110] To hire additional teachers, Ventura's school must obtain hiring freeze exemptions. The exemption request process takes four months, but CDCR Personnel rules prevented the school from initiating the requests until staff transfers took place and the

[107] Robert Gordon and Tom O'Rourke, "Mary B. Perry High School," undated (provided March 1, 2010). The remainder of this paragraph is based on this source.

[108] Statements of DJJ Superintendent of Education Dr. David Murphy during DJJ Court Compliance Task Force meeting, February 25, 2010. The state originally expected that the number of new staff and teachers would be sufficient to fill Ventura's needed extra teacher and staff positions. E-mail of DJJ Superintendent of Education Dr. David Murphy to Aubra Fletcher, April 8, 2010. They were not. Ventura's principal foresaw this circumstance and had already begun looking for additional permanent teachers.

[109] Statements of Mary B. Perry High School principal during DJJ Court Compliance Task Force meeting, March 4, 2010.

[110] *See* e-mail of DJJ Superintendent of Education Dr. David Murphy to Aubra Fletcher, April 8, 2010.

exact number and type of vacancies were known.[111] DJJ's Superintendent of Education is working to expedite the process.[112]

On March 11, the Experts learned that more staff were arriving, but some vacancies remained.[113] The personnel barrier is preventing the hiring of needed science teachers: on paper, Ventura only has an opening for a teacher in a different subject and cannot legally fill it with a science teacher. Other facilities have also experienced gaps in adequate staffing. For example, two psychologists on loan to SYCRCC were transferred elsewhere because their positions at SYCRCC were awarded to two adult-side psychologists with seniority.[114] The two adult-side psychologists never reported to SYCRCC, however.[115] If there are no "re-employment candidates" to consider, the senior psychologist hopes to re-hire the original two psychologists.[116] These circumstances appear to have been beyond DJJ's control.

DJJ's declining population and ongoing financial pressures will likely result in additional facility closures. The OSM and the education Experts' recommend that DJJ's management learn from the problems at Ventura and improve its procedures for the orderly transition of staff in the

[111] *See, e.g., id.* (stating that the exemption process takes four months and Ventura's school could not submit exemption requests until details about the vacancies were known).
[112] *See* statements of DJJ Superintendent of Education Dr. David Murphy during DJJ Court Compliance Task Force meeting, March 4, 2010; e-mail of DJJ Superintendent of Education Dr. David Murphy to Aubra Fletcher, April 8, 2010.
[113] Statements of Tom O'Rourke and Bob Gordon during teleconference, March 13, 2010. The remainder of this paragraph is based on this source.
[114] Statements of SYCRCC chief psychologist during DJJ Court Compliance Task Force meeting, February 25, 2010; statements of SYCRCC senior psychologist during DJJ Court Compliance Task Force meeting, March 4, 2010. The two psychologists at SYCRCC were on loan from Stark, and therefore were affected by the Stark closure; the fact that they were technically employed outside L.A. County was a further complication, as seniority is established by county. *See* e-mail of Sharie Wise to Aubra Fletcher, March 18, 2010.
[115] Statements of SYCRCC senior psychologist during DJJ Court Compliance Task Force meeting, March 4, 2010.

future.[117] The OSM endorses and supports the Education Experts' recommendation that DJJ prioritize "the sequencing of transfer to ensure that adequate educational staff and classroom space are in place prior to the arrival of students." They also emphasize that "adequate numbers of correctional staff and administrative support personnel must be identified and be in place prior to the actual transfer of wards to ensure successful transition."

B. Transition to a Stand-alone Correctional Treatment Center

Staff at the now stand-alone Correctional Treatment Center (CTC) at Stark reports difficulties arising from the new staffing model.[118] The model allots five nurses,[119] and state regulations require at least one registered nurse on duty during all shifts.[120] Currently the CTC does not appear to have a sufficient relief factor for its nurses, particularly in light of required furlough days.[121] Coverage of all shifts is achieved through the use of overtime.[122] Should a nurse take an extended leave, the CTC would be in a very difficult situation, especially without the ability to share staff with an adjacent youth correctional facility.[123] A CTC administrator has also expressed concern at the reduction to one physician and one psychiatrist, five psychiatric

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[116] Statements of SYCRCC senior psychologist during DJJ Court Compliance Task Force meeting, March 4, 2010.
[117] *See* Robert Gordon and Tom O'Rourke, "Mary B. Perry High School," undated (provided March 1, 2010). The remainder of this paragraph is based on this source.
[118] The changes to the CTC's staffing model were not a part of the Court's July 2009 order modifying staffing provisions in various remedial plans. *See* Order, July 31, 2009, Exhibit A.
[119] Statements of CTC administrator during teleconference, March 17, 2010.
[120] *See* Cal. Code Regs. tit. 22, §§ 79631(b); 79757.
[121] *See* statements of *Farrell* Health Care Services Expert Madie LaMarre during teleconference, March 17, 2010; statements of CTC administrator during DJJ Court Compliance Task Force meeting, February 4, 2010.
[122] Statements of CTC administrator during teleconference, March 17, 2010.
[123] *See* statements of *Farrell* Health Care Services Expert Madie LaMarre during teleconference, March 17, 2010.

technicians, and a similar decrease in security staff.[124] The OSM has alerted the Medical and Mental Health Experts to these issues and has asked DJJ to assess staffing at the CTC. DJJ representatives agreed to do so in a February 18, 2010 conference call.

V. CONCLUSION

The Special Master respectfully submits this report.

Dated: July 12, 2010

Nancy M. Campbell
Special Master

[124] *See* statements of CTC administrator during teleconference, March 17, 2010. The CTC employs one full-time Physician and one full-time Psychiatrist, rather than splitting each full-time position to provide coverage when one doctor is out. *See id.*

Dental Comprehensive Report
Summary of First Round of Dental Site Visits

California Department of Rehabilitation and Corrections
Division of Juvenile Justice

Farrell vs. Cate

January 31, 2010

Don T. Sauter DDS, MPA

OVERVIEW

From August 2008 to September 2009 site visits of Division of Juvenile Justice (DJJ) dental clinics were conducted using the approved Dental Audit Tool (Appendix). I visited DJJ Headquarters with the medical experts in August 2008. The medical experts' audit partially overlaps with my dental review, in such areas as nursing, pharmacy, medical records, etc. The medical experts keep me informed of issues that affect the dental program.

With the exception of Ventura Youth Correctional Facility ("VYCF"), I was accompanied at each audit by the Chief Dentist responsible for the respective dental program.

EXECUTIVE SUMMARY

When I began my work with the DJJ it was a relatively small system, poised to get smaller due to changing models in juvenile justice and a continuing budget crisis in California. It was apparent that dental staffing in DJJ far exceeded what was necessary to provide adequate dental care to the DJJ youth. These high staffing levels were a legacy from the days when DJJ had a much larger youth population.

Site visits were conducted using a draft version of the final audit tool at **OH Close Youth Correctional Facility (OH Close) and N. A. Chaderjian Youth Correctional Facility (Chad)**. I was surprised to see how uneven the quantity and quality of care was between the two. During June 2008, OH Close had minimal dental coverage, primarily supplied by Dr. Mark Muckey, Chief Dentist for the Northern Complex. Chad, on the other hand, had a full time dentist. But OH Close was much closer to substantial compliance, as measured by the draft audit tool, than was Chad. There was no formal rating for these facilities, as the audit tool had not yet been approved by all parties.

In August 2008 I conducted a site visit at **Preston Youth Correctional Facility (PYCF)** using for the first time the now approved audit tool. I was very impressed by the progress on recommendations I made to Dr. Muckey and DJJ from just two months prior. Enhancements to the dental record and dental

treatment planning were well underway. The DJJ dentists had created an excellent PowerPoint formatted nurse-training module. The dental policy was being analyzed for revision. However, in reviewing the program at PYCF, I began to believe that DJJ dentists were burdened with excessive paperwork. Paperwork volume seemed disproportionate to the size and mission of the dental program. But the three Chief Dentists could cope with this administrative burden as they had more than adequate numbers of dentists to complete the clinical dentistry.

In February 2009 I visited **Southern Youth Correctional Reception Center and Clinic (SYCRCC), Ventura Youth Correctional Facility and Heman G. Stark Youth Correctional Facility (HG Stark)**. SYCRCC and VYCF were under the supervision of Chief Dentist Dr. George SooHoo. It was clear that Dr. SooHoo provided guidance for Dr. Arturo Villanueva, VYCF Staff Dentist, on preparation of the advance material for my review. But problems I found with patient care and program management made it clear there was a need for closer supervision and monitoring of the VYCF dental program. Dr. Mark Hynum, the VYCF Chief Medical Officer was attentive and remained committed to provide what oversight he could with the help of Dr. SooHoo. I had the opportunity to talk with Dr. SooHoo about the deficiencies at VYCF. He moved swiftly to address the performance issues by using appropriate human resource policies.

VYCF is a significant distance from SYCRCC, making direct oversight by Dr. SooHoo difficult. VYCF was managing to keep up with most of the needs of the youth housed there. I felt the addition of a one-day per week dental hygienist would enhance the quality and quantity of dental preventive services at VYCF. VYCF was in partial compliance overall.

SYCRCC had the highest dental staff-to-youth ratio of all the DJJ facilities. One of the SYCRCC positions was utilized by the Chief Dentist exclusively for paperwork and supervision. I observed two of the dental assistants fully occupied with paperwork during my two-day visit. The youth were receiving a high level of and high quality of care, but the cost was prohibitive. It was clear that any staffing reductions there would require corresponding paperwork and

administrative streamlining. Dr. SooHoo and his staff contributed significantly to the nurse-training PowerPoint module. SYCRCC was substantially compliant overall.

At HG Stark I met Dr. Darrell Simien, Chief Dentist. Dr. Simien was a key player in the creation of the dental nurse- training PowerPoint module and the new dental charting forms. Dr. Simien did provide some patient care as well as handling the administration of the dental program. Dr. Simien was particularly knowledgeable about the policies and procedures for providing dental care to the youth in the Correctional Treatment Center (CTC). HG Stark was in substantial compliance overall. I hope Dr. Simien will continue to be involved in treatment of the youth in the CTC at HG Stark through a Memorandum of Understanding with the California Department of Corrections and Rehabilitation (CDCR).

My last site visits were conducted at **OH Close and Chad**. This time I examined the dental programs using the approved dental audit tool. Dr. Bruce "Toby" Elliot staffed OH Close. Dr Elliott had previously worked at Dewitt Nelson Youth Correctional Facility and moved over to OH Close following the closure of that facility. Dr. Muckey joined me at OH Close and Chad. The youth at OH Close were receiving adequate care, but I found deficiencies in the area of primary preventive services. The program achieved substantial compliance overall.

Chad was generally improved in the area of quantity and quality of dental care since my first site visit. But a significant deficiency in the area of infection control resulted in an overall partial compliance rating. I was told that Dr. Elliott at OH Close had seniority over Dr. Alex Hogue, the dentist at Chad. Staffing reductions as prescribed by the new DJJ business rules would result in Dr. Elliott serving as the dentist for OH Close and Chad. Dr. Muckey was disturbed by the deficiency in infection control and was committed to correcting the problem and monitoring the progress on compliance.

I want to acknowledge medical expert Madeleine LaMarre for her vigilance concerning dental issues contained in the medical policies. She kept me up to speed on concerns she had concerning the provision of dental and medical care

as it relates to the periodic blizzard of Proof of Practice submissions for expert review. Both the medical experts and I feel that DJJ needs to have one overall Chief Dentist who holds a DJJ Headquarters position and reports directly to the DJJ Medical Director. This Chief Dentist should spend part of his time providing dental care.

DJJ and their staff have been highly cooperative. They have taken recommendations seriously and have been proactive in making necessary changes to their procedures.

SUMMARY OF FACILITY FINDINGS

The results of the first round of facility audits are summarized here. The site visit reports have been submitted as they were completed. All parties were provided the final reports with my revisions in response to any written comments from DJJ. DJJ had no comments or requests following the submission of the last two reports for OH Close and Chad. The individual facility reports described the adequacy of five core components of a correctional dental program: access to care, quality of care, physical resources, human resources and dental program management.

DJJ has not had a single Chief Dentist to oversee the statewide program and represent dental interests at the Headquarters level. The medical experts and I believed that having three chief dentists who did not report directly to the DJJ Medical Director was detrimental to the dental program. Communication and involvement of the chief dentists has been improved. The new business rules provide for one DJJ Chief Dentist. This position should be placed on the Headquarters organizational charts as reporting directly to the DJJ Medical Director.

FACILITY SITE VISIT SCHEDULE

- Preston Youth Correctional Facility - August 26-28, 2008
- Ventura Youth Correctional Facility - February 18-19, 2009
- Southern Youth Correctional Facility and Clinic - February 24-25, 2009
- Heman G. Stark Youth Correctional Facility - February 26-27, 2009
- OH Close Youth Correctional Facility - August 24-25, 2009
- N. A. Chaderjian Youth Correctional Facility - August 26-27, 2009

Preston Youth Correctional Facility – Overall Substantial Compliance

Access to Care –Substantial Compliance

Access to care evaluated: orientation of youth to dental services, access to oral hygiene supplies, access to urgent care, training of nurses in handling dental urgent care and broken appointments. All areas scored 100% with the exception of management of broken appointments, which was partially compliant.

Quality of Care – Substantial Compliance

Quality of care evaluated: screening and examinations, primary prevention, dental caries stabilization, dental extractions, routine restorative treatment, removable partial dentures, availability of specialists, care of special needs patients, quality management and dental record documentation. All areas scored 100% with the exception of a 75% score for completion of comprehensive examinations and treatment plans and partial compliance in the area of dental quality management.

Physical Resources –Substantial Compliance

Physical resources evaluated the adequacy of the clinical facility and equipment.

Human Resources – Substantial Compliance

Human resources evaluated: dental staffing, licensure and credentials, quality of providers, and infection control. All areas were substantially compliant.

Dental Program Management –Substantial Compliance

Dental program management evaluated: local dental management, dental policy and procedures, and centralized DJJ dental program management. Dr. Mark Muckey was managing the dental program well at PYCF.

Ventura Youth Correctional Facility - Overall Partial Compliance

Access to Care –Partial Compliance

Access to care evaluated: orientation of youth to dental services, access to oral hygiene supplies, access to urgent care, training of nurses in handling dental urgent care, and broken appointments. All areas scored substantial compliance with the exception of management of broken appointments, which was in non-

compliance due to major inconsistencies with management and reporting of broken appointment data.

Quality of Care –Partial Compliance

Quality of care evaluated: screening and examinations, primary prevention, dental caries stabilization, dental extractions, routine restorative treatment, removable partial dentures, availability of specialists, special needs patients, quality management and dental record documentation. All areas scored substantial compliance with the exception of partial compliance ratings for screenings and examinations, the caries risk component of dental caries stabilization and dental quality management.

Physical Resources –Substantial Compliance

Physical resources evaluated the adequacy of the clinical facility and equipment. The facilities were adequate.

Human Resources –Partial Compliance

Human resources evaluated: dental staffing, licensure and credentials, quality of providers, and infection control. Due to serious problems with biological monitoring of the autoclave, infection control was non-compliant. Dr. George SooHoo, Chief Dentist over VYCF, reviewed the infection control procedures and the inconsistencies with dental care quality. He reportedly provided guidance in writing to the dental staff.

Dental Program Management –Substantial Compliance

Dental program management evaluated: local dental management, dental policy and procedures, and centralized DJJ dental program management. I did observe that the VYCF dentist needed to provide closer oversight of his dental assistant secondary to the broken appointment data inconsistencies and the infection control procedural problems. The Chief Dentist in charge of VYCF should provide close oversight.

Southern Youth Correctional Reception Center and Clinic - Overall Substantial Compliance

Access to Care –Substantial Compliance

Access to care evaluated: orientation of youth to dental services, access to oral hygiene supplies, access to urgent care, training of nurses in handling dental urgent care, and broken appointments. All areas scored 100% with the exception of management of broken appointments, which was partially compliant.

Quality of Care – Substantial Compliance

Quality of care evaluated: screening and examinations, primary prevention, dental caries stabilization, dental extractions, routine restorative treatment, removable partial dentures, availability of specialists, special needs patients, quality management and dental record documentation. All areas scored substantial compliance with the exception of partial compliance in the area of dental quality management.

Physical Resources –Substantial Compliance

Physical resources evaluated the adequacy of the clinical facility and equipment. The facility was considered adequate but with the recommendation to repair or replace the non-functional fourth dental operatory.

Human Resources – Substantial Compliance

Human resources evaluated: dental staffing, licensure and credentials, quality of providers, and infection control. All areas were substantially compliant except infection control which received partial compliance due to a procedural problem with the biological monitoring documentation of autoclave #2.

Dental Program Management –Substantial Compliance

Dental program management evaluated: local dental management, dental policy and procedures, and centralized DJJ dental program management. Dr George SooHoo was managing the dental program well at SYCRCC.

Heman G. Stark Youth Correctional Facility – Overall Substantial Compliance

Access to Care –Substantial Compliance

Access to care evaluated: orientation of youth to dental services, access to oral hygiene supplies, access to urgent care, training of nurses in handling dental urgent care, and broken appointments. All areas scored substantial compliance with the exception of management of broken appointments, which was partially compliant.

Quality of Care – Substantial Compliance

Quality of care evaluated: screening and examinations, primary prevention, dental caries stabilization, dental extractions, routine restorative treatment, removable partial dentures, availability of specialists, special needs patients, quality management and dental record documentation. All areas scored 100% with the exception of partial compliance in the area of dental quality management.

Physical Resources –Substantial Compliance

Physical resources evaluated the adequacy of the clinical facility and equipment. The facility was adequate.

Human Resources – Substantial Compliance

Human resources evaluated: dental staffing, licensure and credentials, quality of providers, and infection control. All areas were substantially compliant.

Dental Program Management –Substantial Compliance

Dental program management evaluated: local dental management, dental policy and procedures, and centralized DJJ dental program management. Dr. Darrell Simien was managing the dental program well at HG Stark.

OH Close Youth Correctional Facility – Overall Substantial Compliance

Access to Care –Substantial Compliance

Access to care evaluated: orientation of youth to dental services, access to oral hygiene supplies, access to urgent care, training of nurses in handling dental urgent care, and broken appointments. All areas scored substantial compliance

with the exception of management of access to oral hygiene supplies, which was partially compliant.

Quality of Care – Substantial Compliance

Quality of care evaluated: screening and examinations, primary prevention, dental caries stabilization, dental extractions, routine restorative treatment, removable partial dentures, availability of specialists, special needs patients, quality management and dental record documentation. All areas scored substantial compliance with the exception of partial compliance in the area of dental quality management.

Physical Resources –Substantial Compliance

Physical resources evaluated the adequacy of the clinical facility and equipment. The facility was adequate.

Human Resources – Substantial Compliance

Human resources evaluated: dental staffing, licensure and credentials, quality of providers, and infection control. All areas were substantially compliant with the exception of infection control. Instruments were available that had not been autoclaved for an extended period. The dentist reported the instruments were in storage yet this was not clear from their placement. The problem was corrected during the site visit.

Dental Program Management –Substantial Compliance

Dental program management evaluated: local dental management, dental policy and procedures, and centralized DJJ dental program management. Dr. Mark Muckey should provide continuing oversight at OH Close. His management was the main reason OH Close reached substantial compliance.

N. A. Chaderjian Youth Correctional Facility – Overall Partial Compliance

Access to Care – Non-Compliance

Access to care evaluated: orientation of youth to dental services, access to oral hygiene supplies, access to urgent care, training of nurses in handling dental urgent care and broken appointments. Access to urgent care scored 55%, a very low score for what may be the most critical function of the dental clinic. Access

to oral hygiene supplies and management of broken appointments scored partial compliance.

Quality of Care – Substantial Compliance

Quality of care evaluated: screening and examinations, primary prevention, dental caries stabilization, dental extractions, routine restorative treatment, removable partial dentures, availability of specialists, special needs patients, quality management and dental record documentation. Dental caries stabilization and its subset of caries risk assessment scored partial compliance. Dental quality management also received a partial compliance rating.

Physical Resources –Substantial Compliance

Physical resources evaluated the adequacy of the clinical facility and equipment. The facility was rated substantially compliant as the second operatory was close to being in full operation.

Human Resources –Partial Compliance

Human resources evaluated: dental staffing, licensure and credentials, quality of providers, and infection control. Infection control was non-compliant due to inadequate autoclave biological monitoring procedures.

Dental Program Management –Substantial Compliance

Dental program management evaluated: local dental management, dental policy and procedures, and centralized DJJ dental program management.. More oversight was needed of the program at Chad. The new business rules call for one dentist to serve both Chad and OH Close. The dentist at Chad during my site visit was leaving as the position was being combined with OH Close. The assistant at Chad is to become the one assistant for both Chad and OH Close. Dr. Muckey committed to provide more direct oversight at Chad.

POLICY AND PROCEDURES

DJJ Dental Policy and Procedures have been under revision for some time. They are now in the final draft stage and soon will be ready for approval[1]. The revised policy and procedure document should provide the appropriate guidance and governance to the dental programs of the DJJ.

[1] Dr. Muckey and I reviewed the final draft of this document on January 29, 2010.

RECOMMENDATIONS

- Change the organizational chart so the one DJJ Chief Dentist reports to the DJJ Medical Director and is considered a headquarters position. The Chief should be based at a facility and provide clinical care with periodic visits to headquarters for select meetings involving issues important to dental care.

- Work to reduce paperwork and administrative duties for clinicians.
- Closely monitor infection control procedures through the quality management subcommittee for review by the DJJ Chief Dentist.

- Maintain dental broken appointments at $\leq$ 10%.
- Provide funding for periodic visits to all DJJ facilities by the DJJ Chief Dentist.

- Utilize dental hygienists to provide primary prevention treatments to include sealants allowing dentists to perform more advanced care.

- Closely monitor the timely delivery of emergency and urgent dental care though the quality management subcommittee.

- Develop clinical peer review tools to supplement their current peer review procedures.

- Implement a revised Dental Utilization Review process for those patients where cast crowns or fixed bridges are indicated.

- Increase the use of topical fluoride treatments preferably using fluoride varnish.

CONCLUSIONS

DJJ and its dentists have made remarkable improvements in the areas of the dental patient record forms and organization, nurse training on dental evaluation and stabilization, and comprehensive treatment planning. Providing acceptable dental treatment to its youth with reduced staff will be a new challenge.

I would like to thank all the DJJ staff and the Office of the Special Master for their help and cooperation.

APPENDIX

CDCR-DJJ Dental Services

Key: SC = Substantial Compliance, PC=Partial Compliance, NC=Non-Compliance, N/A= Not Applicable

		SC	PC	NC	N/A
Question #1	Dental policies and procedures are on file and reviewed by all dental staff-local policies are consistent with statewide policies				
Question #2	Adequate dental operatories, instruments, supplies, and dental clinic space exist to meet the needs of the patient population				
Question #3	Infection control procedures are followed in accordance with state and federal laws and guidelines				
Question #4	A review of dental charts, appointment logs, and statistics reveals that less than 10% of patients failed to arrive at the dental clinic for a scheduled dental appointment.				
Question #5	The dental Quality Assurance Monitoring Program (QAMP) subcommittee meets quarterly. A review of Dental QAMP minutes shows that meaningful content was discussed with studies conducted to improve quality and quantity of dental care. ***TDO #06-62 DJJ Inst. and Camps Manual 1T-59 section 6247.5***				
Question #6	Wards are provided with ADA approved floss, toothbrushes and toothpaste.				
Question #7	All dentists and dental health care workers show evidence of immunity to or immunization against the hepatitis B virus. ***CDC Guidelines***				
Question #8	Review wards Orientation Brochure/Handout. Determine if wards are provided adequate instruction as it relates to access to care.				
Question #9	Documentation of current and appropriate credentials is on file at the facility for all dental staff.				
Question #10	Documentation of initial and periodic dental peer reviews and actions taken if necessary.				
Question #11	Documentation of adequate written protocols for use by registered nurses to make a determination of urgency of dental sick call requests ***TDO #06-62 DJJ Inst. and Camps Manual 1T-59 section 6247.5***				

Review 10 to 20 dental records of wards having arrived at the facility within the last 120 days from a reception center

		1	2	3	4	5	6	7	8	9	10	11
Weight	***State ID #***											
85	Screen #1											
80	Screen #2											
100	Screen #3											

Screen #1 : Within 1day a dentist performs a comprehensive oral examination and treatment plan; caries risk assessment, dental classification, necessary screening radiographs, and meaningful oral hygiene instructions. ***TDO #06-62 DJJ Inst. and Camps Manual 1T-59 section 6247.5,***

Screen #2: Dental hygienist or dentist performs dental prophylaxis, oral hygiene education and fluoride treatment where appropriate within 120 days (up to 150 days will be considered in compliance) ***Primary Prevention- Academy of Pediatric Dentistry Guidelines***

Screen #3: Wards with a high caries risk (Class 3) are scheduled for caries stabilization within 60 days of arrival in DJJ ***TDO #06-62 DJJ Inst. and Camps Manual 1T-59 section 6247.5***

Review 10 to 20 dental records of wards requesting to see the dentist with complaints of a dental emergency and or dental pain and cavities

		1	2	3	4	5	6	7	8	9	10	11
Weight	***State ID #***											
100	Screen #4											
90	Screen #5											

Screen #4: Complaints of dental pain or dental emergency (such as avulsed teeth) are stabilized by a dentist or health services staff within 24 hours.
Screen #5: Complaints of cavities or broken teeth are stabilized to prevent tooth loss

Review the dental and medical records of 5 to 10 wards with significant mental health problems[2]

		1	2	3	4	5	6

Screen #6: Has policy mandated dental treatment been rendered.

Weight	***State ID #***						

[2] This screen is to check to see that youth with significant mental health problems are receiving policy mandated care even if their behavior makes that care delivery more challenging.

80	Screen #6						

Review 5 to 10 records of wards having dental extractions performed

Screen #7: A diagnostic radiograph, signed informed consent form, and a reason for extraction are present for teeth extracted.

		1	2	3	4	5
Weight	***State ID #***					
100	Screen #7					

Review 10 to 15 records of wards who have had restorative treatment performed

		1	2	3	4	5	6	7	8	9	10	11
Weight	***State ID #***											
85	Screen #8											
85	Screen #9											
75	Screen #10											
80	Screen #11											

Screen # 8: Diagnostic radiographs are present for restorative procedures

Screen # 9: A dental prophylaxis, caries risk assessment, and meaningful oral hygiene instructions, are documented prior to routine restorative treatment.

Screen # 10: A comprehensive examination and treatment plan is documented prior to routine restorative treatment.

Screen # 11: Partial dentures to replace front teeth and partial dentures for wards with inadequate opposing natural teeth completed following periodontal stabilization and routine restorative care. ***TDO #06-62 DJJ Inst. and Camps Manual 1T-59 section 6247.5***

Review 10 to 15 records of long term wards

		1	2	3	4	5	6	7	8	9	10	11
Weight	***State ID #***											
85	Screen #12											

Screen #12 Long-term wards (in DJJ > one year) have had their dental treatment completed and or have a class 1 classification, and are in recall status.

CDCR-DJJ Dental Services

Dental Services Summary:

	# of Records	#N/A	Final # of Records	# of Complaint Records	% Compliance	Comments
Screen #1						
Screen #2						
Screen #3						
Screen #4						
Screen #5						
Screen #6						
Screen #7						
Screen #8						
Screen #9						
Screen #10						
Screen #11						
Screen #12						

CDCR-DJJ Dental Services
Calculation of Overall Compliance

Screen	Weight		Min. SC score	Facility score		Weight	Facility score
Screen 1	85	x	0.85	1.00	x	85	
Screen 2	80	x	0.85	1.00	x	80	
Screen 3	100	x	0.85	.80	x	100	
Screen 4	100	x	0.85	.55	x	100	
Screen 5	90	x	0.85	1.00	x	90	
Screen 6	100	x	0.85	1.00	x	100	
Screen 7	100	x	0.85	1.00	x	100	
Screen 8	85	x	0.85	1.00	x	85	
Screen 9	85	x	0.85	1.00	x	85	
Screen 10	75	x	0.85	1.00	x	75	
Screen 11	80	x	0.85	1.00	x	80	
Screen 12	85	x	0.85	.91	x	85	

Minimum total SC Score

Score =

Question	SC	PC	NC
Question 1			
Question 2			
Question 3			
Question 4			
Question 5			
Question 6			
Question 7			
Question 8			
Question 9			
Question 10			
Question 11			
Totals			

Score =

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

DIVISION OF JUVENILE JUSTICE

Preston Youth Correctional Facility
Health Care Audit
August 25-28, 2008

Contents

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 or dental. The Mental Health Experts will develop the Mental Health Audit Instrument, and the Dental Expert will develop the Dental 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 are 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 Farrell Medical Experts conducted a health care audit at Preston Youth Correctional Facility on August 25-28, 2008. The facility population at the time of our visit was 356 youths.

We would like to thank Superintendent Tim Mahoney, Acting Assistant Superintendent, Tony Lucero, Dr. Evalyn Horowitz and staff for their assistance and cooperation during the audit. We were impressed by their desire to provide the youth quality health services.

This was the second formal audit for the facility and we note significant improvement in a number of health care systems since the previous audit. Overall, the facility scored 86% (752 of 750 Screens/Questions). Infection Control was not assessed during this review due to additional focus on clinical issues; as well as selected elements from other areas reviewed. We congratulate staff for their continued progress in improving the health care program.

Despite this progress, we found a serious problem involving one of the physicians. We found several cases in which youth arrived with significant health care problems, but the physician failed to address these health problems and in several cases documented findings which bore no relationship to the actual medical condition of the patient. As a result, youth with potentially serious medical problems were not identified and treated in a timely manner[1]. This included a youth with insulin dependent diabetes who was immediately placed in the outpatient housing unit (OHU) upon arrival due to extremely high blood sugar but who was not examined by the physician[2]. When he performed the youth's physical examination the following day, the physician documented that the 'denied any current health or acute emotional problems that requires medical and/or psychiatric attention at this time"[3]. He did not reference the patient's hyperglycemia and admission to the OHU. Another youth arrived with a fever and infected toe and the physician did not address the patients' condition and documented the examination as normal. A nurse saw the patient several days later and noted that he had purulent drainage on his sock and called a physician who ordered an antibiotic. A few days later the patient underwent a surgical procedure to remove the toenail. Two other youth arrived with elevated blood pressure measurements that the physician did not note or address[4]. Another patient had poor eyesight in the left eye due to prior trauma, and the physician documented his eyesight as being 'grossly normal'. In another case, the physician reviewed an x-ray showing that the youth fractured his hand, but did not assess the patient for another 9 days after reviewing this report[5]. This review showed that the physician documented physical examination findings that were either inaccurate, or did not occur, and in either case failed to address potentially serious medical conditions in a timely manner, if at all. These findings warrant immediate peer review and action by CMO and Statewide Medical Director.

These findings also raise questions about the effectiveness of the Preston and Health Care Services peer review, clinical auditing and quality improvement programs. It is not apparent that these deficiencies were identified and addressed through these programs. The Medical Experts will pursue this further with Dr. Morris, Statewide Medical Director.

Certain information in the report has been updated based on recent comments and clarifications that DJJ presented to the experts in a letter dated March 18, 2009. The letter raised some questions regarding the clinical findings of the experts. The experts have made changes in

response to the State's comments. However in some cases, the experts would need to reevaluate the medical records. We would request that in future case where questions regarding the experts findings arise, that copies of medical records be provided to us. We are also available to discuss these cases at a mutually convenient time. We incidentally note that additional changes would not significantly affect the scoring.

In summary, although the facility met the threshold score of 85% for substantial compliance, this issue is of sufficient concern the Medical Experts do not believe that Preston is in substantial compliance with the requirements of the Health Care Services Remedial Plan to provide adequate medical care to youth.

Summary of Health Care Review

Facility Leadership, Budget, Staffing, Orientation and Training scored 88%.

Dr. Evalyn Horowitz is the Chief Medical Officer. George Watanabe is the Health Care Administrator (HCA) who has been at the facility for about 21 months but is departing DJJ to take a position in the Department of Mental Health. Ms. Leila Mattahil RN is the Supervising Nurse II who has been at the facility for approximately 4 years.

In addition to the CMO and 2 full-time physicians, a 0.5 FTE physician position has been added since our last visit. The half-time physician FTE transferred from El Paso de Robles when the facility closed. The facility now has 3.5 FTEs for 350 youth, a physician to youth ratio of 1:100. Clinical staffing at Preston exceeds that necessary to provide adequate medical care.

The facility has 21 RNs and 18 RN positions filled. This is sufficient nurse staffing for a facility of this size and mission. However, there are plans to reduce the number of RNs by 6.4 because the mental health program is moving to the Northern California Youth Correctional Complex. Should staffing change significantly, the medical experts will reevaluate its adequacy.

Dr. Horowitz believes she has full authority over hiring decisions, but not control of the budget. This in part because non-health care related expenses such as Youth Correctional Counselor (YCC) positions and overtime continue to be charged to the medical budget. Staff again reported that when they attempt to learn how many YCC positions are assigned to the health care budget they are not provided this information[6].

The medical clinic sanitation has improved since our last visit however the facility has not had a janitor for approximately 3 months.

Health care leadership expressed concerns about their ability to provide continuity of contract services. As recently as May 2008 the facility had only two valid medical contracts: one for ambulance services and one for the hospital. In May 2008 an orthopedic group that the facility had a long-term relationship with informed the leadership that they would not accept their patients because their contract had expired in July 2007 and they had not been paid since that time.

We met with health care leadership and business office staff[7] to further explore the contract issues. Health care staff reported that the FY 07-08 medical contracts were not executed in a timely manner. The CMO reported she submitted contract requests for FY 07-08 to the business office in September 2006, but the contracts were not acted upon by the business office[8]. The facility did not have a Health Care Administrator (HCA) until late 2006 and when the HCA arrived he focused his attention on ensuring that the previous vendors got paid rather than the status of the contract renewals. In May 2008 procurement told the CMO that the contracts were not processed. The former health care services janitor went over to procurement and helped process the contracts. In the meantime, Preston obtained access for orthopedic services by identifying an orthopedist at Lodi Hospital and establishing a short-term emergency contract. They have one youth who needs urology surgery. However, Preston does not have a contract with the hospital where the urologist works. Staff reported that if a youth needs emergency care,

they can reimburse providers for the immediate care without a contract. However, any care beyond the initial treatment requires a valid contract. As a result, vendors are not paid for follow-up care unless there is a contract. A minimum of 3 months is required to establish an emergency contracts and 9-12 months for routine contracts. If this is true it should be further explored.

Business office staff reported that 2 staff[9] in the procurement section dedicated to processing contracts for the whole facility and this allocation is insufficient. They believe they need a business services assistant or officer in order to process contracts in a timely manner. They note that with the merger of DJJ with CDCR contract staff at Headquarters is less available than prior to the merger. More recently they have contacted Suzanne Livingston in CDCR Contracts who has agreed to assist them in processing medical contracts. Preston has also hired 120 new staff members but did not get additional personnel to process hiring.

Preston staff believes that DJJ needs a contracting unit devoted solely to medical, mental heath and dental contracts. They also believe DJJ could avoid cost duplication if Health Care Services assumed responsibility for ordering certain items that all the facilities will require for daily operations. For example, the HCA reported that to order medical record forms from a vendor there would be a set-up charge of $1500, regardless of the number of forms ordered. He believed that Health Care Services should survey the facilities to find out how many forms they need and order them at the same time for of all facilities, instead of ordering them individually and allowing all 6 facilities to be charged $1500[10].

Medical reception scored 72% compliance.

This is a declining score from our last visit and serious medical care issues were noted. The physician performing admission history and physical examinations did not address the serious medical conditions of several youth and used a computer template to document physical findings that bore no relationship to the actual condition of the patient[11]. Examples include an insulin dependent diabetic who upon arrival was noted to have a blood sugar of 566 and who was immediately placed in the OHU. When the physician performed his physical examination the following day he documented that the patient denied any health problems requiring medical care. Another patient arrived with a fever of 100.5° and complaints of an infected great left toe. The physician documented that he had no fever and his extremities were normal. The patient's labs showed that he had a systemic infection[12] and underwent incision and drainage of the infected toe several days later[13]. Two other youth arrived with elevated blood pressure readings that the physician did not note or address. Another youth had visual acuity of 20/200 in the left eye due to trauma, and the physician documented his eyesight as being 'grossly normal'. The actions of this physician represent serious inattention to duty and possible falsification of the health record. Consequently, what has been documented in the medical record cannot be relied upon as being accurate. We recommend immediate peer review by the Statewide Medical Director.

Intrasystem Transfer scored 86%.

This is a significant improvement from the score of 56% at our last visit. Areas needing additional attention are the quality of physician evaluations upon arrival and ensuring continuity of care.

Nursing Sick Call scored 77%.
This is a significant improvement from the score of 50% at our last visit and staff is to be commended. Until just weeks prior to the audit, nursing triage was not routinely being conducted in a clinical setting. Staff reported that nurses collected the health service request forms and went to the housing units to triage the youth in an office and then brought youth to the clinic if a clinical examination was necessary. However, staff also reported that there were transport issues that did not consistently result in the youth being brought to the clinic. That procedure has only recently changed. Nurses have not been trained in the use of nursing protocols. On a positive note, for the past six months there has been monthly peer review and feedback to the nurses that has resulted in improved quality of health assessments.

Medical Care scored 89%.
This is a slight improvement over the score of 83% at our last visit. We reviewed 20 records of the three physicians employed at the facility[14]. Record selection included a variety of primary care complaints.

Chronic Disease Management scored 98%.
This is a significant improvement from the score of 83% at our last visit. Congratulations!

Infection Control was not evaluated during this visit[15].

Pharmacy Services scored 100%.
This is a significant improvement from the score of 67% at our last visit. Congratulations!

Medication Administration Process scored 100%.
This is a significant improvement from the score of 92% at our last visit. Congratulations! This evaluation did not include observation of actual medication administration in the housing units that will be included in the next review.

Medication Administration Health Record Review scored 82%.
This score declined from 87% at our last sight visit. Areas that need attention include clinician documentation of route of administration with each order, and accurate transcription onto the MAR and documentation of order discontinuation.

Urgent/Emergent Care scored 78%.
This is a decline from the score of 88% at our last visit. Improvement is needed in nursing use of the SOAP format and nursing subjective and objective evaluations, and implementation and documentation of emergency response drills.

Outpatient Housing Unit Scored 82%.
We did not evaluate this area at our last visit. Improvement is needed in the physician's orders - specifically in terms of the clinical criteria for notifying the physician of a change in the patient's status.

Health Records scored 100%.
This is a significant improvement from the score of 25% at our last visit. Congratulations!

Preventive Services scored 88%.
This is a decline from the score of 96% at our last visit. Even though the facility scored greater than 85%, improvement is needed in addressing youth who are overweight.

Consultations/Specialty Care scored 98%.
This is an improvement from the score of 91% at our last visit. Congratulations!

Peer Review scored 100%.
This is a significant improvement from the score of 20% at our last visit. The medical experts auditing process reviews whether the DJJ peer review system is in place and not the accuracy/validity of individual clinician peer review. Thus we did not determine whether audit findings of physician performance were consistent with DJJ's assessment of physician performance. If there are substantial differences in the audit outcomes of the medical experts and DJJ staff this should be further explored to assess the reasons. Reasons may include sampling methods and differences in interpretations of what constitutes adequate assessment, diagnosis and treatment.

Credentialing scored 86%.
This is a significant improvement from the score of 71% at our last visit. Areas needing improvement include credentialing files that contain all required elements.

Quality Management scored 100%.
This is a significant improvement from the score of 50% at our last visit. The medical experts auditing process reviews whether the DJJ quality management process is in place. We did not compare the quality management findings with our independent review. If there are substantial differences in the medical experts audit findings and those of Preston and Health Care Services staff, this should be further explored to assess the reasons. Reasons may include sampling methods and differences in interpretations of what constitutes adequate medical treatment, etc.

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 HCSRP (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[16]		
Question #4	Budgeted and actual physician staffing hours are sufficient to meet policy and procedures requirements, and to provide quality medical services.	1[17]			
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				n/e
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:	7	1		2

Compliance = 88% (7 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.	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** **92426**[18]	**2** **89402**[19]	**3** **92474**[20]	**4** **91918**[21]	**5** **92496**[22]	**6** **MD782**[23]	**7** **92511**[24]	**8** **92508**[25]	**9** **92520**[26]	**10** **E0651**[27]
Screen # 1	0[28]	0[29]	1	1	0[30]	1	1	0[31]	1	1
Screen # 2	1	0[32]	1	n/a	1	n/a	n/a	n/a	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	0[33]	0[34]	0[35]	0[36]	0[37]	1[38]	0[39]	0[40]	0[41]	0[42]
Screen # 7	0[43]	0[44]	0[45]	0[46]	1	n/a	1	0[47]	1[48]	1
Screen # 8	0[49]	0[50]	1	0[51]	0[52]	n/a	0[53]	0[54]	1	1
Screen # 9	1	1	1	1	1	1	1	1	1	1
Screen # 10	0[55]	n/a[56]	1	1	1	n/a	1	1	1	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	6	
2	10	4	6	5	
3	10	0	10	10	
4	10	0	10	10	
5	10	0	10	10	
6	10	0	10	1	
7	10	1	9	4	
8	10	1	9	3	
9	10	0	10	10	
10	10	2	8	7	
Total	100	8	92	66	Plus 2 of 2 questions

Compliance = 72% (68 of 94 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			
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** **88976**[57]	**2** **92033**[58]	**3** **92503**[59]	**4** **92278**[60]	**5** **91630**[61]	**6** **92134**[62]	**7** **91476**[63]	**9** **92223**[64]	**9** **91574**[65]	**10** **E0558**[66]
Date of arrival	7/24/08	7/11/08	7/23/08	7/10/08	7/11/08	6/19/08	7/22/08	5/29/08	8/14/08	1/30/08
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	n/a	0[67]	n/a	n/a	n/a	n/a	n/a	n/a	1	1
Screen # 4	1	1	1	1	1[68]	0[69]	1	1	1[70]	1
Screen # 5	1	n/a	1	1	n/a	n/a	0[71]	1[72]	0[73]	1
Screen # 6	n/a	1	1	1	n/a	1	n/a	n/a	1	0[74]
Screen # 7	0[75]	1	1	1	n/a	1	1	n/a	0[76]	0[77]

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	10	
3	10	7	3	2	
4	10	0	10	9	
5	10	3	7	5	
6	10	4	6	5	
7	10	2	8	5	
Total	70	16	54	45	Plus 2 of 2 Questions

Compliance = 86% (48 of 56 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			
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[78]		
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[79]	
Question #7	The UHR is available and present for sick call encounters including in specialized housing units and during lockdowns.		0[80]		
Question #8	Nurses conduct sick call with, at a minimum, auditory privacy, and also with visual privacy if a physical examination is performed.		0[81]		
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	3	1	1

State ID# →	**1** **92426**[82]	**2** **91476**[83]	**3** **92474**[84]	**4** **91574**[85]	**5** **92520**[86]	**6** **92384**[87]	**7** **92078**[88]	**8** **91987**[89]	**9** **MD707**[90]
Triage Date HSR →	5/23/08	7/31/08	7/13/08	8/25/08	7/18/08	7/21/08	7/22/08	7/8/08	7/31/08
Date NSC →	5/23/08	7/31/08	7/13/08	8/25/08	7/18/08	7/21/08	7/22/08	7/8/08	7/31/08
	Leg pain	Back pain	Right hand pain/fracture	Leg pain	Nasal cyst	Extreme thirst	Chest pain	Spider bite	Bad headache
Screen # 1	1[91]	1	1	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	1	1	1	1
Screen # 3	1	0[92]	1	0[93]	1	0[94]	1	1	1
Screen # 4	0[95]	0[96]	1	0[97]	1	0[98]	0[99]	1	1
Screen # 5	0[100]	1	1	0[101]	1	1	1	0[102]	1
Screen # 6	1	1	1	0[103]	1	1	1	1	1
Screen # 7	1	1	0[104]	1	n/a	0[105]	1	1	1
Screen # 8	1	1	0[106]	1	1	1	1	1	1
Screen # 9	1[107]	1	0[108]	1	n/a	1[109]	1	1	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	9	0	9	9	
Screen #2	9	0	9	9	
Screen #3	9	0	9	6	
Screen #4	9	0	9	4	
Screen #5	9	0	9	6	
Screen #6	9	0	9	8	
Screen #7	9	1	8	6	
Screen #8	9	0	9	8	
Screen #9	9	1	8	7	
Total	81	2	79	63	4 of 8 Questions

Compliance = 77% (67 of 87 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 91797**	**2 E0563**	**3 E0563**	**4 E0563**	**5 92078**	**6 E0647**	**7 E0473**	**8 92508**	**9 91763**	**10 92508[110]**
Visit date:	7/18/08	6/10/08	6/17/08	7/17/08	6/3/08	7/15/08	7/11/08	8/13/08	7/22/08	7/17/08
Clinician name:	Dr A.	Dr B.	Dr B.	Dr A.	Dr B.	Dr B.	Dr A.	Dr B.	Dr B.	Dr A.
Nature of visit:	Headache	Shoulder problem	Chest pain	Hand pain	Rash	Chest pain	Hand pain	Chest pain	Abdominal pain	Infected L great toe
Screen # 1	1	0[111]	1	1	1	1	1	1	1	0[112]
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	0[113]	1	0[114]	1	1	0[115]	1	1	0[116]
Screen # 4	1	1	1	1	1	1	1	1	1	0[117]
Screen # 5	1	1	1	1	1	1	1	1	1	0[118]
Screen # 6	1	1	1	1	1	1	1	1	1	0[119]
Screen # 7	n/a	1	1	n/a	n/a	1	1	0[120]	1	0[121]

State ID# →	11 90133	12 90133	13 90772	14 92088	15 E0502	16 E0613	17 91090	18 92098	19 91788	20
Visit date:	7/25/08	8/6/08	7/15/08	8/13/08	7/22/08	6/25/08	7/25/8	7/1/08	8/20/08	7/21/08
Clinician name:	Dr A.	Dr. C	Dr B.	Dr. C	Dr A.	Dr A.	Dr A.	Dr A.	Dr A.	Dr B.
Nature of visit:	Abdominal pain	URI	Nasal pain	Back/shoulder pain	Hand pain	Rash	Back pain	Ear pain	Rash	Hand & shoulder pain
Screen # 1	1	1	1	0[122]	1	1	0[123]	1	1	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	1	1	0[124]	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	1	1	1	0[125]	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	20	0	20	16	
Screen #2	20	0	20	20	
Screen #3	20	0	20	15	
Screen #4	20	0	20	19	
Screen #5	20	0	20	19	
Screen #6	20	0	20	19	
Screen #7	20	9	11	8	
Total	140	9	131	116	Plus 1 of 1 Question

Compliance = 89% (117 of 132 Questions + Screens)

Chronic Disease Management

Number of patients enrolled in clinic__45_____ **Percent of clinic health records reviewed ____22___%**

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 92315	2 MD738	3 MD749	4 92433	5 92496	6 89193	7 89208	8 91797	9 92396	10 92474
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	1	1	0[126]	1	1
Screen # 3	n/a	1	n/a	n/a	1	1	1	1	n/a	n/a
Screen # 4	1	1	1	1	1	1	1	1	1	1
Screen # 5	1	1	1	1	1	n/a[127]	1	0[128]	1	1
Screen # 6	1	1	1	1	1	n/a[129]	1	1	1	1
Screen # 7	1	1	1	1	1	n/a[130]	1	1	1	1
Screen # 8	1	1	1	1	1	1	1	1	1	1
Screen # 9	1	1	1	1	1	1	1	1	1	1
Screen # 10	1	1	1	1	1	1	1	1	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	10	
Screen #2	10	0	10	9	
Screen #3	10	5	5	5	
Screen #4	10	0	10	10	
Screen #5	10	1	9	8	
Screen #6	10	1	9	9	
Screen #7	10	1	9	9	
Screen #8	10	0	10	10	
Screen #9	10	0	10	10	
Screen #10	10	0	10	10	
Total	100	8	92	90	

Compliance = 98% (90 of 92 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.				
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.				
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.).				
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 b) A policy describing use of standard precautions to prevent contact with blood or other potentially infectious materials (OPIM) c) A policy describing engineering (sharps disposal, specimen handling) and work practice controls intended to eliminate or minimize employee exposure d) A policy describing housekeeping procedures used to maintain a clean and sanitary environment, including a written schedule for cleaning and methods of decontamination				
Question # 5	Engineering Controls: a) Sharps containers are secure and easily accessible in areas where sharps are used. b) Hand wash facilities are in or near all work areas and antiseptic hand cleaner are available when needed. c) An eyewash station is present and tested quarterly for functionality. The eyewash station functions properly. d) Specimen containers are used for transport of biological specimens (e.g., blood, urine). e) Biohazard storage bins are available. f) Blood and body fluid spills are cleaned appropriately per policy.				
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. b) Staff observes Standard Precautions. c) Refrigerators are labeled appropriately (biohazard for specimens, food only, or medication only). d) Personal Protective Equipment is immediately available in health care delivery areas. e) Staff performs hand-washing as required.				

	Infection Control Continued:					**SC**	**PC**	**NC**	**NA**
Question 7	Are Infection Control Meetings held quarterly (minimum 4 meetings per year)?								
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?								
	For calculating score, only give credit for applicable questions in substantial compliance. **Totals:**								

Compliance = % (of 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?	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)?				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?	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.				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 Documed or night locker and signed it out prior to administration.	

Compliance = 100% (12 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** **89402**[131]	**2** **91918**[132]	**3** **91793**[133]	**4** **92496**[134]	**5** **92508**[135]	**6** **92505**[136]	**7** **92033**[137]	**8** **91574**	**9** **90743**	**10** **MD690**
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	0[138]	1	1	1	1
Screen # 3	1	1	1	0[139]	1	1	1	1	0	1
Screen # 4	1	1	1	1	1	0[140]	0[141]	1	1	1
Screen # 5	1	1	0[142]	1	1	1	1	1	0[143]	1
Screen # 6	1	1	1	1	1	1	0[144]	1	1	1
Screen # 7	1	1	1	0[145]	1	1	1	1	0[146]	1
Screen # 8	n/a	0[147]	0[148]	0[149]	n/a	n/a	1[150]	n/a	n/a	n/a
Screen # 9	1	0[151]	1	1	0[152]	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	10	
Screen #2	10	0	10	9	
Screen #3	10	0	10	8	
Screen #4	10	0	10	8	
Screen #5	10	0	10	8	
Screen #6	10	0	10	9	
Screen #7	10	0	10	8	
Screen #8	10	6	4	1	
Screen #9	10	0	10	8	
Total	90	6	84	69	

Compliance =82% (69 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.	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[153]		
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:	3	1		1

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

State ID# →	1 91895	2 E0428	3 90359	4 91368	5 E0514	6 92272	7 92234	8 92115	9 92220	10 91960
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	0[154]	1	0[155]	0[156]	1	0[157]	0[158]	1	1
Screen # 3	1	0[159]	0[160]	0[161]	0[162]	1	1	1	1	1
Screen # 4	1	1	1	n/a	1	1	1	1	1	1
Screen # 5	1	n/a	n/a	n/a	1	1	n/a	1	n/a	1
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

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	5	
Screen # 3	10	0	10	6	
Screen # 4	10	1	9	9	
Screen # 5	10	5	5	5	
Screen # 6	10	10	0	0	
Screen # 7	10	10	0	0	
Total	70	26	44	35	Plus 3 of 4 Applicable questions

Compliance = 79% (38 of 48 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			1	
	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 92496**	**2 92341**	**3 91895**	**4 92529**	**5 92444**	**6 92520**	**7 92534**	**8 92367**	**9 86204**	**10 91763**
Placement date: →	6/17	6/3	7/16	7/27	7/20	8/21	8/24	7/31	7/25	7/30
Discharge date: →	6/18	6/6	7/17	7/29	7/21	8/23	8/27	8/1	7/27	8/14
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	0[163]	0[164]	0[165]	0[166]	0[167]	1	0[168]	0[169]	0[170]	0[171]
Screen # 3	1	1	1	1	1	1	1	1	1	1
Screen # 4	0[172]	1	1	1	0[173]	1	1	1	1	1
Screen # 5	0[174]	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[175]	1	1	1	1	1	1	1	1	0[176]
Screen # 8	1	1	1	1	1	1	1	1	1	1
Screen # 9	0[177]	1	1	1	1	1	1	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	10	0	10	10	
Screen # 2	10	0	10	1	
Screen # 3	10	0	10	10	
Screen # 4	10	0	10	8	
Screen # 5	10	0	10	9	
Screen # 6	10	0	10	10	
Screen # 7	10	1	9	8	
Screen # 8	10	0	10	10	
Screen # 9	10	0	10	9	
Total	90	1	89	75	Plus 2 of 5 Questions

Compliance = 82% (77 of 94 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[178]			
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:	4			

Compliance = 100% (4 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** **91953**	**2** **92078**	**3** **90677**	**4** **92063**	**5** **92077**	**6** **90780**	**7** **91415**	**8** **90426**	**9** **91672**	**10** **90962**
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[179]	0[180]	1	1	1	0[181]	1	0[182]	1	0[183]
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	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	5	
Screen # 5	10	0	10	10	
Screen # 6	10	9	1	1	
Total	60	19	41	36	Plus 1 of 1 Question

Compliance = 88% (37 of 42 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[184]	
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 E0647	2 92229	3 MD623	4 E0530	5 91702	6 91846	7 91685	8 E0603	9 90973	10 E0612
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	n/a[185]	1	1	1	1	1	1	1	n/a	n/a
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	1	1	1	1	1	0[186]	1	1	1
Screen # 9	1	n/a	1	1	1	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	10	
Screen # 2	10	0	10	10	
Screen # 3	10	0	10	10	
Screen # 4	10	0	10	10	
Screen # 5	10	3	7	7	
Screen # 6	10	0	10	10	
Screen # 7	10	0	10	10	
Screen # 8	10	0	10	9	
Screen # 9	10	4	6	6	
Total	90	7	83	82	Plus 2 of 3 Questions

Compliance =98% (84 of 86 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.	1			
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.	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:	5			

Compliance = 100% (5 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.				n/a[187]
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[188]	
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[189]			
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[190]
	For calculating score, only give credit for applicable questions in substantial compliance. **Totals:**	6		1	2

Compliance = 86% (6 of 7 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.				1			
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: ____7/08_____	**Y**	**N**	**NA**	1			
	a) The CAP identified specific improvements needed.	X						
	b) The CAP identified specific staff members responsible for improvements.	X						
	c) The CAP had a targeted completion date.	X						
	d) There was documentation to indicate any recommended training was held.	X						
	e) Follow-up studies were done to determine whether or not corrective actions solved the problem or issue.	X						
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.				1			
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.				1			
For calculating score, only give credit for applicable questions in substantial compliance.				**Totals:**	10			

Compliance =100% (10 of 10 Questions)

TOTALS:

Total Number of Questions and Screens Evaluated	= 874
Total Number of Questions and Screens in Substantial Compliance	= 752
Total Score	= 86%

ENDNOTES

[1] See Medical Reception findings.

[2] The physician was on site and wrote orders for his admission to the OHU but did not examine the patient.

[3] This was part of a computerized template the physician used to document his findings.

[4] Although the physician signed the health screening form indicating he had reviewed it.

[5] Although the outcome of the patient was ultimately positive, this was an unacceptable delay in reassessing the patient following the initial injury.

[6] Although the state disputes the conclusion that the CMO does not have control over the budget, at the time of this review correctional officer overtime was included in the health care budget. The CMO has no control over CO overtime. Although DJJ is changing this, it was true at the time of the audit.

[7] Ms. Debbie Moffett.

[8] The deadline to submit contracts for fiscal year 2007-2008 was December 31, 2006.

[9] These staff are one Procurement Officer and one Office Technician.

[10] In the letter to the experts dated 3/18/09 the state disputes this paragraph as being inaccurate with respect to the set up fee of $1500 believing that it was related to staff at Preston creating or modifying forms. However the health care administrator was referring to the cost of printing existing forms, not new ones.

[11] The physician's template states "Patient denied any current health or acute emotional problems that requires medical and/or psychiatric attention at this time. Denied any claim of physical/learning or developmental disability, hearing impairment or need for hearing aid or special accommodation. He denied any restriction or limitation for any program, job, sport or housing assignment at the institution. He also enjoys his favorite sport-soccer- which he participates on a weekly basis. Patient states he is willing and ready to participate in any physical and educational activities at Preston at any time without any problem."

[12] Elevated white blood cell count of 12.1 and increased neutrophils.

[13] In a letter to the experts dated 3/18/09 the state disputes that the youth had an infected toe stating that it was only an ingrown toenail and that the surgical procedure was elective. However, on 7/16/09, six days after the youth arrived, he submitted a request in which he stated that his ingrown toe required surgery. The nurse inspected the toe, noting that it was purple with purulent drainage. The nurse called the physician who ordered an antibiotic. The documentation in the record clearly supports that his toe was infected.

[14] This included 10 records of Dr. A., 8 records of Dr. B., and 2 records of Dr. C.

[15] Infection control was not evaluated due to additional time spent with the CMO and physician related to clinical findings. The medical experts will review this at the next site visit.

[16] For the fiscal year 2007-08 the YCC positions and overtime were still charged to the medical budget. The HCA tried to determine how many non-medical positions were assigned to program 23 but was not able to get an answer. The HCA was told that this would be corrected with the new fiscal year. Dave Gransee contacts the HCA for budget reconciliation. The CMO reports there are sometimes finance issues related to budgeted positions. The CMO stated that a position is filled but she receives notice that the position is vacant and subject to being eliminated. She was noticed that a large number of health care

(filled) positions were subject to being eliminated. Dr Horowitz believes the amount of paperwork necessary to order medical equipment and supplies is excessive.

[17] In addition to the CMO, there are 2.5 physicians.

[18]This 17 y.o. arrived at PYCF on 4/17/08. His medical history includes bipolar disorder with previous hospitalization. His medications include Abilify. Medical transfer information from Children's Hospital Juvenile Justice center noted that he sustained trauma/fracture 9/07 to his lower left leg/foot with chronic pain; mental health history and dental brackets on teeth. The Hospital recommended orthopedic follow-up as soon as possible, mental health and dental follow-up.

[19] This 19 y.o. arrived at PYCF on 8/5/08. Upon arrival a nurse completed the health care screening form. The patient had a history of asthma and depression. His medications included Albuterol MDI and he reported daily use of his inhaler. His blood pressure was recorded as 149/79 mm/hg. The patient reported having night sweats for one month but the nurse did not elaborate on this. The physician completed his physical examination the following day but documented that he had no complaints of wheezing or shortness of breath, although he was using his inhaler daily. He did not address the patient's elevated blood pressure. Previous DJJ medical records show he had a history of hyperbilirubinemia in 2005 but this was not noted or addressed. He assessed the patient has having mild asthma. Note: Patient's who have daily symptoms requiring use of an inhaler have moderate persistent asthma. The physician enrolled the patient into the chronic disease program. The patient tested positive for chlamydia and appropriate treatment was ordered.

[20]This 17 y.o. arrived at PYCF on 5/29/08. He had a history of asthma. Upon arrival the nurse completed the screening form. The youth was febrile 100° but this was not addressed. Visual acuity in his left eye was decreased (20/200) secondary to being hit in his with a left eye with a bean shooter 5 years prior. The physician documented his vision as being grossly within normal limits. The optometrist saw the patient on 7/1/08 and noted that the patient had a macular hole in the left eye. He recommended a consult with a retinal specialist. This report was not initialed as reviewed however the same day a physician requested a consult with a retinal specialist. Initially we could not locate the report in the record but it was later found. Due to the time elapsed surgery was not recommended.

[21]This 18 y.o. arrived at PYCF on 8/8/08 at 1000. His medical history included mild asthma and mental health treatment. He was not taking any medications. He complained of a productive cough and runny nose for 3 days. His blood pressure was 153/86 mm/hg. During a previous admission in 2007, labs showed that he had elevated cholesterol and triglycerides. Dr. A saw him the following day. He did not note the patient's history of URI and did not address the patient's elevated blood pressure or history of elevated lipids.

[22] This 18 y.o. arrived at PYCF on 6/17/08. His medical history included diabetes type 1, hypercholesterolemia, ADHD, and depression. His medications included humalog insulin, Lantus, Adderall, Tegretol, Clonidine, Vistaril and Benadryl. Upon arrival his blood sugar was 566. The patient had not received insulin since 6:30 am in the morning. The patient was admitted to the OHU. Dr A, whose was on-site did not examine the patient, although he gave orders. The nurse wrote a good admission progress note. Nurses monitored the patient closely over the next 8 hours, but then his blood sugar was not checked again after 2200 until the following day.

[23] This 17 y.o. arrived at PYCF on 6/5/08. He had a history of anxiety disorder.

[24] This 17 y.o. arrived at PYCF on 7/10/08. He had a history of rheumatoid arthritis and pancreatitis secondary to medications.

[25] This 20 y.o. arrived at PYCF on 7/10/08. Upon arrival he had a fever of 100.5°F and complained of an infected left great toe. The nurse did not further assess the patient's condition at the time of his arrival.

The physician saw the patient the same day but did not note the patient's fever or examine his infected toe. He used the same computerized template that he uses for all patients documenting only that the patient had full range of motion of all extremities. On 7/13/08 the patient had newly diagnosed TB infection and the physician saw the patient on 7/14/08. Labs showed that his white cell count was elevated (Total WBC =12) suggesting a systemic bacterial infection. On 7/16/08 the patient submitted a sick call request stating that he had an ingrown toenail and would like surgery. The nurse saw the patient the same day and noted purulent drainage on his sock and that his left great toe was dark purple. The nurse called the physician who ordered an antibiotic (Bactrim) and Motrin. The wound was not cultured. The nurse routinely referred the patient to the physician who saw the patient the following day. The physician documented that the patient denied any drainage or abscesses despite the nurse's documentation to the contrary. He also documented that the patient 'admitted' that the problem started when he trimmed the edge of the left great toenail the previous week. His diagnosis was stage I or II ingrown toenail. He did not address the patient's abnormal white blood cell count. On 7/19/08 the patient returned to the clinic because of continued pain and the physician removed the patient's toenail. The patient's blood count was repeated and his white count decreased to 9.6. The physician discussed this with the patient on 7/21/08.

[26] This 18 y.o. arrived at PYCF on 7/16/08. His medical history included asthma and a left nasal cyst. His is medication was Albuterol MDI.

[27] This 17 y.o. arrived at PYCF on 6/19/08. His medical history included mild asthma.

[28] The patient complained of being treated for chest pain in the last six months. The nurse did not elaborate to determine the onset of his chest pain or describe the quality, severity, duration, etc.

[29] The patient reported a history of night sweats for one month.

[30] One nurse completed the upper portion except for weight, vital signs, visual acuity, medications and the immunization history. The other obtains TB symptoms and the medical history; however they collect the information on different days and continue to add information for days such as labs, immunization history.

[31] Upon arrival the youth had a fever of 100.5° F and rapid pulse (103 beats/minute). The nurse documented that the patient had an infection of the left great toe and history of a lower leg infection 2 months ago that was resolved. The nurse's disposition was routine, instead of same day referral. The nurse did not document any plan regarding the patient's fever or infected toe.

[32] The patient's inhaler was ordered the day after arrival. The intake screening form does not make it clear whether inhalers arrived with the patient. The medication was ordered the following day and the patient was given his inhaler on 8/7/08, two days after arrival.

[33] Transfer medical information from Children's Hospital Juvenile Justice Center documented a September 2007 history of trauma to his left lower leg with resulting chronic pain. The physician noted a history of a dog bite and documented a grossly normal musculoskeletal examination upon visual inspection. He did not examine strength, sensation or reflexes. This is important given the transfer information suggesting chronic pain. The screening nurse documented a history of chest pain within the past six months but the physician did not reference or explore this other than to document no chest pain in the review of symptoms.

[34] The patient reported night sweats for one month and had an elevated blood pressure reading of 149/69 mm/hg. This was not addressed. We referred this record to the clinician for follow-up.

[35] The physician documented that the patient had no visual problems however he has 20/200 distance vision and 20/100 near vision in his right eye. He documented that the patient had no shortness of breath or wheezing however the patient has asthma for which he uses an inhaler.

[36] The physician did not address the patient's elevated blood pressure and history of elevated cholesterol and triglycerides.

[37] The physician documented that "The patient denied any current health or acute emotional problems that requires medical or psychiatric attention at this time….'At the time he documented this, the patient was in the infirmary with uncontrolled diabetes. The doctor has a cut and paste template that he is using to document the patients current medical problems. He only changes the sport the youth plays (either soccer or football). The physician documented that the patient said there was "no hospital admission, no surgery or any operative procedure and no biopsy" although the patient had a history of being hospitalized at age 3 due to viral pancreatitis that induced his DM. He documented that he had a history of MVA age 13 and then documented he denied a history of MVA.

[38] The examination is a template that is essentially the same for every patient.

[39] The physician did not address the patient's history of rheumatoid arthritis and resolving pancreatitis denied any current health or acute emotional problems.

[40] Under current symptoms, the physician documented the same template that he has for all patients. There is no variability except for the sport the youth plays, always on a weekly basis. He documented that the patient had no fever, although the nurse documented that he had a fever of 100.5° and recently resolved cellulitis. The physician did not document an examination of the patient's left lower leg or left great toe.

[41] The patient had a nasal cyst but the physician documented the review of systems for eyes, ears, nose and throat as being normal. He documented 'no nasal discharges or swelling of the turbinates although the patient had a history of chronic sinusitis with a large left mucocele cyst sphenoid sinus and was pending ENT evaluation.

[42] The patient had a history of asthma but in the review of symptoms the physician did not inquire about the frequency of symptoms, stating no wheezing or shortness of breath.

[43] The physician did not note or describe the history of trauma to the patient's leg in 2007. Since then the patient has had blood work showing elevated creatinine and lipids which are not noted on the Problem list. Dr. A signed off the labs on April 24 and documented he explained the labs to the patient. The patient believes he has sleep apnea.

[44] History of hyperbilirubinemia, elevated blood pressure, risk of sexually transmitted infections.

[45] The patient's history of an injury to the left eye was noted. However the patient's decreased vision and left eye macular hole are not noted.

[46] Elevated blood pressure and lipids not noted.

[47] The physician documented an ingrown toenail. The patient had an infected ingrown toenail requiring surgical I & D.

[48] Dr. A lists two problems on the same line Asthma, nasal polyp. These should be listed separately on the Problem List.

[49] The physician documented that the patient's activity was restricted, however it's unclear what the basis and nature of the restrictions.

[50] No plan to address the patient's elevated blood pressure or history of hyperbilirubinemia.

[51] Plan did not address the patient's elevated blood pressure and lipids. Stated that the patient's depression was well controlled on Seroquel but the patient was not on Seroquel.

[52] The plan did not address the patient's diabetes at all.

[53] The physician documented no plan related to the patient's rheumatoid arthritis. It is unclear based upon previous medical records whether he really has this condition.

[54] The physician did not adequately address the patient's cellulitis of the left toe.

[55] The patient is morbidly obese, has elevated lipids (Total cholesterol = 223, LDL = 169), potassium is 5.8 and creatinine of 1.4 in April 2008. These have not been noted or addressed.

[56] 30 days has not elapsed since arrival on 8/5/08.

[57] This 22 y.o. arrived in DJJ on 7/3/08 at NAC and transferred to Preston on 7/24/08. His medical history includes sickle cell anemia and dental pain. Upon arrival at NAC he refused a history and physical. He had a previous history and physical in February 2008. Upon his arrival at Preston a nurse completed an intrasystem transfer form and he was seen by a physician the following day. He has been enrolled into a chronic disease clinic. On 7/24/08 the physician ordered a CBC, chemistry panel and sed rate but results are not found in the record. The youth was transferred out for a Morrissey hearing and returned on 8/8/08. The patient refused a chronic disease appointment on 8/20/08. The patient's history of splenectomy is not documented not on Problem List.

[58] This 16 y.o. transferred from OHC to PYCF on 7/11/08. His medical history included mood disorder and insomnia.

[59] This 16 y.o. transferred from SYRCC to PYCF on 7/23/08. His medical history includes mild asthma, mental health treatment, and allergy to milk and eggs.

[60] This 16 y.o. transferred from OHC to PYCF on 7/10/08. His medical history includes asthma, mitral valve prolapse with mild tricuspid regurgitation.

[61] This 17 y.o. transferred from SYCRCC to PYCF on 7/11/08. His medical history includes ADHD and mood disorder.

[62] This 19 y.o. transferred from Pine Grove YCC to PYCF on 6/19/08. His medical history includes TB infection and an esophageal tear and gastrointestinal bleeding. A review of his record shows that while he was at PGYCC on 3/3/08 the patient complained of GI upset for several days and requested an x-ray. On 3/3/08 Dr. B saw the patient and performed an appropriate examination. On 4/24 the patient complained of GI upset and diarrhea. On 4/25/08 the nurse saw the patient and elaborated upon his symptoms. The nurses did not take a full set of vital signs (only temp 98° F) or examine the patient's abdomen. Her assessment was GI upset and plan was to have the patient follow-up if diarrhea continued or he became febrile. The nurse did not document a referral to the physician however, the same day Dr R.B. saw the patient and noted that he had abdominal pain and vomited blood while working. He examined the patient and noted dark bloody emesis, and his diagnosis probable peptic ulcer. His plan was to give the patient a Nexium sampler, Omeprazole 20 mg daily, take the patient off work for 2 days and to follow-up as soon as possible for continued bleeding. There are no further notes in the record until 4/28/08. However, a 4/26/08 dictated note by Dr. R.B. indicates that after the patient was sent back to Pine Grove: "*the patient had additional bleeding and past [passed] several large dark stools as well as some bloody emesis. He became lightheaded and passed out several times. He was brought to the emergency room where he was evaluated and treated. His hemoglobin was 8.8 grams and Hct 29.3%. He underwent upper GI endoscopy… and was diagnosed with a Mallory-Weiss Tear. The patient was discharged on 4/27/08."* Following his return to Pine Grove he was regularly monitored by Dr Wisdom and the nurse. He is being treated with iron supplements and on 6/19/08 he was transferred to PYCF. This case is disturbing because the patient had signs and symptoms of an active GI bleed and was not sent to the emergency department.

[63] This 19 y.o. transferred from NCYCC to PYCF on 7/22/08. His medical history included obesity, chest pain and anxiety.

[64] This 18 y.o. was at PYCF and went out to court on 5/2/08 and returned on 5/29/08. He had a history of TB infection.

[65] This 19 y.o. arrived at Preston on 10/3/07, transferred to NAC on ? and transferred back to Preston on 8/14/08. His medical history includes morbid obesity, hypertension, asthma and bilateral hearing loss. He also had a history of a gunshot wound to his left leg in May 2008 with popliteal artery reconstruction, extensive skin grafts and sensory and motor loss of the left leg. He is anemic.

[66] This 16 y.o. transferred from SYCRCC to PYCF on 1/30/08. His medical history includes liver transplant at 2 years of age.

[67] The nurse referred the patient to the physician to evaluate acute wrist pain however the referral did not take place. The physician did sign the form however.

[68] The physician wrote an order to enroll the patient into the hypertension clinic however the patient was not diagnosed with hypertension. The patient was later seen in the clinic and discharged because of lack of a diagnosis.

[69] Dr. A saw the patient but did not obtain an updated history related to his recent GI bleeding and whether he was having any signs or symptoms of GI bleeding. He did renew his iron supplements and order labs. The history appears to be a template that he uses.

[70] The physician did not note the patient's hypertension but did renew medications and enroll the patient into the chronic disease program.

[71] Patient was not seen for 30 days.

[72] The physician uses a template for documentation. It did not reference the patient's medical history of TB infection.

[73] The patient has not been seen for his hypertension since his arrival on 8/14/08.

[74] On 1/30/08 the physician wrote an order for a medication at a lower dosage than what the patient was taking prior to his arrival. This change took place without a clinical evaluation to support the lower dosage. The following day the order was changed to the dosage he was taking prior to arrival in DJJ.

[75] The physician ordered lab tests upon arrival but they have not yet been completed.

[76] The patient has not been seen for hypertension since his arrival. On 8/27/08 the patient was scheduled to see Dr. A. The patient's blood pressure was 151/91 mm/hg. The patient refused to see Dr. A. There is no plan to address the patient's uncontrolled blood pressure

[77] Upon arrival a mental health referral was made but the patient was not seen until 5/7/08.

[78] Until just prior to the audit, staff were conducting assessments on the housing units without the health record.

[79] Nursing protocols have not yet been developed by Health Care Services.

[80] Until just prior to the audit, staff were conducting assessments on the housing units without the health record.

[81] Until just prior to the audit, staff were conducting assessments on the housing units without the health record.

[82] This 17 y.o. arrived at PYCF on 4/17/08. His medical history includes bipolar disorder with hospitalization. His medications include Abilify. Medical transfer information from Children's hospital Juvenile Justice center notes that he has chronic pain in feet and lower legs; sustained trauma/fracture 9/07 to lower left leg/foot. On 5/23/08 he submitted a Health Service Request complaining of inability to

run due to his leg. The nurse documented that he was bitten by a police dog in July 2007 and he has a nerve problem in his leg.

[83] This 19 y.o. transferred from NCYCC to PYCF on 7/22/08. His medical history includes obesity, chest pain and anxiety.

[84] This 17 y.o. was involved in an altercation on 7/9/08. On 7/13/08 he submitted an HSR complaining of right hand pain and that he thought it was fractured. On 7/14/08 the physician saw him and ordered an x-ray that was taken the same day and showed a distal right second metacarpal fracture. On 7/16/08 Dr. A. reviewed and signed the report but did not document a progress note or order referral to an orthopedist. On 7/25/08 Dr. A. wrote a progress note documenting that the patient's hand pain was resolved but exacerbated by frequent fighting. He offered the patient a splint and referral to the orthopedist. On 7/30/08 a physician progress noted documented that he saw the orthopedist and refused a cast. On 8/13/08 he saw the orthopedist for follow-up and a physician progress note indicates that the hand fracture was healing well with follow-up planned on 8/28/08. There are no consultation reports in the record.

[85] This 19 y.o. arrived at Preston on 10/3/07, transferred to NAC on ? and transferred back to Preston on 8/14/08. His medical history includes morbid obesity, hypertension, asthma and bilateral hearing loss. He also had a history of a gunshot wound to his left leg in May 2008 with popliteal artery reconstruction, extensive skin grafts and sensory and motor loss of the left leg. He is anemic.

[86] This 18 y.o. arrived at PYCF on 7/16/08. His medical history included asthma and a left nasal cyst. His is medication was Albuterol MDI.

[87] This 17 y.o. arrived at PYCF on 3/25/08. His medical history includes leukemia, hypogonadism and short stature.

[88] This 18 y.o. arrived at PYCF on 6/7/07. His medical history includes TB infection.

[89] This 19 y.o. arrived at PYCF on 5/24/08. This medical history includes TB infection and acne.

[90] This 17 y.o. arrived at PYCF on 11/1/07. He has a history of scoliosis.

[91] No date and signature of triage.

[92] The nurse did not assess pain severity.

[93] The patient complained of leg pain and swelling. The patient had a history of GSW to the leg. The nurse did not obtain any meaningful history but only documented that the patient had not taken a diuretic and wanted a blue slip so he did not have to walk to chow.

[94] The nurse did not quantify the patients thirst or inquire about other symptoms of diabetes, excessive urination, weight loss, etc.

[95] The nurse noted the patient walked without problems but did not measure strength and sensation of right leg as compared to the left leg. Vital signs were not measured.

[96] The nurse did not examine the patient's back, only noted that he was alert, oriented and ambulated without difficulty. Vital signs were not measured.

[97] The nurse did not take vital signs or examine the patient.

[98] The nurse did not measure vital signs or obtain a dipstick urinalysis.

[99] The nurse measured vital signs but did not auscultate the heart and lungs.

[100] The nursing diagnosis did not reflect impairment with ambulation secondary to injury of the left leg, only 'health seeking behavior'. It is unclear what this assessment means.

[101] The nurse did not document an assessment or plan.

[102] The nurse assessed the lesion as a spider bite. It was more likely a furuncle due to staph infection.

[103] The nurse did not document an assessment or plan.

[104] The nurse made a routine rather than urgent referral.

[105] The nurse should have referred the same day since insufficient information was obtained to determine the safety of a routine referral.

[106] Nursing signature is illegible and there is no name stamp.

[107] The physician's evaluation was sensation and strength intact. Reflexes not checked. Diagnosis was decreased sensation versus manipulation.

[108] The referral to rule out a fracture did not take place until the following day.

[109] The referral took place in accordance with the nursing disposition.

[110] This 20 y.o. arrived at PYCF on 7/10/08. Upon arrival he had a fever of 100.5° F and complained of an infected left great toe. On 7/16/08 the patient submitted a sick call request stating that he had an ingrown toenail and would like surgery. The nurse saw the patient the same day and noted purulent drainage on his sock and that his left great toe was dark purple. The nurse called the physician who ordered an antibiotic (Bactrim) and Motrin. The wound was not cultured. The nurse documented a routine referral to the physician who saw the patient the following day. The physician documented that the patient denied any drainage or abscesses evening though the wound was draining the day before. He also documented that the patient 'admitted' that the problem started when he trimmed the edge of the left great toenail the previous week. On 7/19/08 he performed an Incision and drainage of the toenail. He did not address the patient's abnormal white blood cell count. It was repeated and decreased to 9.6.

[111] No history related to pain, range of motion

[112] The physician documented that the patient denied any drainage or abscesses evening though the nurse documented the day before that the wound was draining and soaked through the patient's sock.

[113] Did not note size of bruise, tenderness, range of motion.

[114] Stated findings consistent with soft tissue injury but did not describe specific physical findings

[115] Stated findings consistent with injury but did not describe specific physical findings

[116] The patient's white blood cell count was increased (patient's WBC =12, normal= 4-10).

[117] His diagnosis is stage I or II ingrown toenail. The patient had an abscess of his great toe.

[118] The treatment plan did not include wound culture.

[119] Based upon incomplete/inaccurate diagnosis.

[120] Noted had follow-up in one week. Seen in one week but did not address chest pain.

[121] This patient arrived at the facility on 7/10/08 with a fever and complaining of an infection of his left great toe. A surgical incision and drainage (I & D) procedure was not performed until 7/19/08.

[122] No history related to range of motion, alleviating/aggravating factors, etc

[123] Inadequate history related to back pain, i.e., location, intensity, radiation, alleviating/aggravating factors

[124] Did not note range of motion, wrote "no VPT", neither Dr. Horowitz, Dr. A or I knew what this meant

[125] Plan was for follow-up in 3 days, did not occur

[126] No past history related to hypertension.

[127] Refused to see MD.

[128] No history related to symptoms.

[129] Refused to see MD.

[130] Refused to see MD.

[131] Order 8/11/08.

[132] Order 8/11/08.

[133] Order 6/25/08.

[134] Order 6/17/08.

[135] Order 7/23/08.

[136] Order 8/11/08.

[137] Order 7/29/08.

[138] Order dated, not timed.

[139] The physician wrote a 2 line entry, not a clinical note.

[140] The nurse did not date or time the order.

[141] There were two orders, one for Trazadone that was transcribed in a timely manner and one for Benadryl that was not transcribed for 24 hours.

[142] Pharmacy printed 6/2008 on the MAR instead of 7/2008 on the newly printed MAR.

[143] The nurse did not document the strength of the ophthalmic solution (0.3%).

[144] Benadryl not started for 48 hours.

[145] No documentation of June 29 and 30 Lantus insulin.

[146] No documentation of Azopt for 8/23 and 8/24.

[147] The nurse did not document the date and initial and draw a line to discontinue the 8/11/08 order.

[148] Nurses cross out the time the medication is given.

[149] Nurses cross out the time the medication is given.

[150] Trazodone was discontinued.

[151] The nurse “NT” did not sign the back of the MAR.

[152] Nurses ‘UB’ and ‘JB’ did not sign the back of the MAR.

[153] Quarterly emergency drills are not being conducted as required by the Remedial Plan.

[154] Subjective information in objective section

[155] Subjective information in objective section

[156] Subjective information in objective section

[157] Subjective information in objective section

[158] Subjective information in objective section

[159] Nurse did not examine patient.

[160] No vital signs.

[161] Inadequate history related to chest pain, i.e., quality, location, exacerbating factors, etc.

[162] Did not examine abdomen.

[163] No initial impression or order for vital signs.

[164] No criteria for notification of MD.

[165] No criteria for notification of MD.

[166] No initial impression, order for vital signs, or parameters for notifying MD.

[167] No criteria for notification of MD.

[168] No criteria for notification of MD.

[169] No criteria for notification of MD.

[170] No criteria for notification of MD.

[171] No criteria for notification of MD.

[172] Patient admitted with hyperglycemia (566). Nurse noted, "no pain or other symptoms." No history related to polyuria, polydipsia, nausea, weakness.

[173] No documentation of orientation to OHU.

[174] Clinician did not perform a clinical assessment. Patient admitted in the afternoon. MD wrote orders – should have seen patient.

[175] This is addressed under screen 9.

[176] No clinician rounds on 8/8.

[177] MD did not write a discharge note. MD completed initial history and physical form on day of discharge from OHU but did not mention or address hyperglycemia or OHU stay.

[178] There is no system for tracking consult reports. This is scored under specialty care.

[179] BMI 27.1 - weight not addressed.

[180] BMI 29.7 - weight not addressed.

[181] BMI 29.7 - weight not addressed.

[182] BMI 24.8 - weight not addressed.

[183] Weight 257, no height in chart, obesity is on problem list but weight not addressed.

[184] Receipt of records is not tracked.

[185] MD saw patient upon return.

[186] Follow-up with orthopedics was ordered for 4 weeks after 6/19. It did not occur and there was no documentation as to why it did not occur.

[187] There is no local policy, only a statewide policy.

[188] Results of National Practitioner Data Bank Inquiry not present for all physicians.

[189] There is a concern related to one physician who had 2 adverse malpractice judgments (from events in 1993 and 1995). Based on these events, the medical board took the following action on his medical license: "revoked, stayed, five years probation with various terms and conditions." (Probation commenced on 11/8/01. His license was restored on 1/19/06.) The physician was hired by DJJ in July 2007 and recently transferred to Preston. Dr. Horowitz reported that Dr. Morris had checked with the Medical Board prior to hiring the physician, and had been informed that the physician's performance during probation was excellent. She also stated that Dr. Morris added that his review of the precipitating incidents revealed that much of the problems were circumstantial and did not represent substandard care.

[190] Have not had any HIV patients in 4 years.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

DIVISION OF JUVENILE JUSTICE

Southern Youth Correctional Reception Center and Clinic
Health Care Audit
March 2009

Contents

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 or dental care. The Mental Health Experts and Dental Expert will develop their respective audit instruments.

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 are 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 Farrell Medical Experts visited Southern Correctional Youth Reception Center and Clinic during the weeks of March 9 and March 30, 2009.

We thank Hung Do, CMO, and Cassandra Stansberry, Superintendent and their staffs for their cooperation and assistance in completing the health care audit. Both health care and custody staff are to be commended for their success in improving the health care program.

The facility scored 88% (743 of 840 applicable screens/questions). This is a significant improvement from the score of 72% at our last visit and meets the criteria to be in substantial compliance. Certain information in the report has been updated based on recent comments and clarifications that DJJ presented to the experts in a letter dated June 9, 2009.

The facility population at the time of our visit was 224 youth in 5 housing units. In addition to the main medical clinic areas, there are two satellite nursing stations, one in the Marshall Intensive Treatment Program (ITP) and a clinic in Drake for county youthful offenders. Youth housed in Drake cannot be mixed with DJJ youth and are brought to the main medical unit on Tuesdays for medical services. The facility currently uses five Outpatient Housing Unit (OHU) beds for medical/mental health purposes. SYCRCC provides infirmary services for the population of Heman G. Stark YCF.

Although the facility has made significant improvements since our last visit, we note that urgent/emergent care scored 64% and requires further attention.

Summary of Health Care Areas Reviewed

Facility Leadership, Budget, Staffing, Orientation and Training scored 88%

All key leadership positions have been filled for the past year. The facility now has a complete set of local policies and procedures, which they did not have last year. The CMO is responsible for the medical budget. The facility has been allocated $10,323,298 for the current fiscal year. If all funds are expended this would average ~$46,086 per youth based upon the current population[1]. All staff had current licenses but the tracking log was not up to date, showing some staff as having expired licenses.

Medical Reception scored 94%

According to the Reception Center Health Screening Tracking Log, 63 youths were received from 1/15/09 to 4/2/09, averaging approximately 6 admissions per week. We reviewed 10 records of youth who were admitted to the facility from July 2008 to March 2009. This area has significantly improved since our last visit, particularly with respect to the quality of the medical history and physical examination and development of appropriate treatment plans.

Intrasystem Transfer scored 92%

According to the Intrasystem transfer log, 18 youth were received from October 2008 to March 2009, averaging 3 youth per month. We reviewed 6 records of youth who were transferred from June 2008 to February 2009. We found no significant issues.

Nursing Sick Call scored 82%

At SRYRCC, nurses collect and triage health service requests and perform limited assessments. This is because all health service requests are to be referred to a clinician. We reviewed the nurses' screening logs that showed the majority of youth requests were for minor complaints (e.g., acne, dry skin, athlete's foot) that could be managed by registered nurses with adequate health assessment training and standardized procedures. We also noted that youth return repeatedly for minor complaints that, in a community setting would not result in a visit to a physician. We selected ten records to assess the timeliness of access to care and the quality of the nursing assessments. We found care to be timely. We found nursing assessments to be abbreviated, which is not surprising given that nurses directly referred patients to a clinician. We recommend that DJJ develop and improve the ability of registered nurses to manage patients with minor complaints in accordance with written standardized procedures and only refer those patients who meet the criteria for referral.

Medical Care scored 95%

Congratulations!

Chronic Disease Management scored 93%

At SYCRCC, 32 (14%) of 224 youth are diagnosed with a chronic disease. We reviewed a sample of 10 (32%) of the 32 records. While the facility met the goal of 85%, areas that could be improved are the assessment of control and the treatment plan.

Infection Control scored 88%

While the facility met the goal of 85%, an area that could be improved is infection control meetings. At each meeting, staff should ensure that previously noted problems have been adequately addressed. For example at the October 2008 infection control meeting problems with roach infestation in the kitchen were noted, but at the following meeting this was not commented upon as to whether the problem was resolved. With respect to communicable diseases, when data is presented there should be discussion as to the significance of the data and whether trends are noted that may require further action.

Pharmacy Services scored 100%

Congratulations! On a consultative note, in addition to the psychiatrist who chairs the committee, we recommend that a medical provider be added to the committee.

Medication Administration Process scored 92%

Medication administration is working well. An area of improvement needed is that nurses transfer medications from properly labeled containers into envelopes to transport medications to

satellite areas. Instead, nurses should take the original container or ensure that the envelope is properly labeled (e.g., have the pharmacy print an extra label for each medication).

Medication Administration Health Record review scored 88%

Although this area scored above 85%, we noted that in 3 of 10 records reviewed there were transcription errors, including failure to transcribe physician orders. We also note that TB preventive medication is given on a Monday-Thursday or Tuesday-Friday regimen at some DJJ facilities was being given on a Tuesday-Thursday schedule at SYCRCC. Dosing this medication this close together may result in an increased incidence of side effects. We recommend that the schedule for administering TB preventive therapy be standardized across DJJ facilities in order to establish consistency in dosing. Finally, in a review of one record we found that 2 different nurses documented giving the same dose of medication on 2 different MARs. We later learned that one nurse documented giving a dose of medication that the nurse did not personally administer. This is tantamount to falsification of the record and raises questions about the integrity of the health record. We reported this to health care leadership who planned to investigate further.

Urgent/Emergent Care scored 64%

We found that urgent/emergent care was problematic. Nurses do not consistently record all urgent/unscheduled events on the urgent care log. This prevents health care leadership from systematically reviewing urgent events to determine areas requiring improvement. We found that nursing evaluations, assessments and treatment plans also need improvement. One case of particular concern involved a youth complaining of abdominal pain. On 2/1/09 at 8:30 p.m., a nurse saw the youth and noted that he stated, “My abdomen hurts.” The nurse did not obtain any further history and did not examine the youth’s abdomen. At 2230, another nurse noted that YCO called because youth was still complaining of a stomachache. The nurse did not evaluate the youth. She paged a physician who gave a telephone order to advise the youth to drink a lot of water and to refer him to sick call the following morning. The youth was seen the next day and sent to the emergency room for appendicitis and had emergency surgery. Finally we note that health care leadership has not conducted quarterly emergency drills.

Outpatient Housing Unit scored 78%

Patients housed in the OHU were not within sight or sound of the medical staff. A nurse does rounds in the unit every 30 minutes. Other areas requiring improvement included the nursing admission notes and the physicians’ admission orders.

Health Records scored 100%

Congratulations!

Preventive Services scored 95%

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 90%
While the facility met the goal of 85%, an area that could be improved is documentation of the urgency of the referral.

Peer Review scored 80%
An area requiring improvement was the review of sentinel events.

Credentialing scored 100%
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 90%
Areas requiring improvement include QM studies, physician review of nursing sick call and OHU, and annual Quality Management Report to the Statewide Medical Director.

Again, we wish to congratulate staff on their continued progress.

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 HCSRP (see page 14).		0[2]		
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			
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	1			
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[3]			
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		2

Compliance = 88% (7 of 8 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.	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**[4]	**2**[5]	**3**[6]	**4**[7]	**5**[8]	**6**[9]	**7**[10]	**8**[11]	**9**[12]	**10**[13]
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	n/a	1	1	1	1	1	0[14]	1	n/a	n/a
Screen # 3	1	1	1	1	1	1[15]	0[16]	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	0[17]	1	1	1	1	1	0[18]
Screen # 7	0[19]	1	1	1	1	1	1	1[20]	1	1[21]
Screen # 8	0[22]	1	1	1	1	1	1	1	1	1
Screen # 9	1	1[23]	1	1[24]	1	1	1	1	1	1[25]
Screen # 10	n/a[26]	n/a	1	1	n/a	n/a	n/a	1[27]	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	3	7	6	
3	10	0	10	9	
4	10	0	10	10	
5	10	0	10	10	
6	10	0	10	8	
7	10	0	10	9	
8	10	0	10	9	
9	10	0	10	10	
10	10	6	4	4	
Total	100	9	91	85	Plus 2 of 2 Questions

Compliance = 94% (87 of 93 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			
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**[28]	**2**[29]	**3**[30]	**4**[31]	**5**[32]	**6**[33]
Date of arrival	8/27/08	6/5/08	6/5/08	1/6/09	6/25/08	2/17/09
Screen # 1	1	1	0[34]	1	1[35]	1
Screen # 2	1	1	1[36]	1	1	1
Screen # 3	n/a	n/a	n/a	n/a	n/a	n/a
Screen # 4	1	1	1	1	1[37]	1[38]
Screen # 5	1	n/a	1	n/a	n/a	n/a
Screen # 6	1	1	0[39]	n/a	n/a	n/a
Screen # 7	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	6	0	6	5	
2	6	0	6	6	
3	6	6	0	0	
4	6	0	6	6	
5	6	4	2	2	
6	6	3	3	2	
7	6	5	1	1	
Total	42	18	24	22	Plus 2 of 2 Questions

Compliance = 92% (24 of 26 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			
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.	1			
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[40]		
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:**	7	1		1

State ID# →	**1[41]**	**2[42]**	**3[43]**	**4[44]**	**5[45]**	**6[46]**	**7[47]**	**8[48]**	**9[49]**	**10[50]**
Triage Date HSR →	3/19/09	3/23/09	3/26/09	3/24/09	3/19/09	2/3/09	1/21/09	10/15/08	3/16/09	3/4/09
Date NSC →	3/19/09	3/23/09	3/26/09	3/25/09	3/19/09	2/3/09	1/21/09	10/15/08	3/16/09	3/4/09
Type of Complaint	Sore throat	Foot blisters	Allergies	Rash	Neck lump	Flank pain	Asthma worse	Neck pain	Left toe pain	Knee 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[51]	1	0[52]	0[53]	0[54]	0[55]	1	0[56]	0[57]	0[58]
Screen # 4	0[59]	1	0[60]	0[61]	1	0[62]	0[63]	0[64]	1	0[65]
Screen # 5	1	1	1	1	1	1	1	1	1	1
Screen # 6	1	1	1	1[66]	1	1	1	1	1	1
Screen # 7	1	n/a[67]	1	1	1	1	1	1	1	1
Screen # 8	1	1	1	1	1	1	1	0[68]	1	1
Screen # 9	1	1[69]	1	n/a[70]	1	1	1	1	1	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	0	10	10	
Screen #2	10	0	10	10	
Screen #3	10	0	10	2	
Screen #4	10	0	10	3	
Screen #5	10	0	10	10	
Screen #6	10	0	10	10	
Screen #7	10	1	9	9	
Screen #8	10	0	10	9	
Screen #9	10	1	9	9	
Total	90	2	88	72	Plus 7 of 8 applicable questions

Compliance = 82% (79 of 96 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**[71]	**2**[72]	**3**[73]	**4**[74]	**5**[75]	**6**[76]	**7**[77]	**8**[78]	**9**[79]	**10**[80]
Visit date:	1/8	11/17	11/10	12/1	2/18	11/12	3/4	3/5	12/12	2/3
Clinician name:	A	A	B	A	B	A	A	A	B	A
Nature of visit:	Elbow and shoulder pain	Nausea and vomiting	Back pain	Headaches	Diarrhea	Abdominal pain, vomiting	Back pain	Shoulder pain	Ankle mass	Eye injury
Screen # 1	1	1	0[81]	1[82]	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	1	0[83]	0	1	1	1	1	1	1
Screen # 4	1	1	n/a	1	1	1	1	1	1	1
Screen # 5	1	1	n/a	0[84]	1	1	1	1	1	1
Screen # 6	1	1	n/a	1	1	1	1	1	1	1
Screen # 7	n/a	0[85]	1	n/a	1	1	1	1	1	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.

State ID# →	11[86]	12[87]	13[88]	14[89]	15[90]	16[91]	17[92]	18[93]	19[94]	20[95]
Visit date:	10/29	2/4	2/2	1/22	2/18	1/29	2/6	2/20	2/9	2/13
Clinician name:	B	A	A	B	B	B	B	B	B	B
Nature of visit:	Irregular heartbeat	Hand injury	Abdominal pain	Bronchitis	Anemia	Nosebleed	URI	Toe nail pain	Bronchitis	Facial pain s/p trauma
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	1	0[96]	1	1	1[97]	1
Screen # 6	1	1	1	1	1	1	1	1	1	1
Screen # 7	1	1	1	1	n/a	n/a	n/a	1	1	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	20	0	20	19	
Screen #2	20	0	20	20	
Screen #3	20	0	20	18	
Screen #4	20	1	19	19	
Screen #5	20	1	19	17	
Screen #6	20	1	19	19	
Screen #7	20	6	14	13	
Total	140	9	131	125	Plus 1 of 1 Question

Compliance = 95% (126 of 132 Questions + Screens)

Chronic Disease Management

Number of patients enrolled in clinic_____32_____ Percent of clinic health records reviewed __31__%

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**[98]	**2**[99]	**3**[100]	**4**[101]	**5**[102]	**6**[103]	**7**[104]	**8**[105]	**9**[106]	**10**[107]
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	n/a	1[108]	1[109]	1	1	1	1	1[110]	1[111]	1
Screen # 3	n/a	n/a	n/a	1	1	1	1	n/a	n/a	0[112]
Screen # 4	1	n/a	n/a	1	1	1	0[113]	1	1	1
Screen # 5	1	n/a	n/a	1	1	1	1	1	1	1
Screen # 6	1	1	1[114]	1	1	0[115]	0[116]	0[117]	1[118]	1
Screen # 7	1	1	1	1	1	1[119]	0[120]	1	1	1
Screen # 8	1	1	1	1	1	1	1	1	1	1
Screen # 9	1	1	1	1	1	n/a	1	1	1	1
Screen # 10	1	1	1	1	1	1	1	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 a 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	1	9	9	
Screen #3	10	5	5	4	
Screen #4	10	2	8	7	
Screen #5	10	2	8	8	
Screen #6	10	0	10	7	
Screen #7	10	0	10	9	
Screen #8	10	0	10	10	
Screen #9	10	1	9	9	
Screen #10	10	1	9	9	
Total	100	12	88	82	

Compliance = 93% (82 of 88 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.).	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). (yes) e) Biohazard storage bins are available. (yes) f) Blood and body fluid spills are cleaned appropriately per policy. (not observed).	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** [121]	**QTR 2** [122]	**QTR 3** [123]	**QTR 4** [124]				
	a) TB skin testing programs for staff and youth	0 [125]	1 [126]	0 [127]	0 [128]				
	b) Exposure control plans and training regarding airborne and blood borne pathogens	1	1	0 [129]	0 [130]				
	c) Hepatitis B training and vaccination programs (e.g., number of employees trained, number accepting vaccine, and number completing vaccination series)	0 [131]	0 [132]	0 [133]	0 [134]		0		
	d) Staff compliance with work practice controls	1	0 [135]	1	0 [136]				
	e) Reporting communicable diseases for the previous quarter, noting any trends present	1	0 [137]	0 [138]	1				
	f) Sanitation reports (institutional and infection control) and any follow-up action taken	1	1 [139]	1 [140]	0 [141]				
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/e
	For calculating score, only give credit for applicable questions in substantial compliance. **Totals:**					1	1		1

Deleted: 1

Compliance = 88% (7 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?	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[142]			
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?	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?	1			
Question #9	Does the nurse administer all legend medication from properly labeled containers and not from stock bottles?			0[143]	
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.				n/e[144]

		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 Documed or night locker and signed it out prior to administration.	

Compliance = 92% (12 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[145]	2[146]	3[147]	4[148]	5[149]	6[150]	7[151]	8[152]	9[153]	10[154]
Screen # 1	1	1	0[155]	0[156]	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	0[157]	1	1	1	1	0[158]	1	1	1	1
Screen # 4	1	1	1	1	1	1	1	1[159]	1	1
Screen # 5	1	1	0[160]	1	0[161]	1	1	1	1	0[162]
Screen # 6	1	1	0[163]	1	1[164]	1	1	1	1	1
Screen # 7	0[165]	1	1	1	n/a	1	1	1	1	1[166]
Screen # 8	n/a	n/a	1	0[167]	n/a	n/a	n/a	n/a	1	n/a
Screen # 9	1	1	1	1	n/a	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	8	Two records did not document the route of administration
Screen #2	10	0	10	10	
Screen #3	10	0	10	8	
Screen #4	10	0	10	10	
Screen #5	10	0	10	7	
Screen #6	10	0	10	9	
Screen #7	10	1	9	8	
Screen #8	10	7	3	2	
Screen #9	10	1	9	9	
Total	90	9	81	71	

Compliance =88% (71 of 81 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[168]		
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[169]	
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**[170]	**2**[171]	**3**[172]	**4**[173]	**5**[174]	**6**[175]	**7**[176]	**8**[177]	**9**[178]	**10**[179]
Screen # 1	0[180]	0[181]	1	1	1	0[182]	1	1	1	1
Screen # 2	0[183]	0[184]	1	0[185]	1	0[186]	0[187]	0[188]	0[189]	1
Screen # 3	0[190]	0[191]	1	n/a[192]	1	1	0[193]	1	0[194]	0[195]
Screen # 4	1	0[196]	1	1	1	1	1	1	1	0[197]
Screen # 5	1	n/a	1	1	n/a	1	n/a	1	0[198]	1
Screen # 6	n/a	n/a	n/a	n/a	1	n/a	n/a	1	n/a	1
Screen # 7	n/a	n/a	n/a	n/a	1	n/a	n/a	1	n/a	1

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	7	
Screen # 2	10	0	10	3	
Screen # 3	10	1	9	4	
Screen # 4	10	0	10	8	
Screen # 5	10	3	7	6	
Screen # 6	10	7	3	3	
Screen # 7	10	7	3	3	
Total	70	18	52	34	Plus 2 of 4 Questions

Compliance = 64% (36 of 56 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.	1			
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[199]	
	For calculating score, only give credit for applicable questions in substantial compliance. Totals:	3		2	

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[200]**	**2[201]**	**3[202]**	**4[203]**	**5[204]**	**6[205]**	**7[206]**
Placement date: →	1/13	2/4	12/31	10/16	11/24	3/2	11/8
Discharge date: →	1/14	2/5	1/2	10/27	11/26	3/3	11/10
Screen # 1	1	1	1	1	1	1	1
Screen # 2	0[207]	0[208]	0[209]	0[210]	0[211]	0[212]	0[213]
Screen # 3	1	1	1	1	1	1	1
Screen # 4	1	1	1	1	0[214]	0[215]	1
Screen # 5	1	1	1	1	0[216]	1	1
Screen # 6	1	1	1	1	1	1	1
Screen # 7	1	1	1	0[217]	n/a[218]	n/a[219]	n/a[220]
Screen # 8	0[221]	1	1	1	1	1	1
Screen # 9	1	1	1	1	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	7	0	7	7	
Screen # 2	7	0	7	0	
Screen # 3	7	0	7	7	
Screen # 4	7	0	7	5	
Screen # 5	7	0	7	6	
Screen # 6	7	0	7	7	
Screen # 7	7	3	4	3	
Screen # 8	7	0	7	6	
Screen # 9	7	0	7	7	
Total	63	3	60	48	

Compliance = 78% (51 of 65 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			
	For calculating score, only give credit for questions in substantial compliance. **Totals:**	4			

Compliance = 100% (4 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**[222]	**2**[223]	**3**[224]	**4**[225]	**5**[226]	**6**[227]	**7**[228]	**8**[229]	**9**[230]	**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	1	0[231]	1	0[232]	1	1	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	1

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	9	1	1	
Total	60	19	41	39	

Compliance = 95% (40 of 42 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**[233]	**2**[234]	**3**[235]	**4**[236]	**5**[237]	**6**[238]	**7**[239]	**8**[240]	**9**[241]	**10**[242]
Screen # 1	0[243]	0[244]	0[245]	0[246]	0[247]	0[248]	1	0[249]	0[250]	0[251]
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	1	1	1	1	1	1	1	1	1
Screen # 9	1	1	1	1	1	1	1	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	1	
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	0	10	10	
Screen # 9	10	2	8	8	
Total	90	2	88	79	Plus 3 of 3 Questions

Compliance = 90% (82 of 91 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.	1			
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[252]		
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:**	4	1		

Compliance = 80% (4 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.	1			
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:**	9			

Compliance = 100% (9 of 9 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.				1			
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**	1			
	a) The CAP identified specific improvements needed.	1						
	b) The CAP identified specific staff members responsible for improvements.	1						
	c) The CAP had a targeted completion date.	1						
	d) There was documentation to indicate any recommended training was held.	1						
	e) Follow-up studies were done to determine whether or not corrective actions solved the problem or issue.	1						
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.				1			
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.				1			
For calculating score, only give credit for applicable questions in substantial compliance.				**Totals:**				

Compliance = 90% (9 of 10 Questions)

Total Number of Questions and Screens Evaluated	=840
Total Number of Questions and Screens in Substantial Compliance	=743
Total Score	= 88%

ENDNOTES

[1] To date the facility has expended $733, 923 on operating expenditures and $7,759, 809 on personnel costs.

[2] The CMO is not board certified in a primary care field.

[3] All licenses were current, but the tracking log was not up to date.

[4] 92780. This 15 year old arrived at SYCRCC on 3/19/09. His medical history includes latent TB infection, left inguinal hernia repair and right arm fracture as a child.

[5] MD809. This 16 year old arrived at SYCRCC on 11/17/08. His medical history included congenital heart valve surgery at age 2 weeks, obesity, hyperlipidemia, migraine headaches, depression and allergies to grass. His medications were Remeron and Simvastin.

[6] JO787. This 17 year old arrived at SYCRCC on 3/5/09. His medical history included obesity, prosthetic right eye secondary to gunshot wound, GERD and asthma. His medications were Pepcid, Albuterol MDI and artificial tears.

[7] 92637. This 17 year old arrived at SYCRCC on 10/23/08. His medical history included congenital heart murmur due to a ventricular septal defect (VSD), sickle cell disease, alopecia areata, mood disorder and allergy to milk. His medications included Seroquel, Folic acid, iron and MVI.

[8] MD879. This 18 year old arrived at SYCRCC on 10/9/08. His medical history included hypertension, latent TB infection, displaced right scaphoid fracture in July 2008, bipolar disorder and sleep disorder. His medications were Trazodone and Depakote. On 3/9/09 hypertension was added to the list of medical problems based multiple elevated readings (systolic 136-150 and diastolic 66-91). The NPs plan was to further monitor BP and follow-up with Dr. Vo for consideration of medication treatment. Dr Vo saw him one week later, diagnosed him with stage 1 hypertension, ordered daily BP checks and to enroll him into the BP clinic. He did not start medications at this time.

[9] J0762. This 16 year old arrived at SYCRCC on 7/31/08. His medical history included obesity, hypertension and asthma. His medications were Albuterol inhaler.

[10] 92756. This 16 year old arrived at SYCRCC on 3/2/09. His medical history includes latent TB infection, obesity and right 5th MCP fracture. His medications were Geodon and Trazodone.

[11] MD867. This 16 year old arrived at SYCRCC on 1/13/09. His medical history included latent TB infection and ventricular septal defect. His medications were Isoniazid.

[12] E0703. This 17 year old arrived at SYCRCC on 10/30/08. His medical history includes migraine headaches. He was not taking any medications.

[13] E0726. This 16 year old arrived at SYCRCC on 12/31/08. His medical history included latent TB infection. Upon arrival he was taking no medications.

[14] The psychiatrist renewed his mental health medications but at a lesser dose without a progress to provide the rationale.

[15] The nurse did not measure visual acuity on the day of arrival, but it was measured 3 days later on 8/3/08. Credit given.

[16] The nurse administered a tuberculin skin test when the patient had documentation of being previously positive.

[17] Upon arrival the youth's blood pressure was 146/85 mm/hg. This was not addressed by the nurse or clinician. Patient has had intermittent elevated blood pressure measurements on 11/9/08 (138/94), 11/10/08 (145/82), 2/2/09 (148/87) and 2/19/09 (149/75). EKG shows LVH. Given his cardiac history, these elevations should be addressed. Treatment may or may not be indicated at this time.

[18] The physician did not document that this patient with a history of TB infection had no fever, cough or weight loss. Although the physician signed that he reviewed the nurse's screening form, this history should be noted in the physician's assessment of the patient.

[19] The problem list did not include the patient's complaints of chest pain.

[20] Recommend to document latent TB infection versus PPD positive only.

[21] Suggest for patients with positive TB for whom active disease is ruled out to document diagnosis of latent TB infection versus simply documenting PPD+.

[22] The treatment plan was appropriate except there was no plan to address the chest pain of questionable etiology and EKG showing ?ST elevation.

[23] The physician has determined that this patient with a history of cardiac surgery has no limitations and the dentist has determined that he should not perform any strenuous activity due to his medical history. This discrepancy should be resolved.

[24] The physician planned to get old medical records for the patient's history of small VSD but not found in records.

[25] The physician ordered that the chest x-ray from Juvenile Hall be obtained demonstrating no signs of active disease. Staff made numerous attempts (4) to obtain the faxed report, but it was not sent to them until 2/18/09 6 weeks after arrival.

[26] Chronic disease clinic visit had not occurred but still within the 30 day window.

[27] The patient was sent out for an echocardiogram on 3/17/09 but the report is not in the record.

[28] MD749. This patient transferred from Preston to SYCRCC on 8/27/08. His medical history included asthma.

[29] 90451. This 18 year old transferred from PYCF to SYCRCC on 6/5/08. His medical history included insomnia, depression and adjustment disorder.

[30] 92075. This 17 year old transferred from PYCF to SYCRCC on 6/5/08. His medical history included latent TB infection.

[31] 90995. This 20 year old transferred from HGS to SYCRCC on 1/6/09. His medical history was unremarkable.

[32] This 17 year old transferred from HGS CTC back to SYCRCC on 6/25/08 and then was admitted directly to the ICF. His medical history includes obesity, asthma, major depressive disorder and hypothyroidism. He transferred back from the ICF to SYCRCC on 10/30/08.

[33] 92527. This 16 year old transferred to SYCRCC from HGS CTC to SYCRCC on 2/17/09. His medical history includes asthma, major depressive disorder. He was taking Zoloft, Claritin and Albuterol.

[34] The sending facility did not complete an intrasystem transfer form and the receiving facility did not notify the sending facility.

[35] Form was not filled out with respect to the assessment.

[36] Progress note addressed transfer needs.

[37] The youth was immediately transferred to the ICF. Records not available for review.

[38] The youth was immediately transferred to the ICF. Records not available for review.

[39] Tetracycline was ordered on 6/5 and administered on 6/7/08.

[40] Health Care Services has not yet developed and implemented standardized nursing procedures.

[41] E0703. This 17 year old arrived at SYCRCC on 10/30/08. His medical history includes migraine headaches. His medication is Motrin. On 3/18/09 the patient submitted a health service request (HSR) complaining of fever, runny nose, sore throat and vomiting.

[42] E0757. This 17 year old arrived at SYCRCC on 3/11/09. His medical history is unremarkable. The youth submitted a HSR dated 3/27/09 complaining of ‘foot’.

[43] E0726. This 16 year old arrived at SYCRCC on 12/31/08. His medical history included latent TB infection. Upon arrival he was taking no medications.

[44] E0748. This 17 year old arrived at SYCRCC on 12/4/08. His medical history includes obesity and onychomycosis. The NP saw this patient on 3/18/09 for complaints of a bilateral axillary rash. She diagnosed the patient with contact dermatitis secondary to deodorant and prescribed hydrocortisone cream. The patient returned on 3/24/09 requesting more cream.

[45] 92728. This 16 year old arrived at SYCRCC on 1/20/09. His medical history includes schizophrenia, asthma and allergy to penicillin, codeine, and aspirin.

[46] J0745. This 17 year old arrived at SYCRCC on 3/27/08. His medical history includes IgG renal nephropathy, congenital right eye blindness, left eye glaucoma s/p cataract removal, medication induced diabetes, and kidney stones. On 2/2/09 the patient submitted a HSR complaining of pain in his left side. He was seen by the nurse and NP in a timely manner. However further review of his record shows that he has been experiencing severe flank pain since 9/28/08 which resulted in hospitalization on 12/5/08 and continued severe pain until just prior to his discharge. We discussed this case with Dr. Vo who indicated that the patient had pain except when he was taking prednisone, but renal medicine had recommended not giving the patient prednisone.

[47] 92424. This 17 year old arrived at SYCRCC on 5/12/08. His medical history includes asthma, allergic rhinitis, GERD and allergy to Levaquin. On 1/20/09 he submitted a HSR complaining of asthma getting worse.

[48] MD749. This 17 year old arrived at SYCRCC on 8/27/08. His medical history includes asthma, shingles and left ulna styloid fracture.

[49] 90729. This 21 year old transferred to SYCRCC in 2006. His medial history includes head injury, depressive and psychotic disorder and obesity.

[50] 92012. This 18 year old arrived at SYCRCC on 12/6/06. His medical history includes depressive disorder and allergic rhinitis.

[51] Subjective history noted in the objective section.

[52] Subjective history noted in the objective section.

[53] Subjective history noted in the objective section.

[54] The nurse did not obtain a history of onset and duration of symptoms.

[55] Subjective history noted in the objective section.

[56] The nurse did not obtain a history of onset and duration of symptoms or describe the rash.

[57] The nurse did not inquire about a history of trauma or signs and symptoms of infection.

[58] Subjective history noted in the objective section.

[59] The nurse did not examine the patient.

[60] The nurse did not examine the patient.

[61] The nurse did not examine the patient.

[62] The nurse did not examine the patient.

[63] The nurse measured the patient's oxygen saturation (94%) and peak flow measurements but did not listen to the patient's lungs.

[64] The nurse did not examine the patient.

[65] Nurse did not observe the knee for erythema or palpate the right knee for tenderness.

[66] The nurse provided more hydrocortisone cream at the patient's request and with the verbal concurrence of the NP.

[67] This patient had foot blisters without signs or symptoms of infection. A referral to the physician was not clinically indicated.

[68] No name stamp used.

[69] The physician noted a ruptured vesicle warranting no intervention. He advised the patient to buy new shoes.

[70] The patient refused to see the NP.

[71] 92313

[72] 92313

[73] 92637

[74] MD809

[75] 92552

[76] 92552

[77] MD879

[78] MD879

[79] 91452
[80] J0774

[81] No history related to radiation or other neurological symptoms.

[82] On a consultative note, NP diagnosed migraine headache but did not obtain history related to quality of pain or presence/absence of aura.

[83] Exam did not include range of motion, straight leg raising, or neurological testing.

[84] NP started youth on medication for migraines but did not order follow-up. Not seen again until youth requested follow-up after his medication expired.

[85] Youth was mildly dehydrated. Plan was to admit to OHU for observation and hydration, and return to the clinic in am for follow-up. Youth refused OHU admission. He was not seen for follow-up.

[86] 91217

[87] E0706

[88] MD815

[89] 92256

[90] 92739

[91] 92518

[92] E0664

[93] 90729

[94] 92551

[95] J0775

[96] No follow-up ordered.

[97] On a consultative note, would consider not treating acute bronchitis with antibiotics.

[98] 92313

[99] E0718

[100] J0777

[101] J0762

[102] E0667

[103] 92637

[104] 91841

[105] 92552

[106] 92424

[107] 92441

[108] On a consultative note, the physician's initial history includes prior hospitalizations, but does not note if there were any recent emergency room visits.

[109] On a consultative note, the physician's initial history includes prior hospitalizations, but does not note if there were any recent emergency room visits.

[110] On a consultative note, the physician's initial history includes prior hospitalizations, but does not note if there were any recent emergency room visits.

[111] On a consultative note, the physician's initial history includes prior hospitalizations, but does not note if there were any recent emergency room visits.

[112] Patient has not had his potassium checked since being started on Lisinopril in 6/08.

[113] MD only examined heart and lungs.

[114] On a consultative note, the physician's assessment was mild, intermittent asthma. Since the youth was using a steroid inhaler, this should be mild, persistent asthma.

[115] See below.

[116] See below.

[117] The MD did not note degree of control. In addition, a consultative note, the physician's assessment was mild, intermittent asthma. Since the youth was using a steroid inhaler, this should be mild, persistent asthma.

[118] On a consultative note, the physician's assessment was mild, intermittent asthma. Since the youth was using a steroid inhaler, this should be mild, persistent asthma.

[119] On a consultative note, the youth has a stated history of sickle cell anemia which was documented on his transfer summary from the county facility. However, he is not anemic and his laboratory results do not support this diagnosis. Further investigation was warranted. After Dr. Goldenson's visit, laboratory tests were obtained which confirmed the diagnosis.

[120] Youth diagnosed with diabetes and started on medication in 6/08. However, his laboratory results prior to treatment do not support this diagnosis – HbA1C was 5.6, fasting blood sugar 105 and 2hr post prandial blood sugar 115.

[121] April 28, 2008.

[122] July 10, 2008.

[123] October 22, 2008.

[124] January 15, 2009.

[125] Results of TB skin testing for youth are not addressed. Minutes should include total number of tests, total number of positive and negative, and any identified trends. Consider tracking the number of youth on preventive therapy and number who have completed preventive therapy since the last report.

[126] There was discussion of the number of total number of youth tested, number positive and number negative. Of note is that 17 (9%) of 186 youth TB skin tests were positive. This is a relatively high number and should be further explored.

[127] No discussion of TB skin testing and results for youth.

[128] Results of TB skin testing for youth are not addressed. Minutes should include total number of tests, total number of positive and negative, and any identified trends. Consider tracking the number of youth on preventive therapy and number who have completed preventive therapy since the last report.

[129] No discussion of blood-borne pathogen training (i.e. numbers of health care and correctional staff trained). If no one was trained suggest this be stated.

[130] No discussion of blood-borne pathogen training (i.e. numbers of health care and correctional staff trained). If no one was trained suggest this be stated.

[131] No discussion of employee hepatitis B vaccination rates (consider consulting Preston YCF infection control nurse).

[132] No discussion of employee hepatitis B vaccination rates (consider consulting Preston YCF infection control nurse).

[133] No discussion of employee hepatitis B vaccination rates (consider consulting Preston YCF infection control nurse).

[134] No discussion of employee hepatitis B vaccination rates (consider consulting Preston YCF infection control nurse).

[135] No discussion of staff compliance with work controls.

[136] The infection control nurse may consider conducting observational studies of employee compliance with work practice controls such as hand-washing, use of personal protective equipment, proper disposal of sharps, etc.

[137] Reportable communicable diseases not commented upon.

[138] Reportable communicable diseases not commented upon.

[139] Excellent discussion regarding environmental issues and control efforts.

[140] Excellent discussion regarding environmental issues and control efforts.

[141] There was no follow-up of roach infestation in the kitchen identified during the October 2008 meeting.

[142] On a consultative note, in addition to the psychiatrist who chairs the meeting, it would be useful to have a medical provider on the committee.

[143] In the main medical clinic, nurses place medications in incompletely labeled envelopes to deliver medications to youth in satellite housing units.

[144] This area was not fully evaluated as we observed a noon medication administration, but only 3 youth were observed taking medication.

[145] 92441. This 16 year old arrived at SYCRCC on 4/29/08. His medical history included hypertension, anxiety and depression. Current medications are Lisinopril and Risperdal. Order 2/18/09.

[146] 92441. This 16 year old arrived at SYCRCC on 4/29/08. His medical history included hypertension, anxiety and depression. Current medications are Lisinopril and Risperdal. Order 3/9/09 for Risperdal.

[147] 91890. This 17 year old arrived at SYCRCC on 5/29/07. His medical history includes latent TB infection. Order 3/4/09 for Isoniazid.

[148] This 17 year old arrived at SYCRCC on 6/25/08. His medical history includes obesity, asthma, depressive disorder and hypothyroidism. Order 12/30/08 for mental health medications.

[149] MD857. This 16 year old arrived at SYCRCC. His medical history includes asthma, migraine headaches and ?rule out dysthymic disorder. His medications are Depakote, Propranolol, Benadryl. Order 2/25/09 for mental health medications. Staff did not transcribe this order onto an MAR because it was written on an OHU discharge order form. Further review of the record showed that nurses did not transcribe a 3/10 physician OHU discharge order.

[150] 91841. This 22 year old arrived at SYCRCC on 1/16/07. His medical history includes obesity, diabetes, GERD and bipolar disorder. Order 1/6/09 Metformin.

[151] MD809. Order 2/3/09 for Zocor.

[152] This 17 year old arrived at SYCRCC on 6/25/08. His medical history includes obesity, asthma, depressive disorder and hypothyroidism. Order 3/2/09 for levothyroxine.

[153] 92463. Order 2/4/09 for Topamax.

[154] 92756. This 16 year old arrived at SYCRCC on 3/2/09. His medical history includes latent TB infection, obesity, and history of right 5th MCP fracture. His medications were Geodon and Trazodone. Order 3/4/09 for Isoniazid and B6.

[155] Route of administration missing.

[156] Route of administration missing.

[157] No documented progress note for 2/18/09 explaining the rationale for the order.

[158] No physician progress note to accompany the order.

[159] The 3/2/09 order was transcribed on 3/12/09. The order was indeed transcribed on 3/2/09. This appears to be a misdating of the transcription.

[160] The physician wrote an order for INH 900 mg to be given twice weekly for 14 days starting on 3/13/09. The nurse transcribed the order to begin on March 6th. The nurse administered two doses before 3/13/09. A second MAR for the same time frame shows that two different nurses gave a dose on 3/6/09. We explored this further and determined that a nurse who did not give the medication documented that he did give it based upon the report of the first nurse.

[161] Staff did not transcribe this order onto an MAR because it was written on an OHU discharge order form. Further review of the record showed that nurses did not transcribe a 3/10 physician OHU discharge order.

[162] The nurse did not transcribe each medication separately onto the MAR, instead using a stamp that contained both medications. The stamp does not include the route of administration.
[163] The nurse administered the medication starting on 3/6 instead of beginning the medication as ordered on 3/13/09.

[164] Although the nurse did not transcribe the new order, the patient continued to get his Depakote and Propranolol from a previous order (1/14/09).

[165] On 2/19/09 the nurse administered the blood pressure medication for a blood pressure of 108/71 when the order stated to withhold the medication if the systolic blood pressure was below 110. This should be considered a medication error.

[166] The patient was sent to ICF after two doses.

[167] The nurse who discontinued the medication did not initial the discontinuation on the MAR.
[168] Not all unscheduled encounters are recorded in the log book.

[169] The staff is not conducting any emergency drills.

[170] 92313

[171] 92313

[172] J0762

[173] 92313

[174] 92637

[175] MD879

[176] J0775

[177] E0714

[178] J0745

[179] MD815

[180] Youth seen by RN on 1/29. There is no entry in the urgent/emergent log.

[181] Youth seen by RN on 2/7. There is no entry in the urgent/emergent log.

[182] Youth seen by RN on 3/5. There is no entry in the urgent/emergent log.

[183] Incorrect SOAP format. Subjective information in objective section.

[184] Incorrect SOAP format. Subjective information in objective section.

[185] Incorrect SOAP format. Subjective information in objective section.

[186] Incorrect SOAP format. Subjective information in objective section.

[187] Incorrect SOAP format. Subjective information in objective section.

[188] Incorrect SOAP format. Subjective information in objective section.

[189] Incorrect SOAP format. Subjective information in objective section.

[190] Youth complaining of dizziness and lightheadedness. Nurse did not obtain postural vital signs.

[191] Youth stated that he went to USC the prior day and "they told me if I don't feel good, to check me out." The RN did not obtain any further history except to note that youth was not complaining of pain and not taking medication.

[192] Patient referred to and seen at that time by NP.

[193] No physical assessment for headache other than "frowning, skin warm + dry".

[194] Youth complaining of flank pain on 9/28. Nurse did not perform physical assessment of flank/abdomen

[195] At 2030, on 2/1, nurse notes youth states, "My abdomen hurts." Did not obtain any further history and did not examine abdomen. At 2230, another nurse noted that YCO called because youth was still complaining of a stomachache. The nurse did not evaluate the youth. She paged Dr. Vo who gave a telephone order to advise the youth to drink a lot of water and refer to sick call the following morning. The Youth was sent to the emergency room the next day for appendicitis and had emergency surgery.

[196] Nurse's assessment was "Deficient knowledge r/t irregular pulse." Youth's pulse was noted to be 68 and regular.

[197] Nurse did not contact on call clinician.

[198] Nurse consulted with MD re: flank pain and referred to clinic the next morning. Not seen until 2 days later.

[199] The nurse makes rounds every 30 minutes.

[200] 92552

[201] MD815

[202] MD749

[203] MD749

[204] E0546

[205] 92649

[206] E0636

[207] Admitting orders do not include clinical criteria for notifying the clinician of a change in clinical status.

[208] Admitting orders do not include clinical criteria for notifying the clinician of a change in clinical status.

[209] Admitting orders do not include clinical criteria for notifying the clinician of a change in clinical status.

[210] Admitting orders do not include clinical criteria for notifying the clinician of a change in clinical status.

[211] Admitting orders do not include clinical criteria for notifying the clinician of a change in clinical status.

[212] Admitting orders do not include clinical criteria for notifying the clinician of a change in clinical status.

[213] Admitting orders do not include clinical criteria for notifying the clinician of a change in clinical status.

[214] The nurse did not document orientation to the OHU.

[215] The nurse did not document orientation to the OHU.

[216] Youth admitted to OHU on 11/24. Clinician did not evaluate until 11/26.

[217] Patient admitted to OHU on 10/16. There were no clinician rounds on Friday 10/17, Wednesday 10/22, Thursday 10/23 or Friday 10/24. Discharged Monday, 10/27.

[218] See above. #93.

[219] Only in OHU overnight.

[220] Only in OHU over the weekend. Discharged Monday.

[221] Vital signs not done every 6 hours as ordered.

[222] 92031

[223] E0477

[224] 92073

[225] 91370

[226] 90180

[227] 90705

[228] 91452

[229] 91447

[230] 90730

[231] Youth noted to be overweight in 5/08. Counseled at that time but there has not been any follow-up and youth has not lost weight.

[232] BMI is 25.6. Weight not addressed.

[233] 92313

[234] MD879

[235] 91452

[236] 92154

[237] 92012

[238] MD857

[239] J0775

[240] 91217

[241] E0706

[242] J0745

[243] Urgency not noted on request.

[244] Urgency not noted on request.

[245] Urgency not noted on request.

[246] Urgency not noted on request.

[247] Urgency not noted on request.

[248] Urgency not noted on request.

[249] Urgency not noted on request.

[250] Urgency not noted on request.

[251] Urgency not noted on request.

[252] The CMO tracks and reports sentinel events, such as unexpected hospitalizations. There is, however, no analysis or review of the events to determine if there were any problems that need to be addressed through corrective action plans.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

DIVISION OF JUVENILE JUSTICE

N.A. Chaderjian Youth Correctional Facility
Health Care Audit
February 17-19, 2009

Contents

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 or dental care. The Mental Health and Dental Experts will develop their respective audit instruments.

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 are 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 Farrell Medical Experts visited NA Chaderjian (Chad) Youth Correctional Facility at the Northern California Youth Correctional Complex (NCYCC) on February 17-19, 2009. NCYCC consists of Chad and OH Close YCF; Dewitt Nelson closed in July 2008. At the time of our visit, the population of Chad was 210 and OH Close was 180 youth.

The facility scored 81% (631 of 780 applicable screens/questions) which is a significant improvement from the previous score of 61%.

We thank Superintendent Mike Minor and Dr. Gabriel Tanson, CMO and their staffs for the cooperation and assistance in completing the health care audit.

Summary of Health Care Areas Reviewed

Facility Leadership, Budget, Staffing, Orientation and Training scored 89%

There has been continued stability in health care leadership at the facility over the past year; all key leadership positions are filled. Previously noted contract issues and delays in hiring due to problems with Livescan (the fingerprint machine) have been resolved.

The CMO reported that a health care budget has been established but not finalized; however the facility has been able to conduct normal business operations and purchase necessary equipment and supplies. We reviewed the NCYCC FY 2008-2009 initial budget allotment for the complex which is $18,632,275; or approximately $49,032 per youth. Of that amount, $17,218,227 (92%) is attributed to personnel costs.

With respect to staffing, we note that in addition to the CMO, the complex currently has 3.0 FTE physicians and 1.7 FTE nurse practitioners; a clinician to youth ratio of 1 to 68. There are 58 nursing positions; a nurse to youth ratio of 1 to 6.5 for the complex[1]. Health care leadership is requesting to fill vacant RN positions although the population has declined over the past year.

With respect to distribution of nursing staff, both the Intensive Treatment Program (ITP) and Intensive Behavioral Management Treatment Program (IBTP) housing units are nurse-staffed 16 hours per day 7 days per week. The ITP has 2 RNs and 2 LPTs assigned 16 hours per day; and the IBTP has 1 RN assigned 16 hours per day. During our visit there were 35 youth in the ITP and 10 youth in the IBTP.

In the ITPs the primary duties of the nurses are to triage sick call requests for the clinician; administer medications; transcribe orders and assist the psychiatrist. RNs and LPTs are also to participate in treatment team meetings. In the IBTP the nurses' primary duties are to triage health service requests and administer medications. However, eligible youth are to attend school 240 minutes per day, and for significant portions of the day there may be few youth in the units.

In our opinion, this staffing pattern incurs considerable cost to the state without sufficient justification. The current duties of the nurses in the specialized housing units could be managed by centralized nursing staff going to the units to perform specific functions (e.g. administering medications, attending groups) and returning to the central clinic for other assignments.

Moreover, the requirement to staff these units has contributed to a staffing pattern in which nurses receive every third weekend off instead of every other weekend which has resulted in low morale among the nurses. We recommend that the specialized housing units not be staffed with registered nurses and that these positions be relocated to the central clinic and assigned specific duties in the housing units only as necessary.

With the implementation of the remedial plans there has been a corresponding increase in the volume of medical and mental health appointments in the Chad central clinic; however there is no correctional officer post in this area. The nearest correctional officer is in the control station which is a mandatory post that officers cannot leave in the event of an emergency. There is also no security post in this control station after 5 pm although youth continue to have scheduled and unscheduled medical and mental health visits. The youth who provides custodial services in the clinic is not actively supervised while performing his duties. We believe that given the trend of receiving more difficult to manage youths into DJJ, that the facility establishes a correctional officer post for the medical clinic and control station for 16 hours per day, 7 days per week.

Medical Reception scored 57%

The volume of youth who return to the facility as a result of parole revocation has significantly decreased since our last visit; with a corresponding decrease in the number of youth undergoing the medical reception process. We requested ten records but only 4 were available for review. We found that staff does not consistently complete the medical reception process in a timely manner. In 2 of 4 records, staff did not complete the medical screening or physical examination form upon the youths' arrival. In 2 of 4 records visual acuity was not measured; in one record a syphilis test and tuberculin skin testing was not performed. Clinicians do not consistently elaborate upon positive findings noted in the patient's medical history. This area requires greater supervision by medical and nursing leadership.

Intrasystem Transfer scored 78%

We reviewed ten records of youth who transferred into the facility from August 2008 to February 2009. In general we found the process is consistently taking place, however there are a few areas requiring improvement. The goal of the intrasystem transfer process is review health care services provided at the previous facility and ensure that continuity of care is provided. In one record, a youth who transferred from Preston YCF had not yet completed the medical reception process, but this was not noted or addressed by the nurse or physician who reviewed the record and his medical reception process was incomplete. In 3 of 10 records the nurse did not completely fill out the form or address positive findings such as high blood pressure. Nurses should note whether patients' are taking medications; and if taking an asthma inhaler, whether the youth has it in his possession at the time of transfer. If not, the nurse should contact the physician to renew the medication on the day of arrival. In one case a psychiatrist did not continue the previous order for psychotropic medication; and in two cases we noted that a period of 10-14 days elapsed before the youth was seen by a psychiatrist.

Nursing Sick Call scored 65%

At Chad, nurses collect and triage health service requests and perform limited assessments. This is because all health service requests are to be referred to a clinician. We reviewed the nurses' screening logs that showed the majority of youth requests were for minor complaints (e.g., acne, dry skin, athlete's foot) that could be managed by registered nurses with adequate health assessment training and procedures. We also noted that youth return repeatedly for minor complaints that, in a community setting would not result in a visit to a physician. We selected ten records to assess the timeliness of access to care and the quality of the nursing assessments. We found care to be timely. We found nursing assessments to be abbreviated, which is not surprising given that nurses directly referred patients to a clinician. We recommend that DJJ develop and improve the ability of registered nurses to manage patients with minor complaints and only refer those patients who meet the criteria for referral in the procedures.

Medical Care scored 87%

While the facility met the goal of 85%, areas that could be improved included the history and physical examination, taking of vital signs, and patient education.

Chronic Disease Management scored 91%

We reviewed 10 (19%) records of the 54 youth identified has having a chronic disease at Chad. Chronic disease management has significantly improved in all respects since our last visit. While the facility met the goal of 85%, areas that could be improved included ordering of laboratory tests prior to the visit and the treatment plan.

Infection Control scored 75%

We evaluated the infection control program by reviewing policies and procedures; reportable disease reports and tracking logs; sanitation reports; infection control meeting minutes; and toured clinic areas to evaluate staff compliance with use of personal protective equipment and engineering controls designed to minimize staff and youth exposure to communicable diseases. This area has improved significantly since our last visit. The infection control nurse has established a strong foundation for an excellent infection control program. Infection control minutes show collection of data, evaluation for trends and meaningful content.

Sanitation in the Chad central clinic has improved since our last visit, but improvements are needed in the ITP and IBTP. There are sanitation schedules for the OHU, Chad and OH Close medical clinics, but not the ITP and IBTP clinic areas. We reviewed compliance with the sanitation schedules and noted some inconsistency in completion of sanitation duties by youth custodians (particularly at OH Close). There are two full time janitors who work in the OHU. We recommend that their duties include terminal cleaning in the outlying medical clinics, with youth providing performing surface cleaning, collecting trash etc. We noted that the Chad physician's office did not contain a sink and there was no hand-sanitizer in the examination room.

The improvements needed at this time require support from health care leadership. This includes installation of an eyewash station in the medical clinic, improved sanitation in the main and satellite clinics and compliance with hand-washing.

Pharmacy Services scored 100%
Congratulations.

Medication Administration Process scored 85%
We evaluated the medication administration process by inspecting medication storage areas and observing the medication process. This area is working well, however, the nurse we observed administering medications did not consistently check the youths' ID and document each dose of medication at the time it was administered. Medications to be administered at bedtime (i.e. HS or hour of sleep) should not begin before 8 pm; however staff reported that this medication administration begins at 7:30 pm.

Medication Administration Health Record Review scored 87%
We reviewed 10 records of patients with medication orders to evaluate the accuracy and timeliness of medication administration and completeness of documentation in the health record. This area is working well. Minor improvements are needed in ensuring that a complete order is written, documentation of the status of each medication dose (i.e., no blank spaces on the MAR), and nursing documentation of discontinuation of medication orders. Nurses should clearly delineate when the medication is discontinued, their initials and date the entry on the MAR. Nurses should refrain from crossing out the original medication order or highlighting over administered doses as it may contribute to illegibility.

Urgent/Emergent Care scored 83%
Areas requiring improvement included use of the SOAP format, nursing evaluations, clinician follow-up and performance of emergency drills.

Outpatient Housing Unit scored 76%.
Areas requiring improvement included the initial nursing assessment (primarily orientation to the OHU) and physician orders (especially noting clinical criteria for which they want to be notified).

Health Records scored 75%
The area requiring improvement was the development of a local policy.

Preventive Services scored 81%
Areas requiring improvement included follow-up of abnormal blood pressures and weights and hepatitis A and B vaccinations.

Consultations scored 80%
Areas requiring improvement included completion of the consultation request forms and clinician follow-up after the consultation.

Peer Review scored 100%
Congratulations.

Credentialing scored 100%
Congratulations.

Quality Management scored 90%
An area requiring improvement was physician review of nursing sick call, SRN review of nursing sick call and annual Quality Management Report to the Statewide Medical Director.

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 HCSRP (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			
Question #4	Budgeted and actual physician staffing hours are sufficient to meet policy and procedures requirements, and to provide quality medical services.	1[2]			
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[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/a
	Totals:	8	1		1

Compliance = 89% (8 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[4]**	**2[5]**	**3[6]**	**4[7]**
Screen # 1	1	1	0[8]	0[9]
Screen # 2	1	n/a	n/a	1
Screen # 3	1	0[10]	0[11]	0[12]
Screen # 4	1[13]	1	0[14]	0[15]
Screen # 5	n/a[16]	n/a[17]	0[18]	1[19]
Screen # 6	0[20]	1	0[21]	0[22]
Screen # 7	0[23]	n/a[24]	1	n/a
Screen # 8	1	1	1	1
Screen # 9	1	1	1	0[25]
Screen # 10	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	4	0	4	2	
2	4	2	2	2	
3	4	0	4	1	
4	4	0	4	2	
5	4	2	2	1	
6	4	0	4	1	
7	4	2	2	1	
8	4	0	4	4	
9	4	0	4	3	
10	4	4	0	0	
Total	40	10	30	17	

Compliance = 57% (17 of 30 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			
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**[26]	**2**[27]	**3**[28]	**4**[29]	**5**[30]	**6**[31]	**7**[32]	**8**[33]	**9**[34]	**10**[35]
Date of arrival	12/23/08	2/9/09	12/04/08	1/29/09	10/30/08	1/2/08	11/3/08	1/28/09	8/13/08	1/6/09
Screen # 1	1	1	1	1	1	1	1	1	1[36]	1
Screen # 2	1	0[37]	1	1	1	1	1	0[38]	0[39]	1
Screen # 3	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Screen # 4	1	0[40]	1	1	1	1	1	0[41]	1[42]	1
Screen # 5	n/a	n/a	n/a	n/a	n/a	1	n/a	n/a	0[43]	1
Screen # 6	1	n/a	0[44]	1	1	0[45]	1	n/a	1	1
Screen # 7	n/a	n/a	0[46]	1	n/a	1[47]	1	0[48]	1	0[49]

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	7	
3	10	10	0	0	
4	10	0	10	8	
5	10	7	3	2	
6	10	2	8	6	
7	10	3	7	4	
Total	70	22	48	37	Plus 2 of 2 Questions

Compliance = 78% (39 of 50 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.		0[50]		
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.	1			
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[51]		
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:	7	2		

State ID# →	**1[52]**	**2[53]**	**3[54]**	**4[55]**	**5[56]**	**6[57]**	**7[58]**	**8[59]**	**9[60]**	**10[61]**
Triage Date HSR →	1/12/09	1/29/09	2/18/09	1/14/09	2/3/09	7/22/08	undated	11/21/08	12/8/08	9/22/08
Date NSC →	1/12/09	1/29/09	2/18/09	1/14/09	No date	7/22/08	9/15/08	11/21/08	12/8/08	9/22/08
Type of Complaint	Headache	Abdominal pain	Diarrhea	Nausea	Sore throat	Acne	Knee pain	Knee pain	Sore Throat	Spider bite
Screen # 1	1	1	1	1	1	1	n/e	1	1	1
Screen # 2	1	1	1	1	0[62]	1	1	1	1	1
Screen # 3	0[63]	0[64]	0[65]	0[66]	0[67]	0[68]	0[69]	0[70]	0[71]	0[72]
Screen # 4	0[73]	0[74]	0[75]	0[76]	0[77]	0[78]	0[79]	0[80]	0[81]	1
Screen # 5	1	0[82]	1	0[83]	1	1	0[84]	1	1	1
Screen # 6	1	1	1	1	1	1	1	1	1	1
Screen # 7	1	1	1	1	0[85]	1	1	1	1	1
Screen # 8	0[86]	0[87]	1	0[88]	0[89]	1	1	0[90]	1	0[91]

Screen # 9	1	1	1	1	1	1	0[92]	1	0[93]	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	1	9	9	
Screen #2	10	0	10	9	
Screen #3	10	0	10	0	
Screen #4	10	0	10	1	
Screen #5	10	0	10	7	
Screen #6	10	0	10	10	
Screen #7	10	0	10	9	
Screen #8	10	0	10	4	
Screen #9	10	0	10	8	
Total	90	1	89	57	Plus 7 out of 9 questions

Compliance = 65% (64 of 98 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**[94]	**2**[95]	**3**[96]	**4**[97]	**5**[98]	**6**[99]	**7**[100]	**8**[101]	**9**[102]	**10**[103]
Visit date:	2/9	2/13	1/22	11/6	11/24	11/24	1/23	1/8	1/12	12/22
Clinician name:	A	B	B	B	A	A	C	A	A	A
Nature of visit:	Ankle injury	Foot fungus	Finger injury	Nose bleeds	Abdominal pain	Abdominal pain	Headache	Soft tissue infection	Back pain	Headache
Screen # 1	1	1	1	1	1	1	1	1	0[104]	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	1	1	1	1	1	1	1	0[105]	1
Screen # 4	1	1	1	1	1	1	1	1	n/a	1
Screen # 5	1	1	1	1	1	1	1	1	n/a	1
Screen # 6	1	1	1	1	1	1	1	1	1	1
Screen # 7	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1	n/a	n/a

State ID# →	11[106]	12[107]	13[108]	14[109]	15[110]	16[111]	17[112]	18[113]	19[114]	20[115]
Visit date:	10/15	11/17	11/24	12/28	1/14	1/5	1/22	2/18	1/2	1/7
Clinician name:	A	A	A	C	A	B	B	B	B	A
Nature of visit:	Painful testicle	Skin infection	Skin infection	Headache	Back pain	Back pain	Rash	Ankle injury	URI symptoms	Chest pain
Screen # 1	1	0[116]	0[117]	0[118]	0[119]	1	1	1	1	1
Screen # 2	1	0	0	1	0	1	1	1	1	1
Screen # 3	1	1	0[120]	0[121]	1	1	1	1	1	1
Screen # 4	1	1	0[122]	n/a	n/a	1	1	1	1	1
Screen # 5	0[123]	1	n/a	n/a	n/a	1	1	1	1	1
Screen # 6	0[124]	1	0	0[125]	1	1	1	1	1	1
Screen # 7	1	1	n/a	n/a	n/a	n/a	1	n/a	1	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	20	0	20	15	
Screen #2	20	0	20	17	
Screen #3	20	0	20	17	
Screen #4	20	3	17	16	
Screen #5	20	4	16	15	
Screen #6	20	0	20	17	
Screen #7	20	15	5	5	
Total	140	22	118	102	Plus 1 of 1 Question

Compliance = 87% (103 of 119 Questions + Screens)

Chronic Disease Management

Number of patients enrolled in clinic = 54 **Percent of clinic health records reviewed = 19%**

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**[126]	**2**[127]	**3**[128]	**4**[129]	**5**[130]	**6**[131]	**7**[132]	**8**[133]	**9**[134]	**10**[135]
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	n/a	n/a	n/a	n/a
Screen # 3	1	1	1	n/a	n/a	n/a	0[136]	1	1	0[137]
Screen # 4	1	1	1	1	1	n/a	1	1	1	1
Screen # 5	1	1	1	1	1	1	1	1	1	0[138]
Screen # 6	1	1	0[139]	1	1	1	n/a	1	1	1
Screen # 7	1	1	0[140]	1	1	1	n/a	1	1	0[141]
Screen # 8	1	1	1	1	1	1	1	1	1	1
Screen # 9	1	1	1	1	1	1	0[142]	1	1	1
Screen # 10	1	1	1	1	1	1	1	1	1	0[143]

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	9	1	1	
Screen #3	10	3	7	5	
Screen #4	10	1	9	9	
Screen #5	10	0	10	9	
Screen #6	10	1	9	8	
Screen #7	10	1	9	7	
Screen #8	10	0	10	10	
Screen #9	10	0	10	9	
Screen #10	10	0	10	9	
Total	100	15	85	77	

Compliance = 91% (77 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.	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 (not complete) 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[144]		
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[145]		
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. (**There was no sink or hand sanitizer in the physician's office**)	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**[146]	**QTR 2**[147]	**QTR 3**[148]	**QTR 4**[149]	1			
	a) TB skin testing programs for staff and youth	1	1	1	1				
	b) Exposure control plans and training regarding airborne and blood borne pathogens	1	1	1	1				
	c) Hepatitis B training and vaccination programs (e.g., number of employees trained, number accepting vaccine, and number completing vaccination series)	1	1	1	1				
	d) Staff compliance with work practice controls	1	1	1	1				
	e) Reporting communicable diseases for the previous quarter, noting any trends present	1	1	1	1				
	f) Sanitation reports (institutional and infection control) and any follow-up action taken	1	1	1	1				
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:**					6	2		1

Compliance = 75% (6 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?	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?	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)?				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[150]			
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).		0[151]		
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[152]		

		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.	N
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 = 85% (11 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[153]	2[154]	3[155]	4[156]	5[157]	6[158]	7[159]	8[160]	9[161]	10[162]
Screen # 1	1	0[163]	1	1	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	1	1	1	1	0[164]
Screen # 3	1	1	0[165]	1	1	1	1	0[166]	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	0[167]	1	1	1	1	1
Screen # 7	1	0[168]	1	1	0[169]	0[170]	1	1	1	1
Screen # 8	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0[171]	0[172]	0[173]
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	9	
Screen #2	10	0	10	9	
Screen #3	10	0	10	8	
Screen #4	10	0	10	10	
Screen #5	10	0	10	10	
Screen #6	10	0	10	9	
Screen #7	10	0	10	7	
Screen #8	10	7	3	0	
Screen #9	10	0	10	10	
Total	90	7	83	72	

Compliance = 87% (72 of 83 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.	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		
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:**	3	1		1

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

State ID# →	**1**[174]	**2**[175]	**3**[176]	**4**[177]	**5**[178]	**6**[179]	**7**[180]	**8**[181]	**9**[182]	**10**[183]
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	0[184]	1	1	1	1	1	0[185]	1	1	1
Screen # 3	0[186]	1	0[187]	1	1	1	1	0[188]	1	1
Screen # 4	n/a	1	n/a	1	1	1	1	1	1	1
Screen # 5	0[189]	1	n/a	1	0[190]	1	1	n/a	0[191]	1
Screen # 6	1	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Screen # 7	1	n/a	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	8	
Screen # 3	10	0	10	7	
Screen # 4	10	2	8	8	
Screen # 5	10	2	8	5	
Screen # 6	10	9	1	1	
Screen # 7	10	9	1	1	
Total	70	22	48	40	Plus 3 of 4 applicable questions

Compliance = 83% (43 of 52 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.	1			
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	1			
	For calculating score, only give credit for applicable questions in substantial compliance. Totals:	4		1	

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**[192]	**2**[193]	**3**[194]	**4**[195]	**5**[196]	**6**[197]	**7**[198]
Placement date: →	11/12	11/13	12/30	1/2	12/15	12/22	11/24
Discharge date: →	11/25	11/19	12/31	1/5	12/21	12/23	11/30
Screen # 1	1	0[199]	1	1	1	1	1
Screen # 2	0[200]	0[201]	0[202]	0[203]	0[204]	0[205]	0[206]
Screen # 3	1	1	1	1	1	1	1
Screen # 4	0[207]	0[208]	0[209]	0[210]	1	0[211]	1
Screen # 5	1	1	0[212]	1	1	1	1
Screen # 6	1	1	1	1	1	1	1
Screen # 7	1	1	1	1	1	1	1
Screen # 8	1	1	1	1	1	1	1
Screen # 9	1	1	1	1	0[213]	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	7	0	7	6	
Screen # 2	7	0	7	0	
Screen # 3	7	0	7	7	
Screen # 4	7	0	7	2	
Screen # 5	7	0	7	6	
Screen # 6	7	0	7	7	
Screen # 7	7	0	7	7	
Screen # 8	7	0	7	7	
Screen # 9	7	0	7	6	
Total	63	0	63	48	Plus 4 of 5 Applicable Questions

Compliance = 76% (52 of 68 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[214]	
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			
	For calculating score, only give credit for questions in substantial compliance. **Totals:**	3		1	

Compliance = 75% (3 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**[215]	**2**[216]	**3**[217]	**4**[218]	**5**[219]	**6**[220]	**7**[221]	**8**[222]	**9**[223]	**10**[224]
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	0[225]	1	1	0[226]	1	1	1	1
Screen # 4	1	1	0[227]	1	1	1	0[228]	1	0[229]	1
Screen # 5	0[230]	0[231]	1	0[232]	1	1	1	1	1	1
Screen # 6	1	n/a	n/a	n/a	1	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	8	
Screen # 4	10	0	10	7	
Screen # 5	10	0	10	7	
Screen # 6	10	8	2	2	
Total	60	18	42	34	Plus 1 of 1 Question

Compliance = 81% (35 of 43 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**[233]	**2**[234]	**3**[235]	**4**[236]	**5**[237]	**6**[238]	**7**[239]	**8**[240]	**9**[241]	**10**[242]
Screen # 1	1	1	0	0	1	1	1	0[243]	0[244]	1
Screen # 2	1	1	n/a	n/a	0[245]	1	1	0[246]	1	1
Screen # 3	0	1	1	0	1	1	1	1	1	1
Screen # 4	1	1	1	1	1	1	1	1	0[247]	1
Screen # 5	n/a	1	1	0	n/a	1	1	1	n/a	n/a
Screen # 6	0	1	1	1	1	1	1	1	1	1
Screen # 7	0	1	0	0	1	1	1	1	1	1
Screen # 8	n/a	1	n/a	0[248]	1	1	1	1	1	1
Screen # 9	n/a	n/a	n/a	0	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	6	
Screen # 2	10	2	8	6	
Screen # 3	10	0	10	8	
Screen # 4	10	0	10	9	
Screen # 5	10	4	6	5	
Screen # 6	10	0	10	9	
Screen # 7	10	0	10	7	
Screen # 8	10	2	8	7	
Screen # 9	10	4	6	5	
Total	90	12	78	62	Plus 3 of 3 Questions

Compliance =80% (65 of 81 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.	1			
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.	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:**	5			

Compliance = 100% (5 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.	1			
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:**	9			

Compliance = 100% (9 of 9 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.				1			
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: _____				1			
	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[249]		
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.				1			
For calculating score, only give credit for applicable questions in substantial compliance.				**Totals:**	9	1		

Compliance = 90% (9 of 10 Questions)

Total Number of Questions and Screens Evaluated	=780
Total Number of Questions and Screens in Substantial Compliance	=631
Total Score	= 81%

ENDNOTES

[1] There are 3 supervising nurses and 36 registered nurse (RN) positions (8 vacant). There are also 20 licensed psychiatric technicians (LPT) positions (4 vacant); and 2 Medical Technical Assistant (MTA) positions (none vacant). This does not include part-time intermittent employees (PIEs).

[2] The facility currently has 1 CMO, 3 full time physicians and 1.7 NPs.

[3] There is no officer dedicated to the medical unit.

[4] 89421. This 22 y.o. arrived at NAC as a parole revocator on 2/11/09. We reviewed a temporary file because the permanent record has not yet been received from Preston. His medical history included bipolar disorder, substance abuse and chronic back pain secondary to spondylosis.

[5] 89634. This 22 y.o. arrived at NAC on 3/5/08. He had no significant medical history.

[6] 91980. This 19 y.o. was a parole revocator who arrived at NAC on 10/8/08. He had been released from Chad on 7/22/08. On 10/10/08 the physicians saw the patient and noted his chart was not available. The physician wrote a progress note but did not complete the history and physical examination form.

[7] 91234. This 20 y.o. parole revocator arrived at NAC on 12/30/08. His medical history included bipolar disorder. Upon arrival his medication was Risperdal and Zoloft.

[8] Upon admission a nurse saw the patient and performed an assessment but did not complete the medical screening form. Vital signs were measured but not visual acuity. His blood pressure was 146/94 mm/hg which the nurse noted.

[9] Upon admission a nurse saw the patient and performed an assessment but did not complete the medical screening form. A nursing progress note is documented but does not document current medications.

[10] Visual acuity not measured.

[11] Visual acuity was not measured.

[12] Visual acuity was not measured. A tuberculin skin test was not planted.

[13] Labs have been obtained but were not yet filed in the record pending physician review.

[14] No documentation of RPR, GC and chlamydia test result notification and counseling.

[15] RPR not performed.

[16] No HIV antibody test counseling documented as of 2/17/09.

[17] Youth refused HIV and RPR testing.

[18] No documentation of HIV notification and counseling of test results noted.

[19] The nurse did not indicate which tests the patient was providing counseling for.

[20] The patient reported a history of chronic back pain with spondylosis but did not obtain a history of the presenting complaint or perform a musculoskeletal examination of any significance, only circling that the patient had no scoliosis.

[21] The history and physical examination was performed without the medical record; there is no subsequent documentation of chart review.

[22] The physician did not perform a complete medical history and physical examination comparable to the approved form.

[23] There is no Problem List in the record.

[24] The youth has no medical problems.

[25] TB skin test and RPR not performed.

[26] 90575. This 20 y.o. arrived at PYCF on 12/8/08 and transferred to NAC on 12/23/08. His medical history includes asthma, chlamydia, and paranoid schizophrenia with previous suicide attempts. Upon arrival his medications were Zyprexa and Retina-A 0.1% gel.

[27] 90112. This 22 y.o. arrived at PYCF on 1/7/09 and transferred to NAC on 2/9/09. His medical history includes substance abuse.

[28] 88294. This 23 y.o. arrived at PYCF on 8/20/08 and transferred to NAC on 12/4/08. His medical history includes obesity and bipolar disorder. Upon arrival his medications were Remeron, Tegretol and Doxycycline.

[29] 91784. This 19 y.o. arrived at PYCF on 1/17/08 and transferred to NAC on 1/29/09. His medical history included headaches and depressive disorder. Upon arrival his medications were Imitrex and Wellbutrin.

[30] 91260. This 18 y.o. arrived at PYCF on 6/8/07 and transferred to NAC on 10/30/08. His medical history included ADHD. Upon arrival his medications were Concerta.

[31] 91906. This 20 y.o. arrived at PYCF on 11/3/08 and transferred to NAC on 1/2/09. His medical history includes asthma and depression. Upon arrival his medications were Albuterol MDI and Trazodone.

[32] 92406. This 18 y.o. arrived at PYCF on 9/2/08 and transferred to NAC on 11/3/08. His medical history includes latent TB infection and seizure disorder. Upon arrival his medications were Isoniazid, Vitamin B6 and Trazodone.

[33] 91922. This 20 y.o. was released from NAC on 11/3/08 and readmitted to PYCF on 1/27/09. His medical history included depression with previous treatment with Geodon. At PYCF the nurse and physician completed the medical reception screening forms and planted a tuberculin skin test. On 1/28/09 he was transferred to NAC. The staff completed the lower portion of his intrasystem transfer form but did not note that his medical reception process was not completed. The physician saw him the following day and did not document that the medical reception process was incomplete. He ordered a chlamydia gonorrhea test, but not an RPR and HIV test. The chlamydia test was positive on 2/2/09 and the patient was treated.

[34] 90688. This 18 y.o. arrived at EPdRYCF on 4/24/07 and transferred to several facilities before his transfer to NAC on 8/13/08. His medical history includes asthma and hypertension. Upon arrival his medications were Singulair, Albuterol MDI and Enalapril. A nurse saw the patient and referred the patient for physician sick call the following morning. On 8/14/08 the physician documented that he reviewed the intrasystem transfer form but did not see the patient or renew the medications at this time. On 8/18/08 the physician saw the patient and renewed his medications, except for his blood pressure medication which was renewed on 9/22/08.MARs show that there was no discontinuity of medication.

[35] 92641. This 17 y.o. arrived at PYCF on 11/7/08 and transferred to NAC on 1/6/09. His medical history included obesity, hypertension and acne. Upon arrival his medications were Tenex, Retin-A, Zyprexa and Concerta.

[36] The sending nurse did not document that the patient was taking medications.

[37] The nurse did not complete all portions of the intrasystem transfer form (appearance). The patient's blood pressure was 150/90 mm/hg. The nurse did not address this.

[38] The nurse did not note that the medical reception process had not been completed.

[39] The receiving nurse did not document that the patient was taking any medications.

[40] The patient's blood pressure upon arrival was 150/90 mm/hg. The physician reviewed the form but did not address the blood pressure and order blood pressure monitoring. His labs show that his lipids were borderline high (Cholesterol =198 and LDL =148) but this was not addressed.

[41]The physician did not address that his medical reception process had not been completed.

[42] On 8/14/08 the physician signed that he reviewed the intrasystem transfer form but did not renew the patient's medication or write any orders related to enrollment in the chronic disease management program. The patient continued to receive his medication because of a previous valid order and there was no discontinuity of medication.

[43] Although the patient arrived on 8/13/08, the physician did not see the patient until 8/18/08. At that time he did not renew the patient's blood pressure medications.

[44] Upon arrival, the psychiatrist continued only the patient's Remeron, and at a lower dose than prescribed by the psychiatrist at PYCF; and did not continue the patient's Tegretol.

[45] Neither the sending or receiving facility noted whether the patient had his Albuterol inhaler in his possession. Orders for the inhaler were not written until 3 days later.

[46] There was not continuity of mental health care. The psychiatrist only continued only the patient's Remeron, and at a lower dose than prescribed by the psychiatrist at PYCF. The patient's Tegretol was not continued. On 12/5/08 a nurse documented that the patient stated that "I'm going crazy without my medications, Remeron and Tegretol. The nurse called a physician who provided a verbal order "If the ward needs it, may give Tegretol 400 mg po at HS until seen by Dr. S." On 12/8 and 12/11 the patient submitted HSRs stating that his Remeron dose was not correct. The psychiatrist did not see the patient until 12/17/08. During this time the physician continued the lower dose of Remeron. There was no clinical evaluation of the patient for two weeks after the patient arrived.

[47] The youth arrived on 1/2/09 and was not seen by mental health until 1/14/09.

[48] The medical reception process was not completed.

[49] The physician ordered lab tests upon arrival but these were not performed. We find no refusal for these laboratory tests.

[50] The locks to the sick call boxes on the ITP are broken.

[51] Most registered nurses have been trained.

[52] 92438. This 18 y.o. has a history of TB infection and migraine headaches.

[53] 91260. This 18 y.o. has a history of adjustment disorder and seasonal allergies.

[54] This 21 y.o. has a medical history of low back pain, right knee injury and depression.

[55] 92045. This 17 y.o. has a medical history of depression and impulse control disorder.

[56] 91666. This 18 y.o. has a history of a head injury and acne.

[57] 91666. This 18 y.o. has a history of a head injury and acne.

[58] 90284. This 21 y.o. has a medical history of asthma and obesity.

[59] 92149. This 20 y.o. has a medical history of obesity and mild asthma.

[60] 910070. This 20 y.o. has a medical history of obesity and bipolar disorder.

[61] 90518. This 18 y.o. has a medical history of exercise induced asthma and ADHD.

[62] The nurse did not document the date he saw the patient.

[63] The nurse did not obtain a history of the patient's headaches (onset, duration, character of pain, etc)

[64] No additional history was obtained.

[65] No additional history was obtained.

[66] No additional history was obtained.

[67] Nurse documented that the patient had sore throat rhinorrhea, vomiting and general malaise. Duration unspecified. Did not inquire about cough, fever, chills.

[68] No additional history was obtained.

[69] The nurse did not obtain a history of the knee pain.

[70] The nurse did not obtain a history of the knee pain.

[71] No additional history was obtained.

[72] No additional history was obtained.

[73] No physical assessment was performed.

[74] No physical assessment was performed.

[75] No physical assessment was performed.

[76] No physical assessment was performed.

[77] No physical assessment was performed.

[78] No description of lesions, presence or absence of drainage.

[79] No physical assessment was performed.

[80] No physical assessment was performed.

[81] The nurse measured vital signs and examined the throat, but did not palpate for lymph nodes or auscultate the lungs.

[82] Alteration to comfort.

[83] Alteration in health maintenance.

[84] No assessment related to the knee.

[85] The nurse did not document a referral.

[86] The nurses' signature was not legible and no signature log on the unit.

[87] The nurses' signature was not legible and no signature log was on the unit.

[88] The nurses' signature was not legible no signature log was on the unit.

[89] The nurse did not sign and date the form.

[90] The nurses' signature was not legible no signature log was on the unit.

[91] The nurses' signature was not legible and no signature was log on the unit.

[92] Dr. L did not see the patient but referred him directly to the consultant who saw the patient 2 weeks later.

[93] The referral did take place but the nurse practitioner did not address the reason for the referral.

[94] 90688

[95] 92290

[96] 89206

[97] 92272

[98] 92045

[99] 92045

[100] 92045

[101] 89189

[102] 91681

[103] 89662

[104] Inadequate history for back pain. This was discussed with Dr. Morris who agreed.

[105] Inadequate physical exam for back pain. This was discussed with Dr. Morris who agreed.

[106] 92438

[107] 91527

[108] 91527

[109] MD802

[110] 91239

[111] 91864

[112] 91727

[113] 92324

[114] 92234

[115] 92484

[116] MD saw patient for infection near umbilicus. MD also noted cellulitis of forearm but no history related to this.

[117] MD noted that patient had rash but did not obtain any history related to rash. This case was discussed with Dr. Morris who agreed.

[118] Inadequate history for headache. This case was discussed with Dr. Morris who agreed.

[119] Inadequate history for back pain, i.e., no history related to severity, radiation, exacerbating/relieving factors, prior history, etc

[120] MD did not describe rash. This case was discussed with Dr. Morris who agreed.

[121] Inadequate physical exam for headache. This case was discussed with Dr. Morris who agreed.

[122] MD did not document an assessment for the rash. This case was discussed with Dr. Morris who agreed.

[123] Physician treated patient for epididymitis with inappropriate regimen and did not order GC, Chlamydia tests. This case was discussed with Dr. Morris who agreed.

[124] No education related to STD's

[125] No education related to headache.

[126] 91027

[127] 90688

[128] 92496

[129] 89799

[130] 89799

[131] 89926

[132] 90912

[133] 92290

[134] 89206

[135] 91809

[136] no metabolic panel or urinalysis in over one year

[137] LDL cholesterol was 128 in 5/08. Has not been repeated. HbA1C not done prior to chronic care visit.

[138] Youth with diabetes and hypertension. Did not address lipids despite LDL of 128 in 5/08.

[139] Youth with diabetes and hyperlipidemia. Did not address hyperlipidemia.

[140] Youth with diabetes and hyperlipidemia. Physician did not order urine for microalbumin.

[141] Diabetes in poor control. Did not address in treatment plan. Also did not address high lipids in 5/08.

[142] Youth was a no-show for his blood pressure medication from 1/14 to 1/17 and there was no follow-up

[143] No documentation of flu vaccine.

[144] The infection control nurse has developed a sanitation schedule for the OHU, NAC and OH Close. Records show that the OH close youth janitor has not been consistent in his cleaning of the OH Close medical clinic. Sanitation schedules show that the NAC youth janitor has been more consistent with daily duties but not weekly and monthly duties. There is no sanitation schedule for the ITP and IBTP. The medical clinic was superficially clean but countertops and sink were not clean. Medication window is cracked and needs to be replaced.

[145] No eyewash station in the medical or dental clinic.

[146] February 07, 2008.

[147] May 13, 2008.

[148] August 21, 2008.

[149] November 13, 2008.

[150] Injectable Ativan is kept in the emergency response bag in a kit that is sealed by a plastic lock. To ensure that this kit is checked each shift, we recommend that the log which documents narcotic checks list this kit separately from narcotics that are double-locked.

[151] Evening nurse advised that the HS medication administration begins at 1930 rather than 2000.

[152] The nurse did not document medications at the time of administration.

[153] 90575. This 20 y.o. arrived at PCCF on 12/8/08 and transferred to NAC on 12/23/08. His medical history includes asthma, chlamydia, paranoid schizophrenia with previous suicide attempts. Upon arrival his medications were Zyprexa and Retina A 0.1% gel. Order 12/23/08.

[154] 92406. Order 11/3/08 for Isoniazid, Vitamin B6 and Trazodone.

[155] 91027. This 21 y.o. arrived at NAC on 1/11/06. His medical history includes HIV infection. His current medications are Atripla, Wellbutrin XL, Effexor, Depakote and MVI. Order 12/3/08.

[156] 92296. Order 1/6/09.

[157] 92484. This 16 y.o. arrived at SYCRCC on 5/29/08 and transferred to NAC on 9/23/08. His medical history includes latent TB infection, asthma, mood disorder and impulse control disorder. His current medications are Trazodone and Effexor. Order 1/20/09.

[158] 92272. Order 12/31/08.

[159] 91922. Order 2/2/09.

[160] 92546. Order 2/6/09.

[161] 92045. Order 1/29/09.

[162] 91527. Order 2/11/09 for Accutane.

[163] The order lacked route of medication administration.

[164] The order was dated but not timed.

[165] On 12/3/08 there was no clinical evaluation of the patient to accompany the order. A progress note documented that it was a renewal of medication. The order is due to expire on 3/3/09. The physician saw the patient on 12/16/08 but did not renew his Atripla.

[166] There is no progress note for the date of the order.

[167] The medication was not started until 1/22/09.

[168] No documentation of administration status for 11/11/08. This medication (Isoniazid) is to be given twice weekly but was administered to the patient on 11/4 and 11/5/08. There is no documentation in the record that addresses the administration of this medication two days in a row and evaluates the patient for medication side effects.

[169] No documentation of administration status for 1/21/09 and 1/29/09.

[170] No documentation status for 1/21/09.

[171] The nurse who discontinued the previous order did not initial the order to discontinue the medication on the MAR.

[172] The nurse who discontinued the medication did not document the date of discontinuation or his/her initials on the MAR.

[173] The nurse who discontinued the previous order did not sign or initial the discontinuation of the previous order on the MAR.

[174] 92211

[175] 92100

[176] 92253

[177] 92484

[178] 92234

[179] 90826

[180] 90070

[181] 89103

[182] 90401

[183] 90467

[184] Incorrect SOAP format. Subjective information in Assessment.

[185] Incorrect SOAP format. Objective information mixed in with subjective information.

[186] Youth complaining of abdominal pain. RN did not palpate abdomen.

[187] Inadequate history related to headache, vomiting. Did not obtain vital signs. Did not perform any physical examination.

[188] Patient complaining of testicular pain. RN did not obtain history related to painful urination or discharge and did not palpate for tenderness.

[189] Youth with abdominal pain. Physician ordered CBC and monitored in OHU. Should have sent patient to ED. Discussed with Dr. Morris who agreed.

[190] Youth complaining of flank pain following trauma. Clinician did not obtain history related to blood in urine.

[191] Referred to MD for evaluation of headaches x one week. No history related to severity, duration, prodromal symptoms, exacerbating factors, etc.

[192] 89189

[193] 92129

[194] 92211

[195] 92111

[196] 92271

[197] 88746

[198] 91534

[199] There is no specific order to admit to OHU

[200] Orders do not include clinical criteria for notifying physician of a change in clinical status

[201] Orders do not include initial impression, clinical criteria for notifying physician of a change in clinical status

[202] Orders do not include clinical criteria for notifying physician of a change in clinical status

[203] Youth had been in OHU and sent to ED on 1/2. He was admitted and had surgery for appendicitis. When he returned to the OHU on 1/5 there are no admitting orders.

[204] Orders did not note frequency of vital signs or criteria for notifying physician of a change in clinical status

[205] Orders do not include frequency of vital signs or clinical criteria for notifying MD of change in clinical status

[206] There are no physician orders

[207] No documentation of orientation to OHU

[208] Youth is post-op, no history related to pain, no documentation of orientation to OHU

[209] There is no admitting note from a nurse

[210] No documentation of orientation to OHU

[211] No documentation of orientation to OHU

212 Youth with abdominal pain. On 12/30, CBC revealed increased white blood cell count. Physician did not send patient to ED until 12/31. The youth was diagnosed with acute appendicitis.

213 There is no nursing discharge note

[214] There are no local policies.

[215] 91845

[216] 91814

[217] 92059

[218] 92244

[219] 91185

[220] 92149

[221] 90515

[222] 92108

[223] 90284

[224] 91143

[225] Blood pressure was 144/64 on 1/5/09. Nurse did not refer youth to clinician.

[226] Blood pressure was 145/87 on 7/20/08. Not addressed.

[227] BMI 28.2. Weight not addressed.

[228] BMI 26.6 in 9/08. Since then weight has increased. Weight not addressed.

[229] BMI 41.2. Obesity was added to problem list in 11/04, but obesity is not being addressed.

[230] Has not had second Hepatitis A vaccine.

[231] Has not received second Hepatitis A or third Hepatitis B vaccine.

[232] Has not received second Hepatitis A or third Hepatitis B vaccine.

[233] 90688

[234] 92496

[235] 89799

[236] 89206

[237] 91809

[238] 92272

[239] 91303

[240] 91534

[241] 88880

[242] 88880

[243] Urgency not noted. Did not use DJJ form, used hospital request form.(? missing documentation)

[244] Physician did not note urgent vs routine on consult form. In his progress note stated that it should be in 2 days.

[245] Physician did not document physical findings.

[246] No history or physical findings documented.

[247] Physician ordered orthopedic consult on 12/1 noting that youth should be seen by ortho on 12/3 for possible elbow subluxation or dislocation. Youth not seen by orthopedist until 12/17.

248 Orthopedist recommended follow-up in one month. The physician did not address this and follow-up did not occur.

249 There is no organized system for physician review of nursing or OHU care.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

DIVISION OF JUVENILE JUSTICE

Heman G. Stark YCF
Health Care Audit
January 13-15, 2009

Contents

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 are 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 Farrell Medical Experts visited Heman G. Stark YCF January 12-15, 2009.

We thank Joe Hartigan, Superintendent, John Close MD, CMO, Mark Bravo SRN III and all staff for their cooperation and assistance in completing the health care audit.

The facility scored 84% (721 of 856 applicable screens/questions). The score is a significant improvement from the previous score of 64% in November 2007. Certain information in the report has been updated based on recent comments and clarifications that DJJ presented to the experts in a letter dated March 12, 2009. Both health care and custody staff are to be commended for their success in improving the health care program.

Since our last visit, the population of HGSYCF has decreased from approximately 800 to 460 youth. According to staff, the decreased population enabled staff to focus on putting health care systems in place. There have been significant improvements in most health care services, with the exception of medical reception. We also found significant improvements in the quality of medical care; however we are concerned regarding the performance of one clinician and we discussed our concerns with the CMO.

It is notable that since our last visit, there was a death at the facility on March 8, 2008. The youth died of natural causes and his death could not have been prevented. Our review of the incident revealed problems with the timeliness of the medical response and failure of custody staff to initiate CPR that had not been noted in the Death Review. The CMO informed us that these issues have been addressed through changes in procedures, training, and the acquisition of new equipment. While it is commendable that this occurred, we are concerned that the Death Review Report did not reflect these problems and corrective actions. A critical function of the death review process is the identification and documentation of system issues that may have affected the delivery of care as well as possible problems in the care provided so that corrective action plans can be developed that will improve future care.

It is reasonable to expect that with the ongoing decreases in the DJJ population, budgetary pressures may result in staffing reductions at all DJJ facilities. The process of putting systems in place is often staff intensive, but once completed, facilities can perform well with fewer staff. We believe that it is important that DJJ begin collecting and analyzing data to determine the appropriate levels of staffing at all facilities.

We are very impressed by the enthusiasm of the staff we met at Heman G. Stark YCF and are confident that they will continue their efforts to improve health care to the youth under their care.

Summary of Health Care Areas Reviewed

Facility Leadership, Budget, Staffing, Orientation and Training scored 89%

At Heman G. Stark, key leadership positions are filled with the exception of the Health Care Administrator position. This position was previously assigned to Health Care Services and was not available to be filled at HGS, however staff advised us that the position is now vacant and is in process of being transferred back to the facility.

The Chief Medical Officer (CMO) is board-certified in a primary care field. The CMO reports that he has never had a budget that is functionally under his control. We note that due to delays in passage of the state budget, DJJ does not have a known budget at the beginning of the fiscal year. In the interim, the agency projects expenditures based upon the prior year; and these figures are used as the projected budget until one is provided to the agency. During this period HGSYCF, as with other DJJ facilities, operates through deficit spending. Although this has not interfered with their ability able to purchase health care services, this process results in an inability to make management decisions regarding expenditures against a known budget. Moreover, because future budget projections are based upon the previous year's budget, there is no incentive to be cost effective. Although the statewide budget process is outside of DJJ's direct control, the medical experts believe that this process does not promote a cost effective system, and contributes to the state budget issues. The medical experts would be happy to assist DJJ in exploring ways to improve cost effectiveness for budget matters that are under their control.

The facility has Health Care Services policies and procedures and local procedures for most, but not all areas. There is documentation that staff has been trained in policy and procedures.

With respect to clinical staffing, there currently 5 full-time clinicians: A chief medical officer, 3 physicians and a nurse practitioner. This is a clinician to youth ratio of 1:92 which is more than adequate. According to staffing information previously provided to us through headquarters, there are also 41 nurses and 20 psych technicians; also more than sufficient to provide adequate health care to the population. Mark Bravo SRN III has made a commendable effort to effectively utilize the psychiatric technicians by having them provide medications in the housing units where they are assigned. This wisely prevents unnecessary duplication of services.

Medical Reception scored 52%

The facility is not a reception center but receives parole revocators who by policy are to undergo the medical reception process. In general, the nurses are performing well with respect to the initial medical screening, measurement of vital signs, and obtaining laboratory tests in a timely manner.

There are, however, significant problems with the timely identification of medical conditions; and development and implementation of appropriate treatment plans. For example, in 3 of 10 records, newly arriving youth had elevated blood pressure readings which the clinician did not note or address. Another youth had discrepant tuberculin skin test results in the record that also were not addressed. Moreover, clinicians do not explore whether youth with previously diagnosed latent TB infection have been adequately treated. Staff does not consistently notify

youth of laboratory results but are piloting a system for written, rather than verbal notification.

We incidentally noted that the most glaring deficiencies were associated with a particular physician. We discussed our concerns with the CMO who shared our concerns.

The clinicians are ultimately responsible for the quality of the history and physical examination; identification of medical conditions; and development and implementation of an appropriate treatment plan. However, as noted in previous reports, the DJJ medical history and physical examination form does not have a section on the form to document medical diagnoses and a treatment plan for each active problem. Instead the form concludes with a classification section (e.g., cleared for all activity), which is not useful. It contains a section for review of symptoms, but does not have a 'yes' or 'no' beside each symptom therefore there is no way to know whether the youth was asked each symptom. We recommend that the form be amended to require a positive/negative answer to each symptom, and to contain a section in which the clinician lists identified medical conditions and a treatment plan for each active problem[1].

Intrasystem Transfer scored 91%

Congratulations. Although the facility scored above 85%, areas that could be improved include continuity of chronic disease medications and timely chronic disease follow-up appointments.

Nursing Sick Call scored 73%

Both nursing and physician sick call is conducted in satellite clinics in each of the three housing units, five days a week. We toured each of the housing units and found that sick call boxes and forms are available in each housing unit. Each clinic was clean, well-organized and properly equipped and supplied. Typically there are 3 clinician-nurse teams that go to housing units each morning to see youth who signed up for sick call the day before. On the day of our tour, one physician had completed sick call by 10 am. In the afternoon, nurses go to the housing units to collect and triage health service requests for scheduling the following day.

Our review of records shows that nurses and clinicians see youth in a timely manner. The quality of nursing assessments is generally lacking, which we attribute to lack of training and nursing protocol guidelines; and ongoing feedback to the nurses regarding their performance.

An area of concern is that we noted that correctional officers are in the room when physicians see patients, thus not providing auditory and visual privacy. While we support the need to provide safety to staff, the default practice of officers placing themselves in the room with the clinician is not appropriate. We discussed this during the executive debriefing.

Medical Care scored 91%

Congratulations, this is a significant improvement over the last visit. While the facility met the goal of 85%, an area that would benefit from improvement includes patient education.

Chronic Disease Management scored 90%

Congratulations, this is a significant improvement over the last visit. While the facility met the goal of 85%, areas that would benefit from improvement include use of the problem list and frequency of visits. On a consultative, note, there are two physicians who see youth for chronic care on Tuesdays and Thursdays. The physician's do not routinely see the same patients for follow-up. In order to better foster continuity of care, we recommend that the physicians maintain their own caseloads of chronic care patients.

Infection Control scored 100%

Congratulations. This is a significant improvement from the previous audit.

Pharmacy Services scored 100%

Congratulations!

Medication Administration Process scored 100%

Congratulations! We observed that medications are securely stored and properly labeled. There were no expired medications. We observed medication administration and noted that nurses followed standard nursing practices. In segregation, a few youth refused their medication. One nurse tended to accept the youth's refusal at face value without addressing the reason. Another nurse was active in exploring and addressing the reason for the refusal which we support and encourage.

Medication Administration Health Record Review scored 83%

In general this area is working well. Areas in need of improvement are primarily related to pharmacy practices. In one instance, a physician wrote an order for a diuretic to be given once daily, and the pharmacist transcribed the order for the medication to be given at bedtime; which is not the typical administration time for diuretics. In another case the pharmacist transcribed an order for an HIV medication to be given with apple sauce, but this was not included with the physicians' order and the package insert instructions advise to give the medication on an empty stomach. The youth was prescribed medications that had different administration requirements (e.g. one to take with food and one to take on an empty stomach) yet was receiving all medications at the same time. Both clinicians and pharmacists should be aware and adhere to medication administration requirements. Finally, the medication administration record (MAR) contains a space for the physician order date for a medication; however the pharmacy prints the date of dispensing of the medication as the order date, and often the two are not the same. We recommend that the pharmacist documents the date of the medication order as indicated by the form.

Urgent/Emergent Care scored 84%

Areas in need of improvement include the use of SOAP format and clinician follow-up. In addition, health care leadership should perform emergency drills on a quarterly basis that involve conditions and situations the staff are likely to encounter (e.g. difficulty breathing, uncontrolled bleeding, cardiac arrest, etc.).

Outpatient Housing Unit was not evaluated.
Heman G. Stark does not have an OHU. Youth requiring infirmary services are transferred to the Southern Youth Correctional Reception Center and Clinic (SYCRCC).

Health Records scored 75%
The facility needs to develop a functional tracking system for laboratory and x-ray results. On a consultative note, in a significant number of the health records, the problem list has so many minor problems noted that the lists have lost their usefulness. We recommend that consideration be given to cleaning up the problem lists so that only ongoing/ serious problems are noted.

Preventive Services scored 85%
While the facility scored 85%, an area that that would benefit from improvement includes clinician identification and development of a treatment plan for youth who are obese. We noted that in 4 of the cases reviewed for Preventive Services, the youth was overweight and the clinician did address this and added it to the problem list. On a positive note, the facility has implemented a special program, POWER; to assist youth who are obese lose weight. We commend the facility on these initial efforts to address this pervasive health issue that we have observed in youth in all of the DDJ facilities.

Consultations scored 92%
Congratulations. This is a significant improvement since the last visit. While the facility met the goal of 85%, an area that would benefit from is the consistent implementation of the consultant's recommendations.

Peer Review scored 100%
Congratulations. This is a significant improvement since the last visit.

Credentialing scored 100%
Congratulations. This is a significant improvement since the last visit.

Quality Management scored 90%
Congratulations. While the facility met the goal of 85%, an area that could be improved is physician review of nursing sick call.

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 HCSRP (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.	1[4]			
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.	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	1			
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:	9			1

Compliance = 100% (9 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		
Question #2	There is a comprehensive verbal and written orientation program (minimum English and Spanish) for youth in a language they understand.	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**[7]	**2**[8]	**3**[9]	**4**[10]	**5**[11]	**6**[12]	**7**[13]	**8**[14]	**9**[15]	**10**[16]
Screen # 1	1	1	1	1	1	1	1	0[17]	1	1
Screen # 2	n/a	n/a	0[18]	n/a	n/a	n/a	n/a	n/a	n/a	1
Screen # 3	1	1	1	1	0[19]	1	1	1	1	1
Screen # 4	1	0[20]	0[21]	1[22]	0[23]	0[24]	0[25]	0[26]	1	0[27]
Screen # 5	1	1	1	1	0[28]	n/a[29]	1	1	1	n/a
Screen # 6	0[30]	0[31]	0[32]	0[33]	1	0[34]	0[35]	0[36]	0[37]	1
Screen # 7	0[38]	n/a	0[39]	1	0[40]	0[41]	1	0[42]	0[43]	1
Screen # 8	0[44]	0[45]	0[46]	0[47]	0[48]	0[49]	0[50]	0[51]	0[52]	1
Screen # 9	1	n/a	1	n/a	1	n/a	n/a	0[53]	0[54]	n/a
Screen # 10	n/a	n/a	0[55]	0[56]	n/a	n/a	n/a	n/a	1	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	9	
2	10	8	2	1	
3	10	0	10	9	
4	10	0	10	3	
5	10	2	8	7	
6	10	0	10	2	
7	10	1	9	3	
8	10	0	10	1	
9	10	5	5	3	
10	10	6	4	2	
Total	100	22	78	40	Plus 1 of 2 Questions

Compliance = 51% (41 of 80 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			
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**[57]	**2**[58]	**3**[59]	**4**[60]	**5**[61]	**6**[62]	**7**[63]	**8**[64]	**9**[65]	**10**[66]
Date of arrival	11/7/08	9/9/08	7/28/08	11/19/08	10/16/08	10/1/08	11/13/08	8/19/08	11/13/08	12/3/08
Screen # 1	1	1	1	1[67]	1	1	1	1	1	1
Screen # 2	1	1[68]	1	0[69]	1	1	1	1	1	1
Screen # 3	1	1	n/a	1	n/a	n/a	n/a	n/a	n/a	n/a
Screen # 4	1	1	1	1	1	1	1	1	1	1
Screen # 5	0[70]	1	n/a	0[71]	n/a	1	1	1[72]	n/a	n/a
Screen # 6	1	1	1	n/a	1	1	0[73]	1	n/a	n/a
Screen # 7	n/a	1	n/a	0[74]	n/a	1	n/a	1	n/a	1

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	7	3	3	
4	10	0	10	10	
5	10	4	6	4	
6	10	3	7	6	
7	10	5	5	4	
Total	70	19	51	46	Plus 2 plus 2 Questions

Compliance = 91% (48 of 53 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			
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.	1			
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.			0	
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:**	7		2	

State ID# →	**1**[75]	**2**[76]	**3**[77]	**4**[78]	**5**[79]	**6**[80]	**7**[81]	**8**[82]	**9**[83]	**10**[84]
Triage Date HSR →	9/12/08	12/23/08	12/23/08	11/6/08	9/20/08	11/20/08	11/16/08	12/5/08	9/26/08	12/23/08
Date NSC →	9/12/08	12/23/08	12/23/08	11/6/08	9/20/08	11/20/08	11/16/08	12/5/08	9/26/08	12/23/08
Type of Complaint	Sore throat	Knee swelling	Sore throat	Abdominal pain	headaches	Body Rash	Spider bite	Chest pain/headache	Testicle	Don't feel good
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	1	1	1	0[85]	1
Screen # 3	1[86]	0[87]	0[88]	0[89]	0[90]	1[91]	1[92]	0[93]	0[94]	0[95]
Screen # 4	1[96]	0[97]	0[98]	0[99]	0[100]	1	0[101]	0[102]	0[103]	0[104]
Screen # 5	1	1	1	0[105]	1	1	1	0[106]	0[107]	0[108]
Screen # 6	1	1	1	0[109]	1	1	1	1	0[110]	1
Screen # 7	1	1	1	0[111]	1	1	1	1	1	1
Screen # 8	1	1	0	1	0[112]	1	1	1	1	1
Screen # 9	1	1	1	1	1	1	1	1	1[113]	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	0	10	10	
Screen #2	10	0	10	9	
Screen #3	10	0	10	3	
Screen #4	10	0	10	2	
Screen #5	10	0	10	6	
Screen #6	10	0	10	8	
Screen #7	10	0	10	9	
Screen #8	10	0	10	8	
Screen #9	10	0	10	10	
Total	90	0	90	66	Plus 7 of 9 Questions

Compliance = 73% (72 of 99 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**[114]	**2**[115]	**3**[116]	**4**[117]	**5**[118]	**6**[119]	**7** [120]	**8**[121]	**9**[122]	**10**[123]
Visit date:	11/24	12/12	10/15	1/7	11/19	12/1	11/12	12/5	10/24	12/14
Clinician name:	A	D	B	B	C	D	D	D	A	D
Nature of visit:	Boil	Sore throat	Hives	Knee injury	Hand pain	Back pain	Hand pain	Shortness of breath	Hand pain	URI
Screen # 1	1	1	1	0[124]	1	1	1	0[125]	1	1
Screen # 2	1	1	0[126]	1	1	1	1	1	1	1
Screen # 3	1	1	1	0[127]	1	1	1	1	1	1
Screen # 4	1	1	1	n/a	1	1	1	1	1	1
Screen # 5	1	1	1	0[128]	1	1	1	1	1	1
Screen # 6	1	1	1	1	1	1	1	1	1	1
Screen # 7	1	1	0[129]	n/a	1	1	1	1	1	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**[130]	**12**[131]	**13**[132]	**14**[133]	**15**[134]	**16**[135]	**17**[136]	**18**[137]	**19**[138]	**20**[139]
Visit date:	12/18	12/2	11/12	9/11	1/2	12/1	11/5	12/17	1/12	12/26
Clinician name:	B	D	D	A	D	A	A	C	C	A
Nature of visit:	Vomiting	Knee pain	Ankle injury	Chest Pain	Abdominal pain	Heartburn	Boil	Abdominal Pain	Arm numbness	Headache
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	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	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.

State ID# →	**11**[140]	**12**[141]	**13**[142]	**14**[143]	**15**[144]	**16**[145]	**17**[146]	**18**[147]	**19**[148]	**20**[149]
Visit date:	12/26	1/14	1/9	12/31	1/14	12/17	11/25	11/31	1/14	12/12
Clinician name:	B	B	C	B	B	B	C	D	B	C
Nature of visit:	Urinary problem	Knee pain	Abdominal Pain	Ankle pain	Abdominal pain	Back pain	Wrist numbness	Migraines	Headache	Swollen finger
Screen # 1	1	1	1	1	1	0[150]	1	1	0[151]	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	1	1	1	0[152]	0[153]	1	1	0[154]	1
Screen # 4	1	1	1	1	n/a	n/a	1	1	n/a	1
Screen # 5	1	1	1	1	n/a	n/a	1	1	n/a	1
Screen # 6	0	0	1	1	0	0[155]	1	1	0[156]	1
Screen # 7	1	n/a	n/a	0[157]	n/a	0[158]	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	30	0	30	26	
Screen #2	30	0	30	29	
Screen #3	30	0	30	26	
Screen #4	30	4	26	26	
Screen #5	30	3	27	26	
Screen #6	30	0	30	25	
Screen #7	30	7	23	20	
Total	210	14	196	180	

Compliance = 91% (179 of 197 Questions + Screens)

Chronic Disease Management

Number of patients enrolled in clinic___43_____ **Percent of clinic health records reviewed ___23____%**

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**[159]	**2**[160]	**3**[161]	**4**[162]	**5**[163]	**6**[164]	**7**[165]	**8**[166]	**9**[167]	**10**[168]
Screen # 1	1	1	1	0[169]	0[170]	1	1	1	0[171]	1
Screen # 2	1	1	n/a	n/a	1	1	n/a	1	1	1
Screen # 3	1	1	1	0[172]	1	n/a	1	1	n/a	n/a
Screen # 4	n/a	1	1	1	n/a	1	1	n/a	0[173]	0[174]
Screen # 5	n/a	1	1	1	1	1	1	1	1	1
Screen # 6	1	1	1	0	1	1	1	1	1	1
Screen # 7	1	1	1	0[175]	1	1	1	1	1	1
Screen # 8	1	1	1	1	1	1	1	1	1	1
Screen # 9	1	1	1	1	1	n/a	1	1	n/a	n/a
Screen # 10	n/a	n/a	1	n/a	n/a	1	1	n/a	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	7	
Screen #2	10	3	7	7	
Screen #3	10	3	7	6	
Screen #4	10	3	7	5	
Screen #5	10	1	9	9	
Screen #6	10	0	10	9	
Screen #7	10	0	10	9	
Screen #8	10	0	10	10	
Screen #9	10	3	7	7	
Screen #10	10	5	5	5	
Total	100	18	82	74	

Compliance = 90% (74 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.	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[176]			
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. (2 staff members could not demonstrate proper usage). 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. (Not observed)	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 observed) c) Refrigerators are labeled appropriately (biohazard for specimens, food only, or medication only). (No) 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)?					**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[177]**	**QTR 2[178]**	**QTR 3[179]**	**QTR 4[180]**	1			
	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	1	1	1	n/a				
	e) Reporting communicable diseases for the previous quarter, noting any trends present	1	1	1	n/a				
	f) Sanitation reports (institutional and infection control) and any follow-up action taken	1	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?								
	For calculating score, only give credit for applicable questions in substantial compliance. Totals:								

Compliance = 100% (8 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?	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 IBTP?	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)?				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?	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.	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.	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.	n/a

Compliance = 100% (13 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[181]	2[182]	3[183]	4[184]	5[185]	6[186]	7[187]	8[188]	9[189]	10[190]
Screen # 1	1	1	1	1	1	1	0[191]	1	1	1
Screen # 2	1	1	1	1	1	1	1	1	1	1
Screen # 3	1	1	1	1[192]	1	1	0[193]	1	1	1
Screen # 4	1	1	1	1	1	1	1	1	1	1
Screen # 5	1	1[194]	0[195]	1	0[196]	0[197]	0[198]	1	1	1
Screen # 6	0[199]	1	1	1	0[200]	1	1	1	1	1
Screen # 7	0[201]	1	0[202]	1	1	0[203]	1	1	1	1
Screen # 8	0[204]	n/a	1	n/a	n/a	n/a	n/a	0[205]	n/a	n/a
Screen # 9	1	1	1	1	1	1	1	0[206]	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	9	
Screen #2	10	0	10	10	
Screen #3	10	0	10	9	
Screen #4	10	0	10	10	
Screen #5	10	0	10	6	
Screen #6	10	0	10	8	
Screen #7	10	0	10	7	
Screen #8	10	7	3	1	
Screen #9	10	0	10	9	
Total	90	7	83	69	

Compliance =83% (769 of 83 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.	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[207]		
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**[208]	**2**[209]	**3**[210]	**4**[211]	**5**[212]	**6**[213]	**7**[214]	**8**[215]	**9**[216]	**10**[217]
Screen # 1	1	1	1	1	1	1	0[218]	1	1	1
Screen # 2	0[219]	1	1	1	1	0[220]	1	1	0[221]	1
Screen # 3	1	1	0[222]	1	1	1	1	1	1	1
Screen # 4	1	1	1	1	1	1	1	1	1	1
Screen # 5	0[223]	1	1	1	1	1	0[224]	0[225]	1	n/a
Screen # 6	n/a	n/a	n/a	n/a	1	n/a	n/a	n/a	1	n/a
Screen # 7	n/a	n/a	n/a	n/a	1	n/a	n/a	n/a	1	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	9	
Screen # 4	10	0	10	10	
Screen # 5	10	1	9	6	
Screen # 6	10	8	2	2	
Screen # 7	10	8	2	2	
Total	70	17	53	45	Plus 3 of 4 Questions

Compliance = 84% (48 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.				
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				
	For calculating score, only give credit for applicable questions in substantial compliance. 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 = % (of 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.		0[226]		
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:	3	1		

Compliance = 75% (3 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**[227]	**2**[228]	**3**[229]	**4**[230]	**5**[231]	**6**[232]	**7**[233]	**8**[234]	**9**[235]	**10**[236]
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	0[237]	1	1	1	1	1	1	1	1	1
Screen # 4	1	1	0[238]	1	0[239]	0[240]	0[241]	1	1	1
Screen # 5	1	0[242]	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	9	
Screen # 4	10	0	10	6	
Screen # 5	10	0	10	9	
Screen # 6	10	10	0	0	
Total	60	20	40	34	

Compliance = 85% (35 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**[243]	**2**[244]	**3**[245]	**4**[246]	**5**[247]	**6**[248]	**7**[249]	**8**[250]	**9**[251]	**10**[252]
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[253]	1	1	1	1	1	1	1	1
Screen # 4	1	1	0[254]	1	1	1	1	1	1	1
Screen # 5	1	0	1	1	1	1	1	1	1	1
Screen # 6	1	1	1	1	1	1	1	1	1	1
Screen # 7	1	0	1	1	1	1	1	1	1	1
Screen # 8	0[255]	0[256]	1	1	1	1	1	1	1	1
Screen # 9	0[257]	1	1	1	1	1	1	1	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	10	
Screen # 2	10	0	10	10	
Screen # 3	10	0	10	9	
Screen # 4	10	0	10	9	
Screen # 5	10	0	10	9	
Screen # 6	10	0	10	10	
Screen # 7	10	0	10	9	
Screen # 8	10	0	10	8	
Screen # 9	10	0	10	9	
Total	90	0	90	83	Plus 3 of 3 Questions

Compliance =92% (86 of 93 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.	1			
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.	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:	5			

Compliance = 100% (5 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.	1			
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:**	9			

Compliance = 100% (9 of 9 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.				1			
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**	1			
	a) The CAP identified specific improvements needed.	1						
	b) The CAP identified specific staff members responsible for improvements.	1						
	c) The CAP had a targeted completion date.	1						
	d) There was documentation to indicate any recommended training was held.	1						
	e) Follow-up studies were done to determine whether or not corrective actions solved the problem or issue.	1						
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.				1			
For calculating score, only give credit for applicable questions in substantial compliance.				**Totals:**	9	1		

Compliance = 90% (9 of 10 Questions)

Total Number of Questions and Screens Evaluated	=856
Total Number of Questions and Screens in Substantial Compliance	=721
Total Score	= 84%

ENDNOTES

[1] Policies and procedures and accompanying forms were developed in consultation with the experts but not subject to their approval. The experts provided verbal feedback regarding the history and physical form related to its length, absence of yes/no questions in response to review of symptoms, and lack of space for documenting diagnoses and a medical plan. DJJ implemented the form in its original format. We encourage DJJ to reconsider the experts' recommendations with respect to the form, believing it will assist the providers in documenting a more complete assessment and treatment plan.

[2] The Health Care Administrator position occupied by Dave Gransee is now open and has been transferred back to Stark but is frozen.

[3] The CMO is board certified in family practice.

[4] The CMO indicated that he has never had a budget under his control. The facility functions by deficit spending. According to staff, correctional officer staffing and overtime has been removed from the medical budget.

[5] 1 CMO, 3 physicians, 1 FNP. 3 psychiatrists.

[6] 24 RNs, 2 MTAs and 14 psych techs. 3 MTA positions are vacant.

[7] 88272. Admission on 5/9/08. Released on 5/30/08. Dr. D.

[8] 88272. Parole revocator that was released on 5/30/08 from HGSYCF and readmitted on 11/24/08. Dr. B

[9] 84425. This 21 year old arrived on 10/9/08. His medical history includes obesity and asthma and newly diagnosed hyperlipidemia. Dr B. did his physical on 10/14/08.

[10] 86908. This 24 year old was a parole violator who was released from HGSYCF in February 2008 and readmitted on 10/7/08. His medical history includes asthma and insomnia. He was not taking any medications upon arrival. Dr. B performed his history and physical. Under current problems he documented that the patient had asthma but obtained no additional history regarding the frequency of symptoms, night time awakening, and previous medication use. He did not measure peak expiratory flow rates at the time of the physical or reference previous measurements obtained by the nurses. On 10/23/08 an unsigned order was written to enroll the patient in the asthma clinic and on 10/31/08 Dr. S wrote a note to discharge the patient because he was not on an inhaler. Dr. B.

[11] 91266. This 19 year old parole violator was discharged from Preston after 2/28/08 (?) and readmitted to HGSYCF on 12/30/08. His medical history included Right 4th finger fracture now healed. TB infection.

[12] 90291. This 19 year old arrived at HGSYCF on 11/3/08. His medical history included bipolar disorder, decreased visual acuity OD, cholecystectomy in 2003, and elevated blood pressure reading at intake (147/74 mm/hg).

[13] 89341. This 23 year old arrived at HGSYCF on 10/16/08. His medical history included a broken foot in July 2008 that was untreated.

[14] 89169. This 22 year old arrived at HGSYCF on 11/19/08. His medical history included TB infection. Dr B.

[15] 89503. This 23 year old parole revocator arrived at HGSYCF on 6/18/08. His medical history includes obesity, dyslipidemia, and onychomycosis. He is taking Simvastin for his high cholesterol. His blood pressure upon arrival was 153/83 mm/hg. Dr D.

[16] 90610. This 22 year old arrived at HGSYCF on 7/15/08. His medical history includes asthma. His medications included Albuterol inhaler. Dr. D.

[17] The nurse did not complete the question: Do you have any current medical problems?

[18] This patient had a history of moderate asthma with treatment with inhaled steroids and beta-agonist. He was discharged from DJJ in December 2007 on these medications. Upon arrival he reported that he was not currently taking any medications but had asthma exacerbations earlier in the year. The physician signed the form the same day but did not evaluate the patient for the need to renew his medications. On 10/12/08 the patient had an acute asthma attack while playing in the gym.

[19] The medical records show that on 2/23/06 a nurse documented that the patient had a positive TB skin test on 8/4/04 and that he received INH treated that was completed on 5/17/05. The nurse did not document the location where the he youth was tested, test results in millimeters, or the duration of therapy and whether the patient was compliant. For unknown reasons, on 4/27/07 the patient was TB skin tested again and the result was read as 0 mm. On 12/30/08 a nurse documented that the patient tested positive in 2003, but did not document where, skin test results, etc. The patient was noted to have completed treatment in 5/17/05. This discrepant information should be reconciled.

[20] The physician wrote a 12/1/08 progress note indicating intent to inform the patient of lab results, and a nurse documented a 12/19/08 note indicating intent to notify the patient, but there is no documentation that the patient was notified of test results.

[21] This obese patient's labs showed that a nonfasting glucose was 158. This may represent impaired glucose tolerance but this lab was not listed as a potential problem, and the physician did not document a plan or what was discussed with the patient. Dr B documented his labs as being within normal limits.

[22] Documentation that patient refused post-test counseling but was advised of test results during the refusal.

[23] Patient counseled regarding initial labs but not repeat labs. No further follow-up after repeat labs of 1/6/09.

[24] No specimen received for GC/CL test. RPR result pending but final result not in the record. No follow-up.

[25] The patient was not notified of lab test results.

[26] The patient was not notified of lab test results.

[27] RPR and HIV test not done. No refusal documented.

[28] Pre-test counseling documented, but not post-test counseling. 1/6/09 lab result not initialed as reviewed.

[29] The youth refused HIV testing.

[30] Although the clinician listed TB infection, left shoulder dislocation and tinea pedis as current medical problems when he conducted the history and physical, the clinician did not obtain any history of TB symptoms or describe the symptoms and physical findings related to his left shoulder dislocation either on the physical examination form or the progress notes. The patient's blood pressure was elevated at 149/83 mm/hg, but this was not addressed.

[31] The physician documented that the patient had no changes from his last physical that was performed on 5/15/08, and did not perform a history and physical. However this is not consistent with policy and there was not an adequate evaluation and treatment plan for the patient's chronic left shoulder dislocation at the May 2008 evaluation, and this should have been done.

[32] The physician did not take a history of the frequency of the patient's asthma symptoms or obtain a peak flow meter reading when he performed his physical examination. The physician did not note that the patient was obese (BMI >32) and develop a plan.

[33] Dr. B performed his history and physical. Under current problems he documented that the patient had asthma but obtained no additional history regarding the frequency of symptoms, night time awakening, and previous medication use. He did not measure peak expiratory flow rates at the time of the physical or reference previous measurements obtained by the nurses.

[34] The clinician did not address the patient's elevated blood pressure upon admission (147/74 mm/hg), pending syphilis result and lack of GC/CL specimen.

[35] The youth had fractured his left great toe in July 2008 that was "untreated" according to the nurse's note. The physician noted the fracture but did not inquire about residual pain or examine the patient's foot. On 10/26/08 the youth submitted a HSR complaining of pain in his foot. He requested a blue slip so he could continue to wear sandals. Dr B. ordered an x-ray of the foot that showed subacute fractures of the proximal and distal phalanx of the great toe each with progression of healing and visible fracture lines. The physician saw the patient for follow-up on 10/30/08.

[36] Dr. B did not address the patient's history of TB infection, and specifically note the absence of fever, cough, weight loss, etc. and previous treatment with preventive therapy.

[37] The patient's blood pressure upon arrival was 153/83 mm/hg, this was not noted by the physician and plans for blood pressure monitoring were not implemented.

[38] The clinician did not note the patient's elevated blood pressure.

[39] The physician did not note the patient's obesity as a problem. This was later added by Dr. Shaw. The patient's hyperlipidemia is not noted on the Problem List.

[40] Discrepant TB skin testing results not noted on the Problem List. Suggest Quantiferon test.

[41] Elevated blood pressure reading not listed on the Problem List.

[42] The clinician did not note that the patient had a recurrent left varicocele.

[43] Chlamydia infection/Risk for sexually transmitted infections.

[44] The clinician did not develop an appropriate treatment plan for the patient's elevated blood pressure, chronic right shoulder dislocation or history of TB infection (i.e., TB disease ruled out, treatment completed and no follow-up indicated).

[45] The physician documented that the patient had no changes from his last physical that was performed on 5/15/08, and did not perform a history and physical. However this is not consistent with policy and there was not an adequate evaluation and treatment plan for the patient's chronic left shoulder dislocation at the May 2008 evaluation, and this should have been done.

[46] Dr. B. did not identify and develop a treatment plan for the patient's obesity and increased glucose level.

[47] No evaluation of current status of asthma symptoms or treatment plan for asthma; which may include no treatment and only patient education.

[48] The clinician performing the history and physical examination did not address the patient's discrepant TB skin test results.

[49] No treatment plan for the patient's elevated blood pressure.

[50] No treatment plan regarding the fractured left toe.

[51] The physician did not document any patient education related to the patient's varicocele.

[52] No plan for blood pressure monitoring. Blood pressure measurements since then have been within normal limits to borderline (130/85 mm/hg).

[53] On 11/25/08 the physician ordered a scrotal ultrasound and made a referral to urology. The ultrasound was completed on 12/23/08 and showed a recurrent left varicocele. The referral to urology has not occurred.

[54] The physician ordered spirometry, but it was not done. No refusals found.

[55] A physician did not see the patient for chronic disease management until 12/23/08, more than 2 months after the patient's arrival. At that visit, the patient's obesity and dyslipidemia were addressed with initial plans to enroll the patient in the Power program to lose weight. A chemical profile was repeated and his fasting glucose was normal.

[56] The patient was enrolled and discharged from the clinic without a documented clinical evaluation for asthma.

[57] 92595.

[58] 92047. This 18 year old transferred to HGSYCF from SYCRCC on 9/9/08. His medical history included hypothyroidism, asthma, bipolar disorder and insomnia. His medications were levothyroxine, Risperdal and Benadryl.

[59] 91327. This 19 year old transferred from PYCF to HGSYCF on 7/29/08. His medical history includes obesity, hypertension, acne, and s/p ruptured appendix and s/p appendectomy in 2003. Upon arrival his medications were Benzoyl Peroxide gel and Cleocin Lotion. On 9/24/08 his blood pressure at a sick call visit was 151/90 mm/gh, 9/25/08 =147/83 mm/hg, 10/1-10/5 BP =125-138/84-86.

[60] 89296. This 23 year old was transferred from SYCRCC to HGSYCF on 11/19/08. His medical history included seizure disorder. On the day of his arrival at HGSYCF he was discharged from the DMH Metropolitan State Hospital where he was evaluated for slowness in responding to others and neurological deficits. His diagnosis was subclinical (possible) temporal cortical seizure for which no treatment was recommended, PTSD and mild mental retardation. Patient was offered and refused Depakene. Dr. Shaw saw him upon his arrival and planned to see the patient in sick call to discuss the consultation and seizure problem. On 12/16/08 Dr. B saw the patient and noted that the patient did not know why he was referred to neurology, denied seizures and stated the medication will not do anything for him. Dr B. prescribed the medication anyway. The patient was not enrolled into the chronic disease clinic.

[61] 91856. This 19 year old transferred from SYCRCC to HGSYCF on 10/16/08. His medical history included migraine headaches, moderate acne, and s/p fasciotomy of the left arm due to compartment syndrome.

[62] 91211.

[63] 89268. This 18 year old transferred to HGSYCF on 11/13/08. His medical history included syncopal and questionable seizures. He was taking Depakote. His November and December MARs show that he is getting his medication daily but his Depakote level is subtherapeutic at 7.3 (therapeutic 50-100).

[64] 91839. This 18 year old transferred from SYCRCC to HGSYCF on 8/19/08. His medical history included anxiety disorders, TB infection and hypothyroidism. His medications included levothyroxine.

[65] 91163. This 17 year old transferred from SYCRCC to HGSYCF on 11/13/08. His medical history includes mild onychomycosis and chest pain after being struck in the chest by a basketball.

[66] 92650. This 18 year old transferred from HGSYCF to SYCRCC on 12/3/08. His medical history includes Obesity and gynecomastia.

[67] The sending facility did not complete the sending portion of the intrasystem transfer form. A HGSYCF staff member completed the lower portion of the form. On the top portion of the form is the statement "SYCRCC supervisor notified". We note that this entry is undated and untimed and is in a different handwriting that the nurse who completed the form or the supervisor who signed the form. Recommend that the staff member who notified the SYCRCC supervisor document the name of the supervisor notified along with a signature, date and time. The medical records reflect that the patient was transferred directly from DMH Metropolitan State Hospital and not SYCRCC.

[68] The nurse did not document a referral to the chronic disease clinic.

[69] The nurse did not document that the patient had a seizure disorder.

[70] Patient was not seen until 11/18/08.

[71] The patient was not evaluated until 12/16/08.

[72] The physician ordered thyroid labs ASAP because of previous labs showing that the patient may be receiving too much thyroid medication. The patient refused the labs twice and was referred to the physician on 8/27/08 for counseling.

[73] The patient missed the 11/13 and 11/14/08 doses of Depakote.

[74] The 11/19/08 discharge instructions form the DMH hospital recommended that the patient be evaluated for medication the first week at the facility. This was not done until 12/16/08. At that time the patient expressed his belief that the medication would not help him. On 12/31/08 Dr. B. wrote an order enrolling the patient in the chronic disease clinic. He had not been seen as of January 15.

[75] 89991. This 21 year old has a history of hypertension and dizziness. Unit I.

[76] 92477. This 19 year old has a history of s/p right ACL repair in October 2008. Unit II.

[77] 89993. This 21 year old has a history of GERD and H. Pylori infection. Unit I.

[78] 90464. This 21 year old has a history of shortened bowel syndrome, GERD and nonspecific chest pain. Unit III.

[79] 91184. This 20 year old has a history of asthma and TB infection. The youth was involved in a physical altercation on 9/18/08.

[80] 83973. This 24 year old had a history of tinea corporis and tinea capitus. Unit III.

[81] 91308. This 21 year old has a history of left shoulder ac separation. Unit III.

[82] 86989. This 24 year old has a history of lactose intolerance. Unit III.

[83] 91566. This 19 year old has a history of obesity and TB infection. Unit II.

[84] 89990. This 22 year old has a history of moderate acne. Unit II.

[85] Form was collected on 9/26/08, triaged and seen on 9/29/08.

[86] The nurse is confused about the difference between subjective and objective information.

[87] Nurse documented that the patient had swelling s/p knee surgery, no pain. Did not document which knee, time frame of surgery (recent or remote).

[88] The history was limited to "I've had a sore throat and hard to swallow' Pain 5/10. No documentation of onset, URI symptoms, etc.

[89] On 11/4/08 he presented with a 4 day history of morning vomiting and abdominal pain. The nurse did not inquire about fever, chills, and diarrhea or assess the severity of pain.

[90] The patient presented with intermittent headaches with pain behind the eyes, pain level 4/10. The nurse did not describe the quality of the pain, associated symptoms (nausea, vomiting, visual aura) or history of head injury.

[91] Nurse indicated it might be an allergic reaction but did not indicate to what (youth had recently been treated with ketoconazole for tinea infections).

[92] The patient complained of a slightly swollen sore on his penis that he thought was a spider bite.

[93] The nurse did not take an appropriate history of onset, quality of pain, radiation, associated symptoms, etc.

[94] Nurse documented that patient reported intermittent testicular pain for approximately a year, pain was 6/10. The nurse did not inquire about which testicle, presence or absence of lesions, dysuria or discharge.

[95] The patient complained of a cold. The nurse documented that the patient sounded nasal and had watery eyes. The nurse did not inquire duration of symptoms, fever, chills, sore throat or cough.

[96] The nurse is confused about the difference between subjective and objective information.

[97] The nurse did not obtain vital signs, describe whether there were any signs of infection or palpate the knee for tenderness.

[98] Physical assessment limited to vital signs and "slight redness noted". Presence or absence of exudates, adenopathy and lung sounds not noted.

[99] Nurse did not obtain vital signs or examine patient's abdomen.

[100] The nurse did not measure vital signs or perform a gross neurological assessment (alert, oriented to person, time and place, etc).

[101] The nurse did not examine the patient.

[102] The nurse performed a gross neurological examination but did not assess the lung and heart sounds.

[103] Nurse did not examine the patient.

[104] The nurse obtained a temperature reading but not full vital signs but did not otherwise examine the patient.

[105] The assessment did not make sense. "Comfort readiness for enhanced resolution of c/o.

[106] The nurse's conclusion was based upon inadequate data.

[107] Nurse documented 'unable to assess, private area'.

[108] The nurse documented “health seeking behavior for relief of symptoms’.

[109] The nurse documented educate and referral for sick call.

[110] The plan was reassurance.

[111] Should have been an urgent referral.

[112] The nurse did not sign or date the form.

[113] The patient was later sent to urology and diagnosed with an epididymal cyst.

[114] 87450

[115] 84425

[116] EO653

[117] 92051

[118] 92051

[119] 92051

[120] 91820

[121] 91582

[122] 91582

[123] 91582

[124] No history related to pain, locking, instability

[125] Patient complaining of chest tightness, wheezing on exam. Treated for possible asthma. MD did not ask about prior history of asthma.

[126] No temperature.

[127] No exam for joint laxity

[128] The patient’s blood pressure was elevated (142/74). This was not addressed.

[129] Follow-up ordered in one week. Not seen until 2 weeks later.

[130] 91743

[131] 91538

[132] 91269

[133] 89684

[134] 92305

[135] 92305

[136] 91549

[137] 91191

[138] 89063

[139] 89934

[140] 91981

[141] 91068

[142] 92305

[143] 92051

[144] 92462

[145] 92462

[146] 90444

[147] 90444

[148] 91743

[149] 91743

[150] MD did not obtain adequate history re: back pain, i.e., severity, radiation, weakness, numbness, bladder or bowel problems, etc.

[151] MD did not obtain appropriate history re: headache, i.e., prior history, intensity, visual symptoms, etc.

[152] MD did not examine abdomen.

[153] MD did not perform adequate back exam, i.e., straight leg raising, reflexes, etc.

[154] MD did not perform adequate examination, i.e., pupils, neurological, etc

[155] MD did not provide appropriate education for back pain.

[156]MD did not provide education for headache.

[157] MD ordered follow-up in one week. Seen by same MD in one week, but did not address ankle pain. Addressed different problem.

[158] MD ordered follow-up in one week. Seen by same MD in one week, but did not address ankle pain. Addressed different problem.

[159] 91327

[160] 89991

[161] 89496

[162] 85197

[163] 89208

[164] 91304

[165] 88688

[166] 92047

[167] 91068

[168] 91743

[169] Patient with hypertension and renal disease. Renal disease not on problem list.

[170] Patient with hypertension. Not on problem list.

[171] Patient with asthma. Not on problem list.

[172] No lipid studies or recent renal function tests, despite history of renal problem

[173] Physician saw patient 1/30/08 and ordered follow-up in 3 months. Not seen until 7/31/08.

[174] Physician saw patient 8/19/08 and ordered follow-up in 3 months. Not seen since 8/19.

[175] Physician did not order laboratory tests.

[176] Andy Jose attended CDCR training in 2008.

[177] April 17, 2008.

[178] July 16, 2008.

[179] October 29, 2008.

[180] Has not yet taken place.

[181] 92047. Order 9/9/08 for levothyroxine.

[182] 92047. Order 9/9/08 for Risperdal and lab tests.

[183] 91327. Order 10/9/08 for Dyazide for 14 days expiring on 10/22/08. He was seen for chronic disease management on 11/14/08 >30 days after his diagnosis was made. His medication order elapsed on 10/22/08 and was not renewed until 10/30/08.

[184] 89296. Order 12/16/08 for Depakene.

[185] 89268. Order 11/13/08. Depakene.

[186] 91839. This 18 year old arrived at HGSCYCF on 8/19/08. His medical history included anxiety disorders, TB infection and hypothyroidism. His medications included levothyroxine. Order 8/19/08.

[187] 88688. This 20 year old has been arrived at HGSYCF in 2006. His medical history includes HIV infection since birth. His current medications are Viread, Videx, Reyataz and Norvir Bactrim. All medications are being given at bedtime with applesauce, including Videx which should be administered on an empty stomach. His most recent CD4 count was 630 on 12/22/08 and previously was 346 on 8/8/08. According to the record the patient's CD4 count has never dropped below 300. Although the consultant has recommended continuation of Bactrim, Pneumocystis prophylaxis is not recommended for CD4 counts > 200. Order 10/28/08.

[188] 87946. This 22 year old arrived at HGSYCF in 2005. His medical history included obesity, hypertension, GERD, asthma, and TB infection. His current medications are Norvasc, Albuterol MDI and QVAR. Order 12/16/08.

[189] 89503. Order 6/24/08.

[190] 89503. Order 12/10/08.

[191] Administration requirements were not addressed. Videx should be taken on an empty stomach, Viread, Reyataz and Norvir should be taken with food.

[192] The patient stated that he never had seizures and did not believe the medication would help him. The diagnosis at DMH was 'subclinical (possible) temporal cortical seizure (no treatment recommended)'.

[193] The physician did not perform a clinical evaluation, only a medication renewal.

[194] The physician wrote the order for Risperdal and Benadryl to be given at hour of sleep. The pharmacy wrote the order to give the medication at 2100.

[195] The physician order states to give the Dyazide once daily. The pharmacy label states to give the medication at bedtime. Diuretics are not typically given at bedtime.

[196] The pharmacy documented 11/14/08 as the order date, but the medication was ordered on 11/13/08.

[197] The pharmacy documented 8/20/08 as the order date, but the medication was ordered on 8/19/08.

[198] The pharmacy added "give with apple sauce" to the order for all medications. However, Videx should be given on an empty stomach. DJJ has responded that the youth will only take his medications with apple sauce. If this is the case, the patient's medication regimen should be changed to one not requiring medications to be taken on an empty stomach. Not taking antiretroviral medication in accordance with the approved administration recommendations may result in subtherapeutic blood levels and lead to viral resistance which is not in the long term interests of the patient.

[199] The medication order was written on 9/9/08 but the levothyroxine was not administered until 9/11/08.

[200] The patient did not receive Depakote doses on 11/13 and 11/14/08.

[201] Documentation shows that the patient received 2 doses on 9/11/08.

[202] No administration status for 10/21/08.

[203] No administration status for 8/28 and 8/29/08.

[204] The pharmacy sent the medication with a label that a nurse placed on the line below the handwritten order. The nurse crossed out the handwritten order and wrote DC, and did not sign it. This order was not discontinued; the nurse intended to show that the all future doses should be documented on the MAR where the pharmacy label is located. In these instances the nurse should document "see order below", not discontinue.

[205] The medication orders on the MAR are crossed out and highlighted as a way to discontinue medications, causing an excessively messy appearance.

[206] The medication orders on the MAR are crossed out and highlighted as a way to discontinue medications, causing an excessively messy appearance.

[207] There is no documentation of three emergency and one disaster drill for the last year.

[208] 85976

[209] 88307

[210] 88307

[211] 87838

[212] 91856

[213] 91068

[214] 90610

[215] 90610

[216] 92268

[217] 92650

[218] Nurse saw patient on 10/14. There is no entry in the log.

[219] Incorrect SOAP format. Subjective information in objective section.

[220] Incorrect SOAP format. Subjective information in objective section.

[221] Incorrect SOAP format. Subjective information in objective section.

[222] Nurse saw patient on 12/8 for abdominal pain (youth had multiple encounters related to this problem.) Nurse did not palpate abdomen for tenderness.

[223] Diabetic patient had hypoglycemic episode on 12/2. Referred to MD next day. MD saw patient for history and physical. Did not address hypoglycemic episode.

[224] Clinician saw patient for follow-up and ordered x-ray and follow-up after x-ray. There is no documentation that either occurred.

[225] Patient with asthma seen by nurse for shortness of breath. Referred to MD for follow-up. Patient not seen for follow-up of this problem – seen for other problem.

[226] The facility needs to develop a functional tracking system for laboratory and x-ray results.

[227] 88275

[228] 83465

[229] 86465

[230] 89290

[231] 89151

[232] 89990

[233] 90267

[234] 87516

[235] 89851

[236] 89054

[237] Nurse checked blood pressure on 11/2/08 when youth fell in shower. BP was 166/81. Youth not referred and there was no follow-up. (Nursing staff was notified of this problem on 1/14 and the youth's BP was re-checked. It was 146/84 and he was referred to the MD for follow-up).

[238] BMI 30, weight not addressed

[239] BMI 32.6, weight not addressed

[240] BMI 28, weight not addressed

[241] BMI 26, weight not addressed

[242] No documentation of hepatitis A vaccine

[243] 85197

[244] 89208

[245] 89684

[246] 88307

[247] 91856

[248] 89181

[249] 92268

[250] 91211

[251] 89268

[252] 91856

[253] Consult dated 9/22. No corresponding progress note.

[254] Cardiology consult ordered 4/16/08 as within one week. Not seen until 9/24/08.

[255] Renal specialist saw the patient on 7/10/08 and recommended a complete metabolic panel and 24-hour urine. The tests were not done. This case was discussed with Dr. Close.

[256] Ophthalmologist saw patient on 10/4 and recommended further studies. They were not ordered or scheduled by facility clinician.

[257] On 8/8/08, physician ordered return to renal specialist. This did not occur. This case was discussed with Dr. Close.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

DIVISION OF JUVENILE JUSTICE

Ventura Youth Correctional Facility
Health Care Audit
December 4-6, 2008

Contents

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 or dental care. The Mental Health and Dental Experts will develop the Mental Health and Dental Audit Instruments.

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 are not being adequately addressed.

We are available to answer questions as well as provide training to staff regarding the audit instrument.

Executive Summary

The Farrell Medical Experts visited Ventura Youth Correctional Facility (VYCF) on December 4-6, 2008. At the time of our visit, the facility population was 248 youth. This included 80 females and 89 males in the main facility and 74 males in the fire camp. There are currently seven living units that include 3 specialized housing units, plus the camp.

We thank Mark Hynum MD, CMO, Superintendent David Finley and staff for their assistance and cooperation during the audit.

Overall, the facility scored 80% (610 of 766) applicable screens and questions). This is compared to 76% at our last visit one year ago. We congratulate staff on their continued progress.

Since our last visit in December 2007, the facility has been challenged by both the budget crisis and threat of closure due to the Plata Receiver's desire to use the facility to construct medical beds in CDCR. The uncertainty over the facility's future has resulted in departure of staff with the prospect of more staff leaving in the near future. Despite these challenges, our review showed a slight improvement in the overall score from a year ago (76%). The increase in the overall score was primarily due to improvements in peer review, quality management, intrasystem transfer, and chronic disease management. Certain information in the report has been updated based on recent comments and clarifications that DJJ presented to the experts in a letter dated March 16, 2009.

However, we were concerned about findings related to the medical reception process and urgent care. These findings include lack of timely identification, treatment and monitoring of medical conditions, including a case of pneumonia that is described under Medical Care findings. This case is illustrative of both clinical and system issues that need to be resolved to provide assurance that among a relatively healthy population, youth with serious medical problems are identified and treated in a timely manner.

Although the facility's internal peer review and quality management program had identified similar problems, this did not result in meaningful corrective action, resulting in similar findings during our review. DJJ has responded that they believe that the medical care provided to this youth was for the most part, timely and appropriate. The experts do not agree with DJJ's response and still have significant concerns regarding the care of this youth. We plan to discuss issue further with the CMO and Statewide Medical Director.

With respect to the possible closure of Ventura Youth Correctional Facility, the medical experts continue to be impressed with the professionalism of the staff and concern for the well-being of the youth under their care. Were DJJ to lose VYCF, we believe it would be a significant obstacle to progress in reforming the agency.

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

Summary of Health Care Areas Reviewed

Facility, Leadership, Budget, Staffing, Orientation and Training scored 100%.

There has been relative stability among the health care leadership positions including the chief medical officer, supervising nurse III and health care administrator. However, the experienced SRN II left in August 2008 because of the uncertainty about the future of Ventura YCF.

With respect to staffing, we note that clinical staffing includes a chief medical officer, full-time physician and nurse practitioner, and physician retired annuitant (from El Paso de Robles) who was providing services several days per week. Including full-time clinicians only (3.0), this is a clinician to youth ratio of 1:83 youth, which is more than adequate clinical staffing. We noted that there were 7 nursing vacancies for 21 budgeted positions. It is unclear to what extent this vacancy rate impacts services given the size of the population. We again note that registered nurses are used to administer medications in specialized housing units, although licensed psychiatric technicians (SPT) staff the units for 16 hours per day and are licensed to perform this function[1].

Due to delays in passage of the state budget, DJJ does not have a known budget at the beginning of the fiscal year. In the interim, the agency projects expenditures based upon the prior year; and these figures are used as the projected budget until one is provided to the agency. During this period VYCF, as with other DJJ facilities, operates through deficit spending. Although this has not interfered with their ability able to purchase health care services, this process results in an inability to make management decisions regarding expenditures against a known budget. Moreover, because future budget projections are based upon the previous year's budget, there is no incentive to be cost effective. Although the statewide budget process is outside of DJJ's direct control, the medical experts believe that this process does not promote a cost effective system, and contributes to the state budget issues. The medical experts would be happy to assist DJJ in exploring ways to improve cost effectiveness for budget matters that are under their control.

The health care administrator indicated that they have been able to execute medical contracts in a timely manner because of the use of emergency contracts and use of addendums. However, the routine process for executing contracts typically takes 6-9 months.

Health care services policies were available. However local policies had not been developed for medication administration, infection control and outpatient housing unit.

Based upon staff interviews and observation, it appears that cooperation between custody and health care staff has improved.

Medical Reception scored 59%.

This score is a decline from the previous score of 69%. The facility is a medical reception for females only. There is a medical reception local policy and procedure. We reviewed a Reception Center Health Screening Log that is to track the completion of all medical reception activities. Staff did not utilize this log to record new arrivals from July until November 2008. During this time staff recorded newly arriving females in the intrasystem transfer log along with males who

transferred into the facility. It is unclear whether the two logs capture all newly arriving youth. Nurses are doing an excellent job conducting the receiving screening process.

However there were significant problems with the quality of the medical history and physical examinations; identification and development of appropriate treatment plans; and completeness of the Problem List. The current history and physical form is complex and does not include space to note the patient's medical problems and corresponding treatment plans. Rather it is structured more like a classification form {i.e., 'cleared for duty').

We understand that staff has been instructed to document treatment plans in the Progress Notes; however, it may be useful to staff to revise this form to permit staff to document the information on the form. In addition, we noted important medical information contained in transfer documentation that was not consistently reviewed and addressed by the clinician. We also found inconsistency with notification of patients regarding laboratory test results. Contributing to this is that a clinician performs the physical examination before blood test results have returned, and even though clinicians write orders to notify the patient of test results, this does not consistently take place. A system needs to be developed to ensure that the notification system is more reliable.

Intrasystem Transfer scored 94%.

Congratulations! We reviewed 10 records of youth who transferred to the facility between March and October 2008.

Nursing Sick Call scored 62%.

Areas requiring improvement include 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 89%.

Even though the facility scored greater than 85%, improvement is needed in the areas of medical follow-up and implementation of the treatment plan.

In addition to the medical records selected for this area, Dr. Goldenson reviewed a record of a patient who had been admitted to the OHU for treatment of pneumonia. Review of this case revealed a number of significant concerns, which will be discussed here. It was not included in the scoring because the issues raised by this case are not sufficiently covered in either the Medical Care or OHU audit tools.

On 11/3/08 in the evening, a nurse saw the patient for complaints of fever, chest congestion, and headache. The nurse noted that his temperature was 101.8° F., with a pulse of 96 beats/minute, respiratory rate of 18 breaths/minute, and blood pressure of 124/64 mm/hg. The nurse contacted the on-call clinician, and the nurse practitioner (NP) ordered an antibiotic (Zithromax) for 5 days. She also gave an order for the patient to be housed in the OHU, but the patient refused to be housed there. The nurse informed the nurse practitioner of the patient's refusal to be house in the OHU, and the NP stated that the patient should be seen the following morning by the physician.

Dr. A saw the patient the next morning. The patient's temperature was 100° F., with a pulse of 100 beats/minute, respiratory rate of 16 breaths/minute, and blood pressure of 119/73 mm/hg. On physical examination, the physician noted that the patient's lungs were clear. His assessment was "viral infection, rule out cocci [coccidiomycosis]." He ordered a chest x-ray and laboratory tests, including a test for coccidiomycosis. The chest x-ray was done that day and revealed findings suggestive of pneumonia. On 11/4/08 the radiologist documented on the x-ray report that he notified the facility of the chest x-ray findings at approximately 4 p.m. On 11/5/08 at approximately 9 a.m. the results were also faxed to the facility. Dr. B did not review the report until approximately 2:25 p.m. that afternoon. He wrote a note in the patient's medical record at that time stating, "Will inform youth and follow-up." However, Dr. B did not see the patient until 11/7/08. At that time, the patient's temperature was 103°, with a pulse of 115 beats/minute, respiratory rate of 20 breaths/minute, and blood pressure of 145/83 mm/hg. Dr. B admitted the patient to the OHU, ordered Augmentin for 10 days and ceftriaxone intramuscularly for 3 days (medications used to treat pneumonia), and fluconazole (a medication used to treat coccidiomycosis).

A repeat chest x-ray was obtained on 11/10. It revealed worsening of the prior findings and new nodular densities. The radiologist noted, "Findings discussed via telephone immediately after dictation of this study. The possibility of TB was brought up in discussion." Dr. B noted in the medical record that the x-ray seemed to be consistent with tuberculosis or coccidiomycosis. He further noted that the patient was clinically improved and had had a negative skin test for tuberculosis in 4/08. Dr. B discharged the patient from the OHU and continued the fluconazole, but discontinued the antibiotics. The patient's skin test for tuberculosis was repeated on 11/12 and was negative. Dr. B saw the patient again on 11/17 and noted that he was clinically better. He further noted that the patient's test for coccidiomycosis was negative and he discontinued the fluconazole. He also ordered a repeat chest x-ray.

The x-ray was obtained on 11/20 and revealed an interval decrease in the infiltrate and nodule noted in the prior study. The radiologist further noted, however, that there were new findings which were "suggestive of an atypical pneumonia including granulomatous disease [including diseases such as tuberculosis, fungal infections, and immune disorders]. Correlate clinically and follow-up for complete resolution." The report was faxed to the facility at 11/21 at 8:45 a.m. Dr. B did not review the results until 11/23. He did not address the new findings noted by radiologist.

Dr. B next saw the patient on 12/1. He noted that the patient was feeling better. He did not note the findings in the most recent x-ray report, but did order a repeat chest x-ray. The x-ray was scheduled to be done on 12/9.

In summary, the following problems are noted with the care provided to this patient:

- The NP ordered antibiotics without examining the patient when contacted by the nurse on 11/3.
- The radiologist documented on the x-ray report that he contacted the facility regarding the chest x-ray findings on 11/4 at approximately 4 p.m. and a faxed copy arrived at the facility at approximately 0900 a.m. on 11/5. The report was not reviewed, however, until approximately 2:30 p.m. on 11/5.
- Dr. B did not evaluate the patient after reviewing the x-ray results on 11/5. In fact, he did not see the patient until two days later.

- Dr. B did not appropriately address the radiologist's concern that the chest x-ray could be consistent with tuberculosis. A negative skin test does not rule out the possibility that a patient may have tuberculosis. This patient should be placed in respiratory isolation until tuberculosis is ruled out.
- Dr. B discontinued the patient's antibiotics prior to completion of an adequate course of therapy.
- The results of the chest x-ray performed on 11/21 were not reviewed until 11/23.
- When Dr. B reviewed the results of the above chest x-ray, he did not address the new findings.

These concerns were discussed with Dr. Hynum, who later notified us that the patient was diagnosed with pulmonary coccidiomycosis and was being treated with fluconazole (note: in up to 15% of patients with coccidiomycosis the initial blood test can be negative. DJJ has responded that they agree with the experts' findings regarding the nurse practitioner ordering without examining the patient and that there was a delay in review of the 11/20/09 chest x-ray report, but continue to defend the care in the case.

Chronic Disease Management scored 84%.

There were 40 youth enrolled in the chronic disease management program. Most of the youth had asthma. There were no youth with diabetes, hypertension or HIV infection. Improvement is needed in frequency of visits, assessment of control, treatment plan, and ordering vaccines.

Infection Control scored 63%.

Areas requiring improvement include provision of training to the infection control nurse, 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 86%.

This is an improvement from the previous score of 77%. Areas requiring improvement include the development of a local policy, compliance with the policy of not crushing medications without a patient specific order, and consistently requiring youth to identify themselves with their ID card or MAR photo.

Medication Administration Health Record review scored 85%.

Remaining areas requiring attention include the timely and accurate transcription of orders and documenting administration status of all doses. If clinicians desire that medications be crushed prior to administration of medication, they should write a specific order for a given patient.

Urgent/Emergent Care scored 61%.

This is a decline from the previous score of 75%. Areas requiring improvement include use of the urgent/emergent tracking log; checking emergency equipment and emergency drills; nursing assessment skills and the timely clinical follow-up of patients with a clinician.

Outpatient Housing Unit

We did not evaluate this area primarily due to its infrequent use; however we note that there is no local policy. In addition, in the previously cited case of pneumonia we noted that the acutely ill youth refused admission to the OHU. Although youth have the right to refuse treatment, they do not have the right to refuse a housing assignment. In our opinion, this youth should have been admitted and monitored in the OHU.

Health Records scored 25%.

There was no local policy, the problem list was often not visible upon opening the chart, and the tracking system for laboratory results and specialty appointments was not up to date.

The medical experts have another concern related to the medical records. While at Ventura, we received a copy of a memo issued by Dr. Morales on November 17, 2008 regarding access to medical records. The memo states, "In an effort to bring the treatment team together, all members of the treatment team [including Youth Correctional Counselors and Officers, Casework Specialists, Treatment Team Supervisors and all other facility staff] will have access to the mental health record." The medical experts strongly believe that, in order to ensure the confidentiality of medical/mental health information, a policy and procedure needs to be developed and implemented that specifies exactly which staff members can have access to the mental health record and which portions of the record they will have access to. The medical experts discussed this with the mental health experts and they agree that a policy and procedure needs to be developed and implemented.

Preventive Services scored 88%.

Even though the facility scored greater than 85%, improvement is needed in addressing youth who are overweight.

Consultations/Specialty Care scored 91%.

Even though the facility scored greater than 85%, improvement is needed in implementation of the consultant's recommendations.

Peer Review scored 100%.

Congratulations!

Credentialing scored 100%.

Congratulations!

Quality Management scored 80%.
Physician and Nursing Supervisor chart reviews were not occurring.

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 III], 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 HCSRP (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			
Question #4	Budgeted and actual physician staffing hours are sufficient to meet policy and procedures requirements, and to provide quality medical services.	1[2]			
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[3]
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	1			
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.	1			
Question #10	Existing staff is trained regarding changes in new policies and procedure within 60 days of distribution.				n/a
	Totals:	6			4

Compliance = 100% (6 of 6 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:				

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[15]	1	1	0[16]	1	1	1	1	0[17]	1
Screen # 2	0[18]	n/a	1	1	1	1	1	1	1	n/a
Screen # 3	1	1	1	1	1	1	1	1	1	1
Screen # 4	0[19]	0[20]	0[21]	1	0[22]	0[23]	1	1	1	1
Screen # 5	0	0	0	1	1	1	1	1	1	0
Screen # 6	0[24]	1	0[25]	0[26]	0[27]	1	1	0[28]	0[29]	0[30]
Screen # 7	1	1	0[31]	0[32]	0[33]	0[34]	0[35]	0[36]	0[37]	1
Screen # 8	0[38]	1	0[39]	1	0[40]	1	1	1	0[41]	0[42]
Screen # 9	0[43]	n/a	n/a	0[44]	1	1	n/a	1	n/a	n/a
Screen # 10	1	n/a	0[45]	0[46]	n/a[47]	n/a[48]	n/a	1	0[49]	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	8	In two cases the nurse did not elaborate on a positive response.
2	10	2	8	7	
3	10	0	10	10	
4	10	0	10	5	
5	10	0	10	6	
6	10	0	10	3	The nurse practitioner does not consistently address all positive findings
7	10	0	10	3	
8	10	0	10	5	
9	10	5	5	3	
10	10	5	5	2	
Total	100	12	88	52	Plus 1 of 2 Questions

Compliance = 59% (53 of 90 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.	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:				

Write the youth's ID number in top row.

State ID# →	**1**[50]	**2**[51]	**3**[52]	**4**[53]	**5**[54]	**6**[55]	**7**[56]	**8**[57]	**9**[58]	**10**[59]
Date of arrival	10/30/08	7/31/08	10/2/08	6/4/08	5/1/08	9/18/08	4/14/08	6/26/08	3/27/08	6/5/08
Screen # 1	1	1	0[60]	1	1[61]	1	1	1	1	1
Screen # 2	1	1	1	1	0[62]	1	1	1	1	1
Screen # 3	n/a	n/a	n/a	1	n/a	n/a	n/a	n/a	n/a	n/a
Screen # 4	1	1	1	0[63]	1	1	1	1	1	1
Screen # 5	1	n/a	1	n/a	1	1	1	n/a	n/a	n/a
Screen # 6	1	n/a	1	n/a	n/a	1	1	n/a	n/a	n/a
Screen # 7	n/a	n/a	1	1	n/a	1	1	n/a	n/a	1

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
Screen #1	10	0	10	9	
Screen #2	10	0	10	9	
Screen #3	10	9	1	1	
Screen #4	10	0	10	9	
Screen #5	10	5	5	5	
Screen #6	10	6	4	4	
Screen #7	10	5	5	5	
Total	**70**	**25**	**45**	**42**	**Plus 2 of 2 Questions**

Compliance = 94% (44 of 47 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			
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.	1			
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[64]	
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:**	8		1	

State ID# →	**1**[65]	**2**[66]	**3**[67]	**4**[68]	**5**[69]	**6**[70]	**7**[71]	**8**[72]	**9**[73]	**10**[74]
Triage Date HSR →	7/7/08	10/27/08	9/24/08	10/12/08	10/13/08	9/26/08	11/10/08	11/23/08	11/24/08	11/8/08
Date NSC →	7/7/08	10/27/08	9/24/08	10/14/08	undated	9/26/08	11/10/08	11/23/08	11/24/08	11/8/08
Complaint	Abdominal pain/Nausea	Ingrown Toenail	Rash Left arm	Ear ache	Chest pain	Back pain	Cough	Cough	Ear pain/HA	Ankle pain
Screen # 1	1	1	1	1	n/e[75]	1	1	1	1	1
Screen # 2	1	1	1	0[76]	0[77]	1	1	1	1	1
Screen # 3	0[78]	0[79]	1	0[80]	0[81]	1	0[82]	0[83]	0[84]	0[85]
Screen # 4	0[86]	0[87]	1	0[88]	0[89]	0[90]	0[91]	0[92]	n/a[93]	1
Screen # 5	1	0[94]	1	0[95]	0[96]	1	0[97]	0[98]	n/a	1
Screen # 6	0[99]	0[100]	1	0[101]	0[102]	1	1[103]	1[104]	n/a	0[105]
Screen # 7	n/a	n/a	1	0[106]	0[107]	n/a	1	0[108]	1	1
Screen # 8	1	1	1	1	0[109]	1	1	1	1	1
Screen # 9	n/a	n/a	1	n/a	n/a	1	1	n/a	1	0[110]

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	9	
Screen #2	10	0	10	8	
Screen #3	10	0	10	2	
Screen #4	10	1	9	2	
Screen #5	10	1	9	4	
Screen #6	10	1	9	4	
Screen #7	10	3	7	4	
Screen #8	10	0	10	9	
Screen #9	10	5	5	4	
Total	90	12	78	46	Plus 8 of 9 Questions

Compliance = 62% (54 of 87 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[111]	2[112]	3[113]	4[114]	5[115]	6[116]	7[117]	8[118]	9[119]	10[120]
Visit date:	7/24	11/21	10/9	11/15	10/5	9/28	10/9	11/30	11/16	11/18
Clinician	A	A	B	C	C	C	B	C	C	C
Nature of visit:	Back pain	Vaginal discharge	Foot pain	Acne	Eye trauma	Folliculitis	Chest pain	Epigastric pain	Elbow infection	Epigastric pain
Screen # 1	1	1	1	1	0[121]	1	0[122]	1	1	1
Screen # 2	1	1	1	n/a	1	n/a	1	1	1	1
Screen # 3	1	1	1	1	0[123]	1	1	1	1	1
Screen # 4	1	1	1	1	n/a	1	1	1	1	1
Screen # 5	1	1	0[124]	1	n/a	1	0[125]	1	1	0[126]
Screen # 6	1	1	1	1	1	1	1	1	1	1
Screen # 7	n/a	n/a	1	n/a	n/a	1	n/a	n/a	1	0[127]

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[128]	12[129]	13[130]	14[131]	15[132]	16[133]	17[134]	18[135]	19[136]	20[137]
Visit date:	11/26	12/1	11/14	8/22	9/8	8/26	11/6	11/24	11/25	11/6
Clinician name:	B	C	C	A	D	A	A	B	A	C
Nature of visit:	Back pain, diarrhea	Chest pain	Sore throat, ankle pain	Heartburn	Knee pain	Chronic headaches	Finger pain	Pain in ears	Back pain	Abdominal 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	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	0[138]	1	0[139]	0[140]
Screen # 6	1	1	1	1	1	1	1	0	1	1
Screen # 7	n/a	1	1	1	0[141]	0[142]	n/a	0[143]	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	20	0	20	18	
Screen #2	20	2	18	18	
Screen #3	20	0	20	19	
Screen #4	20	1	19	19	
Screen #5	20	1	19	13	
Screen #6	20	0	20	19	
Screen #7	20	10	10	6	
Total	140	14	126	112	Plus 1 of 1 Question

Compliance = 89% (113 of 127 Screens +Questions)

Chronic Disease Management

Number of patients enrolled in clinic = 40 **Percent of clinic health records reviewed =25%**

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**[144]	**2**[145]	**3**[146]	**4**[147]	**5**[148]	**6**[149]	**7**[150]	**8**[151]	**9**[152]	**10**[153]
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	1	1	0[154]
Screen # 3	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Screen # 4	1	1	0[155]	0[156]	1	0[157]	0[158]	1	1	1
Screen # 5	1	1	1	1	1	1	1	1	1	1
Screen # 6	1	0[159]	0[160]	1	1	1	1	0[161]	1	1
Screen # 7	1	1	1	1	1	1	1	0[162]	0[163]	0[164]
Screen # 8	1	1	1	1	1	1	1	1	1	1
Screen # 9	1	1	n/a	n/a	n/a	n/a	1	1	1	1
Screen # 10	1	0[165]	0[166]	1	1	1	1	1	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	10	
Screen #2	10	7	3	2	
Screen #3	10	10	0	0	
Screen #4	10	0	10	6	
Screen #5	10	0	10	10	
Screen #6	10	0	10	7	
Screen #7	10	0	10	7	
Screen #8	10	0	10	10	
Screen #9	10	4	6	6	
Screen #10	10	0	10	8	
Total	100	21	79	66	

Compliance = 84% (66 of 79 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[167]	
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[168]		
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). **(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. (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):	**QTR 1**[169]	**QTR 2**[170]	**QTR 3**[171]	**QTR 4**[172]		0		
	a) TB skin testing programs for staff and youth	1[173]	1	0[174]	0[175]				
	b) Exposure control plans and training regarding airborne and blood borne pathogens	1	1	1	1				
	c) Hepatitis B training and vaccination programs (e.g., number of employees trained, number accepting vaccine, and number completing vaccination series)	1	1	0	1				
	d) Staff compliance with work practice controls	0	0	0	0				
	e) Reporting communicable diseases for the previous quarter, noting any trends present	1[176]	0[177]	0[178]	0[179]				
	f) Sanitation reports (institutional and infection control) and any follow-up action taken	1	1	1	1				
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 = 63% (5 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?	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?			0[180]	
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?	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.		0[181]		
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.	N
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

Compliance = 86% (12 of 14 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[182]	2[183]	3[184]	4[185]	5[186]	6[187]	7[188]	8[189]	9[190]	10[191]
Screen # 1	1	1	1	1	1	1	0[192]	1	1	1
Screen # 2	1	1	1	1	1	1	0[193]	1	1	1
Screen # 3	0[194]	1	1	1	1	1	1[195]	1	1	1
Screen # 4	1	0[196]	1	1	1	0[197]	1	1	0[198]	1
Screen # 5	1	0[199]	1	1	1	0[200]	1	1	1	1
Screen # 6	1	1	1	1	1	1	1	1	1	0[201]
Screen # 7	1	0[202]	0[203]	1	1	1	1	1	1	0[204]
Screen # 8	1	n/a	1	1	1	1	n/a	n/a	0[205]	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	9	
Screen #2	10	0	10	9	
Screen #3	10	0	10	9	
Screen #4	10	0	10	7	
Screen #5	10	0	10	8	
Screen #6	10	0	10	9	
Screen #7	10	0	10	7	
Screen #8	10	4	6	5	
Screen #9	10	0	10	10	
Total	90	4	86	73	

Compliance = 85% (73 of 86 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[206]		
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[207]		
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[208]		
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:**	1	3		1

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

State ID# →	1[209]	2[210]	3[211]	4[212]	5[213]	6[214]	7[215]	8[216]	9[217]	10[218]
Screen # 1	0[219]	0[220]	1	1	1	0[221]	0[222]	1	0[223]	1
Screen # 2	1	0[224]	1	1	0[225]	1	1	0[226]	1	0[227]
Screen # 3	1	0[228]	1	1	0[229]	1	1	1	1	0[230]
Screen # 4	1	n/a	1	1	n/a	1	1	1	1	n/a
Screen # 5	1	0[231]	n/a	n/a	0[232]	0[233]	0[234]	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 # 7	n/a	n/a	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	5	
Screen # 2	10	0	10	6	
Screen # 3	10	0	10	7	
Screen # 4	10	3	7	7	
Screen # 5	10	2	8	4	
Screen # 6	10	10	0	0	
Screen # 7	10	10	0	0	
Total	70	25	45	29	Plus 1 of 4 applicable Questions

Compliance = 61% (30 of 49 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.			0[235]	
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.				
	For calculating score, only give credit for applicable questions in substantial compliance. 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					0 of 1 Questions

Compliance = (0 of 1 Questions)

NOTE: Outpatient Housing Unit was not reviewed during this visit except for the local policy.

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[236]	
Question # 2	The Movement and Problem List is visible upon opening the UHR.		0[237]		
Question # 3	There is a functional tracking system for laboratory, diagnostic, and consultation reports.		0[238]		
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:	1	2	1	

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**[239]	**2**[240]	**3**[241]	**4**[242]	**5**[243]	**6**[244]	**7**[245]	**8**[246]	**9**[247]	**10**[248]
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	1	n/a	n/a	n/a	1	1	n/a	1	n/a
Screen # 3	1	1	1	1	1	1	1	1	1	1
Screen # 4	0[249]	1	0[250]	1	0[251]	0[252]	0[253]	1	1	0[254]
Screen # 5	1	1	1	1	1	1	1	1	1	1
Screen # 6	n/a	1	n/a	n/a	1	1	n/a	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	5	5	5	
Screen # 3	10	0	10	10	
Screen # 4	10	0	10	4	
Screen # 5	10	0	10	10	
Screen # 6	10	5	5	5	
Total	60	10	50	44	Plus 1 of 1 Question

Compliance = 88% (45 of 51 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[255]		
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 92483	2 91277	3 91277	4 92193	5 92007	6 91198	7 92274	8 91441	9 92422	10 E0454
Screen # 1	1	1	1	1	1	1	1	1	1	1
Screen # 2	1	1	1	1	1	1	1	0[256]	1	1
Screen # 3	1	1	1	n/a	1	1	1	1	1	1
Screen # 4	1	1	1	1	1	1	1	0[257]	1	1[258]
Screen # 5	n/a	1	1	1	1	n/a	1	n/a	1	1
Screen # 6	1	1	0	1	1	1	1	1	1	1
Screen # 7	1	1	0	1	1	1	1	1	1	1
Screen # 8	0[259]	1	0	1	1	1	1	n/a	1	1
Screen # 9	n/a	1	n/a	n/a	1	n/a	n/a	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	10	
Screen # 2	10	0	10	9	
Screen # 3	10	1	9	9	
Screen # 4	10	0	10	9	
Screen # 5	10	3	7	7	
Screen # 6	10	0	10	9	
Screen # 7	10	0	10	9	
Screen # 8	10	1	9	7	
Screen # 9	10	6	4	4	
Total	90	11	79	73	Plus 2 of 3 Questions

Compliance = 91% (75 of 82 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.	1			
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.	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:	5			

Compliance = 100% (5 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.				n/a[260]
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 PAs 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:	7			2

Compliance = 100% (7 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, 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.				1			
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**	1			
	a) The CAP identified specific improvements needed.	1						
	b) The CAP identified specific staff members responsible for improvements.	1						
	c) The CAP had a targeted completion date.	1						
	d) There was documentation to indicate any recommended training was held.	1						
	e) Follow-up studies were done to determine whether or not corrective actions solved the problem or issue.	1						
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[261]		
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.				1			
For calculating score, only give credit for applicable questions in substantial compliance.				**Totals:**	8	1	1	

Compliance =80% (8 of 10 applicable Questions)

Total Number of Applicable Questions and Screens Evaluated		**= 766**
Total Number of Questions and Screens in Substantial Compliance		**= 610**
Total Score	**÷**	**= 80%**

Endnotes

[1] The court experts understand that the psych technicians are under the clinical supervision of the mental health program and administrative supervision of nursing. To the extent that this does not fully utilize skills that fall under their scope of practice, we find this to be inefficient and a poor use of health care expenditures.

[2] Currently there is a full time nurse practitioner working 4 days a week, a pediatrician works 35 hours per week. Dr. Rodriguez is working as a retired annuitant.

[3] Not fully evaluated during this visit.

[4] Staff reported that there is no written orientation manual for youth.

[5] 92451. This 17 year old arrived at VCYF on 5/20/08 at 1625. Her medical history included asthma, depression with previous suicide attempts, peptic ulcer disease with h. pylori infection. The patient was taking Zyprexa, Albuterol, Advair, Prilosec and Flonase. Upon arrival a nurse documented a thorough admission note including vital signs and visual acuity but did not complete the Receiving screening form which was completed the following day. Only the patient's Zyprexa was renewed the day of arrival and not her asthma medications. The nurse documented that the patient had signs of a communicable disease but did not describe what the signs were. The NP did not address the patient's alleged history of peptic ulcer disease, assess GI symptoms or develop a treatment plan. On 6/29/08 patient complained of stomach pain.

[6] 92536. This 15 year old arrived at VYCF on 8/4/08. Her medical history was unremarkable.

92516. This 18 year old arrived at VYCF on 7/31/08. Her medical history included alcohol and methamphetamine and tobacco abuse; sexual, physical and emotional abuse and depression, PTSD and psychotic disorder. Upon arrival her medications included Depakote, Wellbutrin and Seroquel. Labwork obtained just prior to her arrival show that she had hypercholesterolemia (243) and hypertriglyceridemia (431). This was not reviewed or addressed by the nurse practitioner.

[8] 92555. This 18 year old arrived at VYCF on 10/1/08. Information from the juvenile court indicates that she has a history of abdominal trauma with tenderness all 4 quadrants and abnormal vaginal bleeding. A physician progress note documented the day after arrival indicates that she was hospitalized for fever, vomiting and abdominal pain a month prior to her arrival. The nurse practitioner did not address either the information sent by the juvenile court or the physician's note and the history and physical examination does not address this medical history. ?Diagnosis. Her mediations were Ambien, Cipro, Flagyl Cleocin and birth control pills.

[9] E0676. This 17 year old female arrived on 8/7/08. Her medical history included depression, gastritis and onychomycosis. Her medications included Zantac.

[10] E0704. This 17 year old female arrived on 11/3/08. The patient's medical history included bipolar disorder, PTSD and psychosis and overactive bladder. Upon arrival her medications were Prozac, Seroquel, and Ditropan. Medical information sent from the juvenile court on 11/1/08 indicated that she has a follow-up appointment with urology on 10/28/08 related to overactive bladder. No attempt was made to obtain these medical records. Dr. Rodriquez saw the patient and requested a urology consult in 3 months. Urology consult has not yet been scheduled. This patient's Pap smear was abnormal. The patient's pap was ASCUS and reflexive testing showed the patient had HPV high risk DNA. According to the literature in adults these patients should be immediately referred for colposcopy (see UptoDate). However for adolescents, it is recommended to repeat cytology in 12 months. Currently the plan is to repeat the Pap smear in 3 months.

[11] 92659. This 18 year old arrived at VYCF on 11/4/08. Her medical history includes depression with suicidal ideation, mild acne and amenorrhea due to Depo-Provera. Her medications were Trazodone, Zoloft, Colace and Retin-A.

[12] MD742. This 18 year old arrived at VYCF on 3/5/08. Her medical problems include asthma, depression and allergy to Ibuprofen and seafood. Her medications included Prozac and Benadryl.

[13] MD805. This 16 year old arrived at VYCF on 8/5/08. Her medical history included TB infection, depression with previous suicide attempts, PTSD, and adverse reaction to Isoniazid. Her medications were Prozac and Seroquel.

[14] 88575. This 23 year old arrived at VYCF on 4/22/08. Her medical history included major depressive disorder with paranoid features, bulimia, and substance abuse.

[15] Receiving screening form not completed on the day of arrival, but progress note written.

[16] The nurse did not elaborate on the patient's positive response to "do you have any medical problems?" Patient was hospitalized a month prior to arrival at VYCF.

[17] The nurse did not elaborate upon the patient's positive response to "Do you have any medical problems?"

[18] Only the patient's Zyprexa was renewed on the day of arrival, not the patient's asthma medication or Prilosec.

[19] Youth notified of Pap smear results but not other test results.

[20] No documentation of notification.

[21] Youth notified of chlamydia and GC results but not other test results.

[22] No notification of test results. Incidental finding is that lab reports on 8/7/08 and 9/13/08 indicated that the specimens were not properly labeled.

[23] Patient informed of Pap smear and HIV tests but not of other test results.

[24]The nurse practitioner did not elaborate upon the patients' history of asthma or peptic ulcer disease, treatment of h. pylori infection in May 2008 or assess the patient for GI symptoms.

[25]The nurse practitioner did not elaborate upon the patients' positive review of symptoms (headache and visual problems). The information received upon arrival included lab work showing that she had hypercholesterolemia and hypertriglyceridemia however this was not or addressed or lab tests repeated.

[26] The patient was hospitalized a month prior to arrival for fever, nausea, vomiting and abdominal pain according to a note by Dr. Lowe. Intake information indicated that the patient had abnormal vaginal bleeding. Neither one of these conditions was addressed by the NP. The only history documented is heartburn. The patient's medications upon arrival included Cipro and Flagyl which should have prompted additional history.

[27] On 8/7/08 the NP saw the patient and noted that the patient had a history of gastritis and occasional black tarry stools. Zantac had been ordered for the patient prior to arrival at VYCF but had not yet started the medication. The NP planned to start the Zantac and perform her physical examination in 7 days. On 8/14/08 the NP performed the patient's physical examination but did not take any further history of the complaint, inquire about GI symptoms, perform a rectal examination or order fecal occult blood testing.

[28] The patient gave a history of asthma but the nurse practitioner did not obtain any history regarding her frequency of symptoms. Information from the juvenile court indicated that she had not used an inhaler for 5 years and that she had a history of kidney stones. This was not explored by the NP.

[29] The NP did not describe the patient's history of TB infection with unspecified duration of treatment with Isoniazid (INH). The patient apparently had an adverse reaction to INH but this was also not described.

[30] The nurse practitioner did not address the patient's history of bulimia.

[31] Patient has hypercholesterolemia. Mental health diagnoses not listed.

[32] Did not include hospitalization for abdominal pain.

[33] The NP did not list gastritis.

[34] Mental health diagnoses not listed.

[35] Patient had a history of head injury with loss of consciousness 3 years prior. Mental health diagnoses not listed.

[36] Allergy to Ibuprofen not listed. History of kidney stones not listed.

[37] The NP did not document the diagnosis of TB infection. Mental health diagnoses are not listed.

[38] Did not address history of peptic ulcer disease and treatment for h. pylori infection.

[39] No treatment of hypercholesterolemia.

[40] The NP did not develop an appropriate plan for the patient's complaints of gastritis and tarry stools. The patient should be evaluated for h. pylori infection.

[41] Chest x-ray not ordered to rule out active TB.

[42] The nurse practitioner did not develop a treatment plan for the patient's history of bulimia, including education, etc.

[43] Stool for h.pylori antigen and fecal occult blood tests x 3 ordered on 5/21/08 not done.

[44] On 10/6/08 the NP requested follow-up visit in 30 days for evaluation of heartburn symptoms. This did not take place.

[45] 9/19/08 order to place in chronic care clinic for minimal scoliosis not done. Probably not indicated.

[46] 10/6/08 request for 30 day follow-up did not occur.

[47] The patient is on chronic medications for gastritis. Needs additional follow-up.

[48] The patient is on chronic medications for an overactive bladder. Needs additional monitoring.

[49] Hepatitis B vaccine ordered but not implemented.

[50] 92483. This 18 year old arrived in DJJ through SYCRCC and transferred to VYCF on 10/30/08. His medical history includes asthma. His medications included Albuterol MDI and Flovent. Upon arrival a nurse completed an intrasystem transfer form.

[51] EO639. This 18 year old transferred from SYCRCC to VYCF on 7/31/08. His medical history includes allergic rhinitis. He was not taking medications.

[52] 92575. This 18 year old transferred from SYCRCC to VYCF on 10/2/08. His medical history includes depression, asthma, allergic rhinitis, asthma, onychomycosis, tinea pedis, nasal polyp and umbilical hernia. His medications are Albuterol MDI and Flovent.

[53] 90010. This 19 year old initially arrived at VYCF in 2004. Her medical history includes bipolar disorder, PTSD and borderline personality. Her current medications include Adderall XR. In May 2008 she was sent to the CTC at YTS for psychological reasons. She transferred to VYCF on 6/4/08. At that time staff completed an intrasystem transfer form. There are no medical progress notes in her record from October 2007 until May 2008. Unclear whether she was paroled during this time or if there is another record.

[54] 92385. This 18 year old male transferred from SYCRCC to VYCF on 5/1/08. His medical history included asthma. His medication was Albuterol MDI.

[55] E0562. This 18 year old male transferred from SYRCC to VYCF on 9/18/08. His medical history included moderate asthma. His medications are Advair and Albuterol.

[56] E0454. This 17 year old male transferred from EPdRYCF to VYCF on 4/14/08. His medical history includes asthma, perforated right tympanic membrane, ADHD and acne. Upon arrival his medications were Albuterol MDI, Flovent and tetracycline.

[57] 92038. This 18 year old transferred from SYCRCC on 6/26/08. His medical history includes obesity, anxiety/panic disorder, onychomycosis, acne and allergy to bee stings. His current medications are Zyprexa, Retin-A, and Lamisil.

[58] 91947. This 19 year old arrived in DJJ through SYCRCC in February 2007 and transferred to DWN in May 2007 and then to HGSYCF in March 2008. He transferred from HGSYCF to VYCF on 3/27/08. His medical history was unremarkable prior to his arrival at VYCF. On April 27/08 his tuberculin skin test was positive. He was negative for symptoms of TB. A 5/01/08 chest x-ray showed ill-defined opacities projecting over the upper lung regions, probably representing part of the overlying soft tissues in the shoulder or chest wall. The radiologist recommended a lateral view to make sure these were not lung infiltrates. The NP initialed the report on 5/1/08. A repeat study in one week was

negative. On 6/29/08 Dr Lowe saw him and started him on Isoniazid 900 mg biweekly for 9 months. Baseline and bimonthly liver function tests are normal. His MARs show he is compliant with his medication until November. Then the MAR is blank. At that time, the youth was at the fire camp; out to fire?

[59] 91886. This 17 year old transferred from HGSYCF to VYCF on 6/5/08. His medical history includes anxiety disorder and allergy to penicillin.

[60] SYCRCC staff did not complete the intrasystem transfer form. No documentation that VYCF notified SYCRCC staff.

[61] SYCRCC did not identify that the patient had asthma.

[62] The receiving nurse did not note the patient had a history of asthma or document a disposition.

[63] Record was not reviewed by medical staff until 6/10/0, 6 days after transfer.

[64] Statewide protocols and training have not been conducted.

[65] 91329. This 20 year old female arrived at VYCF on 4/12/06. Her medical history includes asthma, ADHD. On 7/7/08 the patient submitted an HSR complaining of nausea.

[66] 92536. This 15 year old arrived at VYCF on 8/4/08. Her medical history was unremarkable. On 10/27/08 the patient complained of a painful foot due to an ingrown toenail. The nurse did not assess the patient rather told her that the medical unit no longer trims toenails. The patient returned on 11/21/08 with an infected left big toe and underwent surgical excision of the left ingrown toenail.

[67] 91168. This 19 year old arrived at VYCF on 4/24/08. His medical history is unremarkable. On 9/23/08 he submitted a HSR for complaints of a rash on his arm.

[68] 92365. This 19 year old arrived at VYCF on 5/22/08. His medical history included obesity and onychomycosis. On 10/10/08 he submitted a HSR for complaints of an ear ache. The form was triaged on 10/12/08.

[69] 92001. This 19 year old arrived at VYCF in April 2007. Her medical history included asthma and allergic rhinitis. The patient submitted an undated HSR complaining of chest pains. The form was triaged on 11/13/08. The nurse did not sign the date of the encounter.

[70] 91441. This 21 year old female has been at VYCF since 5/19/08. Her medical history includes an abnormal pap smear. She submitted an HSR on 9/2508 for back pain.

[71] 92241. This 19 year old male arrived at VYCF on 11/19/07. His medical history includes TB infection. His chest x-ray was negative in November 2007. On 11/9/08 he submitted an HSR complaining of weakness and a cough. He submitted a second and third compliant on 11/13 and 11/22/08.

92241. This 19 year old male arrived at VYCF on 11/19/07. His medical history includes TB infection. His chest x-ray was negative in November 2007. On 11/9/08 he submitted an HSR complaining of weakness and a cough. He submitted a second and third compliant on 11/13 and 11/22/08.

[73] 92537. This 18 year old arrived at VYCF on 8/4/08. On 11/23/08 she submitted an HSR complaining of headaches and ear pain.

[74] 92007. This 19 year old male arrived at VYCF on 6/14/07. His medical history includes obesity and fracture of his saphead with ORIF in April 2008.

[75] Youth did not date the form.

[76] The nurse documented at 10/12/08 at 2200 that she was unable to assess the youth to due an emergency in the facility and she referred the youth for evaluation to the morning shift on 10/13/08. The youth was not seen until 10/14/08.

[77] Nurse did not date the encounter.

[78] The nurse did not take a history of the duration of the patient's symptoms, inquire about vomiting.

[79] The nurse did not conduct an assessment of the patient's painful feet.

[80] The nurse did not describe the onset or duration of symptoms, or associated symptoms (upper respiratory symptoms). There was no assessment of pain.

[81] Nurse did not document the onset, character, severity location or radiation of pain.

[82] The nurse did not obtain a history of the cough.

[83] The nurse did not note the patient's history of TB infection. Review of the record shows that the patient has been complaining of a cough since 10/20/08.

[84] The nurse did not document the duration of the symptoms.

[85] The patient complained of ankle pain x 3 weeks. No description of precipitating event or injury. Pain 4 out of 10.

[86] The nurse took vital signs but did not examine the patient.

[87] The nurse did not examine the patient's feet.

[88] The nurse did not obtain vital signs. She examined the external ear but not the internal ear.

[89] The nurse did not auscultate the chest or lungs.

[90] The nurse did not conduct a physical assessment of the patient's back.

[91] The nurse obtained vital signs but did not auscultate the patient's chest.

[92] The nurse did not listen to the patient's chest.

[93] Direct referral to the physician.

[94] The nurse did not document a clinical assessment.

[95] The nurse did not document a nursing diagnosis.

[96] The nurse did not document a nursing diagnosis.

[97] The nurse did not document a nursing diagnosis.

[98] The patient has had a persistent cough for over a month and should be referred.

[99] The nurse attributed the patient's symptoms/behavior to secondary gain to get out of school. That may be true but was not based upon a complete assessment.

[100] The nurse did not document an appropriate plan, only advising the patient that toenail clippers must be obtained from the housing unit.

[101] The nurse should have referred the youth to a clinician for evaluation.

[102] The nurse did not document a plan.

[103] The nurse's plan was referral.

[104] The plan was appropriate for symptomatic measures.

[105] The nurse did not address the patient's pain.

[106] The nurse did not refer the patient to a clinician.

[107] The nurse did not refer the patient to a clinician.

[108] The patient has had a persistent cough for over a month and should be referred.

[109] The nurse did not date the encounter.

[110] The routine referral did not take place. Dr Lowe did see the patient on 11/14/08 but addressed another problem.

[111] 92387.

[112] 92046.

[113] 89864.

[114] 92575

[115] E0639

[116] 92385

[117] 92001

[118] 92366

[119] 92366

[120] 91277

[121] No history related to pain

[122] Inadequate history related to pain, i.e., location, radiation, exacerbating/alleviating factors, accompanying symptoms, i.e., shortness of breath

[123] Did not palpate area for pain, r/o orbital fracture

[124] No follow-up ordered.

[125] No follow-up ordered.

[126] No follow-up ordered.

[127] Stool for h pylori ordered but not done. Dr. Lowe re-ordered test on 11/30

[128] 92193.

[129] 92168.

[130] 92007.

[131] 91627.

[132] 91198.

[133] 91198.

[134] 92038.

[135] 92534.

[136] 92053.

[137] 91299.

[138] No follow-up ordered

[139] No follow-up ordered

[140] No follow-up ordered

[141] Follow-up ordered in one week – did not occur

[142] Ordered Topamax for headaches and follow-up in 2 weeks; Seen 915 – notes patient does not want to take Topamax, but does not address headaches

[143] In plan, MD stated Motrin x 3 days then follow-up, no follow-up in orders and patient not seen

[144] 91866

[145] 90259

[146] 92387

[147] E0454

[148] 92029

[149] 92046

[150] 89864

[151] 92575

[152] 88193

[153] 92451

[154]Initial chronic care visit on 6/6. No history of frequency of attacks, ED visits.

[155] Arrived 3/12/08, chronic care intake not until 10/5/08

[156] Seen 5/16 with follow-up in 3 months, Not seen until 9/28

[157] Seen 7/2 with follow-up ordered in 2 months, not seen until 11/23

[158] Seen in 1/08, not seen again until 7/08

[159] 10/15 visit - awakening every night with asthma symptoms, should be poor, not fair control

[160] Awakening 2 nights/week, should be poor, not fair control

[161] At initial visit, noted uses less than 1 Albuterol/month, no nighttime symptoms and no ETA visits. Stated degree of control fair – should be good.

[162] Added Singulair without clinical indication. This was discussed with Dr. Hynum

[163] On 9/16 ordered Albuterol and QVAR for this new patient with a history of exercise induced asthma. Not clear why MD ordered inhaled steroid before seeing how patient did on Albuterol. On 10/15, saw patient in chronic care clinic and noted that she was coughing in evenings and short of breath with exercise. Using less than 1 Albuterol inhaler/month and no nighttime symptoms. Orders to change QVAR to Advair and to add Singular. Unclear clinical indication for adding Singulair. This was discussed with Dr. Hynum.

[164] MD saw patient on 6/21 for chest pain and shortness of breath after walking for 30 minutes. She had not taken Albuterol prior to walking. MD noted that lungs were clear, PEFR was 360. MD added Singulair to regimen – not clinically indicated. Not clear this was an asthma exacerbation since she was not wheezing (PEFR may have been d/t poor effort) and even if it was, it would be just one exacerbation in one month and she had not used Albuterol prior to walking. This was discussed with Dr. Hynum.

[165] No influenza vaccine this year

[166] No pneumococcal vaccine.

[167] There was no LOP.

[168] There is no designated infection control nurse. A registered nurse was appointed infection control duties May 2008. However in July, staffing issues related to the proposed closure of Ventura resulted in diminished focus on infection control duties. The SRN II who had extensive infection control experience left in August resulting in less focus on infection control duties.

[169] January 8, 2008, February 13, 2008, March 11, 2008.

[170] April 8, 2008, May 13, 2008.

[171] August 12, 2008, September 9, 2008.

[172] November 18, 2008.

[173] TB skin testing program should report the number of youth and staff tested, number of positive tests and skin test conversion among staff and youth. This was not covered in the January meeting but was addressed in a February 13, 2008.

[174] No data on TB skin testing for youth and staff.

[175] No data on TB skin testing for youth and staff.

[176] There was no documentation of reportable diseases, MRSA infections, positive culture reports, etc discussed in the January meeting but this was addressed in the February meeting.

[177] No data on communicable disease testing and positivity rates.

[178] No data on communicable disease testing and positivity rates.

[179] No data on communicable disease testing and positivity rates.

[180] No local policy.

[181] We anecdotally noted some MARS that listed the patient's medications to be crushed but there was no order for it.

[182] 90420. Order 10/3/08.

[183] 92451. This 17 year old arrived at VCYF on 5/21/08. Her medical history included asthma, depression with previous suicide attempts and h. pylori infection. Order 5/21/08.

[184] 92038. This 18 year old transferred from SYCRCC on 6/26/08. His medical history includes obesity, anxiety/panic disorder, onychomycosis, acne and allergy to bee stings. His current medications are Zyprexa, Retin-A, and Lamisil.

[185] E0454. Order 9/30/08.

[186] 92451. Order 11/24/08.

[187] 92659. Order 11/10/08.

[188] 90010. This 19 year old initially arrived at VYCF in 2004. Her medical history includes bipolar disorder, PTSD and borderline personality. Her current medications include Adderall XR. Order 9/30/08.

[189] 82281. Order 11/12/08.

[190] E0454. This 17 year old male transferred from EPdRYCF to VYCF on 4/14/08. His medical history includes asthma, perforated right tympanic membrane, ADHD and acne. Upon arrival his medications were Albuterol MDI, Flovent and tetracycline. Order 4/14/08.

[191] E0454. This 17 year old male transferred from EPdRYCF to VYCF on 4/14/08. His medical history includes asthma, perforated right tympanic membrane, ADHD and acne. Upon arrival his medications were Albuterol MDI, Flovent and tetracycline. Order 4/14/08.

[192] This order was a verbal or telephone order that was not documented as such and the nurse who documented the order did not sign the order noting her credentials.

[193] This was a verbal order taken by a nurse that was not cosigned by a physician.

[194] The psychiatrist did not document a progress note for the 10/3/08 order.

[195] Nursing note.

[196] The order was written on 5/21/08 at 1140 and transcribed on 5/21/08 at 1930.

[197] The 11/10/08 order was written at 0930 and transcribed at 1410.

[198] The nurse transcribed the order 8 hours after it was written.

[199] The order was written Prilosec 20 mg now and daily x 60 days. The nurse left off now and there is no documentation that the patient received the medication.

[200] The nurse transcribed the physician order on the MAR to include crushing the Trazodone, but it was not in the physician order.

[201] The nurse did not document administration status from 4/17 until 4/30/08.

[202] No documentation for 5/29/08.

[203] Nurse did not document administration status for throat lozenges. Ward had permission to refuse but spaces left blank.

[204] QVAR not administered to ward until 13 days later on 4/30/08.

[205] The nurse did not correctly document discontinuation of the Advair inhaler by writing D/C on the date the medication was discontinued and initialing/signing the MAR.

[206] Health record review showed that the urgent emergent log did not capture all urgent encounters.

[207] Review of the emergency checklist showed that ER equipment was not checked on each shift since 11/23/08. The log showed that ER equipment was checked only once on 11/25/08, 11/27/08, 2 shifts on 11/24, 11/26, and 12/1/08.

[208]Ventura staff conducted emergency drills on 10/3/08, 10/2/08 and 7/10/08. All drills were conducted on the day shift. , No drills were performed for the 1st and 2nd quarter of the year. The remedial plan requires that “Quarterly medical emergency response training and drills shall be conducted to provide health care staff and custody staff continued training and review of emergency medical response procedures. Drills shall be conducted on various shifts and conditions during the course of a year to allow for a broad based experience.

[209] 91866. 11/27/08.

[210] 92387. 10/20/08.

[211] 92387. 9/17/08.

[212] 92046. 9/6/08.

[213] 92046. 10/12/08.

[214] 91277. 11/9/08.

[215] 92193. 11/14/08.

[216] 92168. 11/30.08

[217] 92038. 1/6/08.

[218] 92038. 9/20/08.

[219] Not in log

[220] Not in log

[221] Not in log

[222] Not in log

[223] Not in log

[224] Not in SOAP format

[225] Subjective information in objective section

[226] Subjective information in objective section

[227] Subjective information in objective section

[228] Inadequate history related to complaint of urinary symptoms, i.e., frequency, abdominal pain, etc.

[229] No history related to pelvic pain

[230] Patient complaining of possible foreign body in eye and numbness in hand. Nurse did not check vision and did not check hand for strength and range of motion

[231] Referred to clinician, did not occur

[232] Referred for follow-up next day, 10/13 – not seen until 10/16

[233] Referred for follow-up 11/11, did not occur; seen 11/18 for different problem

[234] Referred for follow-up on 11/16, did not occur; seen 11/19 for different problem

[235] There is no local OHU policy.

[236] There are no policies and procedures regarding health record management.

[237] Problem list is often covered by medication list.

[238] Consultative note - chronic care forms are not consistently filed in the same area of the chart.

[239] 91441.

[240] 91880.

[241] MD517.

[242] 91604.

[243] 90593.

[244] 91422.

[245] 88521.

[246] 90487.

[247] 91034.

[248] No number recorded.

[249] BMI 32, weight not addressed

[250] BMI 27.1, weight not addressed

[251] BMI 25.6, weight not addressed

[252] BMI 29.3, weight not addressed

[253] BMI 29, weight not addressed

[254] BMI 27.9, weight not addressed

[255] There is a log but it does not track the receipt of the reports.

[256] Lack of adequate history, no history related to past medications

[257] Consult submitted 5/21, seen 10/27

[258] Consultative note - consult submitted as routine for youth with finger fx; should have been an urgent request – despite this, youth was seen in 2 days

[259]

[260] The medical experts have agreed that no local policy is required for the statewide credentialing policy.

[261] Dr Hynum has started reviewing records.