NATIONAL COMMISSION
ON CORRECTIONAL HEALTH CARE

February 23, 2024

Nichole Brown, Superintendent
Coffee Creek Correctional Facility
24499 SW Graham's Ferry Rd
Wilsonville, OR 97070

Dear Superintendent Brown:

The Accreditation and Standards Committee of the National Commission on Correctional Health Care (NCCHC), during its meeting on February 9, 2024, reviewed the accreditation status of the Coffee Creek Correctional Facility in terms of its compliance with the *Standards for Health Services in Prisons*. After considerable deliberation, the Committee voted to place the facility on probation.

The Committee has also directed that focused surveys be conducted to verify compliance. More specifically:

- Coffee Creek Correctional Facility will have a focused survey before June 30, 2024 to verify corrective action and improvement efforts are underway.
- An additional focused survey will occur in approximately 18 months (by July 31, 2025) to monitor continuing compliance with the areas of noncompliance identified during the last survey.
- Focused surveys may be conducted on-site or virtually, depending upon the compliance indicators cited.
- Costs associated with these focused surveys will be billed shortly after the survey is completed.

Although the facility remains accredited, probation is a very serious matter. Failure to appropriately respond to the deficient areas in a timely manner could result in your facility's loss of accreditation. Attached is the accreditation report listing cited standards and recommendations for achieving compliance.

NCCHC staff is prepared to provide you with assistance, if necessary, in maintaining the accreditation for your facility, and welcome your call.

Sincerely,

Amy Panagopoulos, RN, MBA
Vice President, Accreditation

cc: Deborah A. Ross, Chief Executive Officer
Aimee Hughes

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NATIONAL COMMISSION
ON CORRECTIONAL HEALTH CARE

Health Services Accreditation Report

Coffee Creek Correctional Facility
Wilsonville, Oregon

Survey Date: January 10-12, 2024

Report Date: February 9, 2024

Coffee Creek Correctional Facility OR
February 9, 2024

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

Survey Information

On January 10-12, 2024, NCCHC conducted its onsite review for continued accreditation of this facility. We commend the facility staff for their professional conduct, assistance, and candor during the course of our review. The NCCHC's team of experienced certified correctional health professionals utilized NCCHC's 2018 *Standards for Health Services in Prisons* as the basis of its health services analysis. It is most effective when read in conjunction with the *Standards* manual. The information in this report is privileged and confidential and is intended for the sole use of persons addressed.

Essential Standards

There are 39 essential standards, 38 are applicable to this facility and 19 (50%) were found to be in full compliance. One hundred percent (100%) of the applicable essential standards must be met for to achieve accreditation. Listed below are standards that were not compliant, partially compliant, or not applicable.

Standard number and name not compliant:
None

Standard number and name partially compliant:
P-A-01 Access to Care
P-A-02 Responsible Health Authority
P-A-04 Administrative Meetings and Reports
P-A-05 Policies and Procedures
P-A-06 Continuous Quality Improvement Program
P-B-02 Infection Disease Prevention and Control
P-B-03 Clinical Preventive Services
P-C-01 Credentials
P-C-04 Health Training for Correctional Officers
P-C-05 Medication Administration Training
P-D-01 Pharmaceutical Operations
P-D-07 Emergency Services and Response Plan
P-E-04 Initial Health Assessment
P-E-06 Oral Care
P-E-07 Nonemergency Health Care Requests and Services
P-E-09 Continuity, Coordination, and Quality of Care During Incarceration
P-F-01 Patients with Chronic Disease and Other Special Needs
P-F-04 Medically Supervised Withdrawal and Treatment
P-G-02 Segregated Inmates

Standard number and name not applicable:
P-E-03 Transfer Screening

Important Standards

There are 21 important standards; 18 are applicable to this facility and 12 (67%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. If a facility meets or exceeds the 85% threshold of compliance, submission of corrective action is not required. NCCHC encourages facilities to address all important standards that have non-compliance issues. Listed below are standards that were not compliant, partially compliant, or not applicable.

Standard number and name not compliant:
P-B-04 Medical Surveillance of Inmate Workers

Standard number and name partially compliant:
P-A-09 Procedure in the Event of An Inmate Death
P-C-02 Clinical Performance Enhancement
P-C-07 Staffing
P-C-09 Orientation for Health Staff
P-E-08 Nursing Assessment Protocols and Procedures

Standard number and name not applicable:
P-C-08 Health Care Liaison
P-G-06 Medical and Other Research
P-G-07 Executions

Decision: On February 9, 2024 Coffee Creek Correctional Facility was placed on probation. Based on the areas of non-compliance, the facility will undergo a focused survey within the next four months June 30, 2024.

An additional focus survey will occur in approximately 18 months (by July 31, 2025) to monitor continuing compliance with the areas of noncompliance identified during the survey.

FACILITY PROFILE

The facility's security classification is: minimum-medium
The facility was built in: 2001

There have been the following changes in mission or purpose since the last survey: none
Since the last NCCHC survey, there have been the following major renovations/expansions/closures in the facility: none
The following major renovations/expansion/closures in the facility are anticipated: none
The following major renovations/expansion/closures in the facility are anticipated: none

The facility is located in: Northwest region of the US
The facility's supervision style is: direct/indirect
The facility's structural layout is: modular and dormitory

Total Inmate Count on day of survey:	1234
Total number of adult males on day of the survey:	361
Total number of adult females on day of the survey:	873
Average Daily Population (ADP) for last completed calendar year:	1234
The design-rated capacity for the facility is:	1975

There has not been a substantial increase or decrease in the inmate population.
Admissions to the facility arrive: on a scheduled basis

The total number of admissions to the facility last year was:	496
The average daily intake to the facility last year was:	males-15; females-2.5
The total number of custody staff assigned to this facility is:	269

The usual shift coverage for custody staff is: 3 shifts
There has not been a recent change in health care contractor.
Health services are provided by: primarily state employees with some contracted/agency staff
They have provided health services since: inception
There have not been any distinctive events that may affect the delivery of health care. However, facility states that long-term Covid has impacted health care staff requiring significant agency staff to supplement.
The facility has one satellite.

Survey Method

We toured three clinic areas, two infirmaries, numerous inmate housing areas in three buildings, Intake/receiving areas both male and female, special housing units and multiple segregation areas. We reviewed more than 30 health records; policies and procedures; provider licenses; administrative, health staff, and continuous quality improvement (CQI) meeting minutes; job descriptions; and health services personnel and custody training curricula. We interviewed the superintendent and assistant superintendent, responsible physician, health services administrator, health records technician, psychiatrist, one staff physician, three nurse practitioners, two nurse managers, two behavioral health managers, three mental health professionals, two dentists and dental assistant, six nurses including the infection control nurse, a pharmacy technician and pharmacy assistant, 13 custody staff, and 10 inmates selected at random.

Survey Findings and Comments

A. GOVERNANCE AND ADMINISTRATION

Standards in this section address the establishment of a health care system that ensures access to care, professional administration of all aspects of health care, and monitoring and quality improvement policies that effectively process health care issues from identification through resolution.

Standard Specific Findings

P-A-01 Access to Care (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The responsible health authority identifies and eliminates any unreasonable barriers, intentional and unintentional, to inmates receiving health care.		X	
Comments:			
There are barriers and extended delays in obtaining ordered required assessments, diagnostics, and specialty consultations. There are multiple factors that may impact reasonable access to care and should be explored, such as the efficiency of the UR (utilization review) weekly reviews to approve/disapprove outside specialty care. Consultations and most procedures are presented weekly and require unanimous agreement for approval. Additionally, some medication classes that are evidence-based and used in community practice in cardiology, endocrinology, and nephrology, are considered non-formulary and must also be approved by this committee. The process is further compounded by excessive delays of up to six months to schedule any outside appointments once they are approved.			
Corrective action:			
The facility is to submit corrective action to NCCHC for Compliance Indicator #1. The facility should undertake a comprehensive review of the delivery of health services. As described in detail in the report, the current system allows for excessive delays in care. Access to care means that, in a timely manner, a patient can be seen by a clinician, be given a professional clinical judgment, and receive care that is ordered. This standard intends to ensure that inmates have access to care to meet their serious health needs and is the principle on which all NCCHC standards are based. Unreasonable barriers to inmates' access to health services are to be avoided. An example of an unreasonable barrier includes having an understaffed, underfunded, or poorly organized systems with the result that it is not able to deliver appropriate and timely care for patients' serious health needs. The facility should carefully review and improve each step of accessing health care in the facility. The facility is to submit a plan by the RHA describing how the issues with access to care cited in this report will be corrected including any policy and procedure changes and necessary staff training.			

P-A-02 Responsible Health Authority (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The RHA arranges for all levels of health care and ensures quality, accessible, and timely health services for inmates.	X		
2. The RHA's responsibilities are documented in a written agreement, contract, or job description.	X		
3. The RHA must be on-site at least weekly.	X		
4. Final clinical judgments rest with a single, designated, licensed *responsible physician*.	X		
5. Where there is a separate organizational structure for mental health services, there is a *designated mental health clinician*. may be N/A)	N/A		
6. Where there is a separate organizational structure for dental services, there is a *designated dental clinician*. (may be N/A)	X		
7. The responsible physician (and designated mental health clinician and dental clinician, if applicable) is available to the facility frequently enough to fulfill the position's clinical and administrative responsibilities.		X	
8. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

The responsible physician is also the statewide medical director. The facility was unable to provide defined schedules or duties consistent with the required clinical supervision, per the standard, at this site. It was difficult to determine if sufficient time was allotted to provide the necessary oversight and guidance of this intensive multifaceted facility. The responsible physician does not regularly attend meetings such as administrative, staff meetings or CQI. There was no active orientation reported with new medical providers. This resulted in the inability of a provider to see patients for two weeks, particularly given the excessive backlog of patient care. Timely mortality reviews, routine oversight, review minutes, training curricula, protocols, orientation, emergency training etc. was not evident with the exception of signing policies for 2023. A onetime recent chart review of providers was completed. It was stated that communication with the responsible physician was primarily by email and there is no designated medical director in his absence. Organizational charts and FTE staffing allocations were not made available although requested.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #7 and #8. Acceptable documentation and evidence of compliance includes:

- A plan by the RHA that addresses how the responsible physician will be available at the facility frequently enough to fulfill clinical and administrative responsibilities
- Evidence the Responsible Physician is available to the facility frequently enough to fulfill the position's clinical and administrative responsibilities as described in the standards.

Submission of any applicable policy and procedure changes made (with changes highlighted for easy identification by NCCHC staff)

P-A-03 Medical Autonomy (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Clinical decisions are determined by qualified health care professionals and implemented in an effective and safe manner.	X		
2. Administrative decisions are coordinated, if necessary, with clinical needs so that patient care is not jeopardized.	X		
3. *Custody staff* support the implementation of clinical decisions.	X		
4. Health staff recognize and follow security regulations.	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

P-A-04 Administrative Meetings and Reports (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Administrative meetings are attended by the facility administrator and the responsible health authority (RHA) or their designees, and other members of the medical, dental, and mental health and correctional staffs as appropriate.		X	
2. Administrative meetings are held at least quarterly. Minutes or summaries are made and retained for reference, and copies available and reviewed by all appropriate personnel.		X	
3. Health staff meetings occur at least monthly to address pertinent health care issues. Minutes or summaries are made and retained for reference, and copies are available and reviewed by all health staff.		X	

4. Statistical reports of health services are made at least monthly. They are provided to the facility administrator and others as appropriate and are used to monitor trends in the delivery of health care.			X
5. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

There were no documents or minutes for administrative meetings available for the past 3 years. It was stated that there are monthly meetings that include the RHA but the policy is vague and states that the medical team will meet regularly. There are documented staff meetings for 2023 but none for the past two years. The staff meetings do include mental health and dental staff.

No statistics are produced, and routine health care activities are not tracked. There are no statistical reports for all of the three years, which makes it difficult to provide planning or evaluate the needs and resources of the facility. It is anticipated that statistics will be generated from the implementation of the new EMR system, which is due this year.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #1-#5. Acceptable documentation and evidence of compliance includes:

- A plan by the RHA that addresses:
  - How administrative meetings will be conducted and documented in accordance with this standard going forward
  - How monthly health staff meetings will be held and documented in accordance with this standard going forward
  - How statistical reports of health services will be completed at least monthly and provided to the facility administrator in accordance with this standard going forward
- A copy of the minutes of the next administrative meeting held following the date of the survey with evidence of those in attendance (i.e., sign in sheets showing names and titles)
- Submission of a copy of monthly statistical report of health services, with evidence of distribution to the facility administrator and others as appropriate, for two consecutive months
- Submission of the applicable policy and procedure changes made (with changes highlighted for easy identification by NCCHC staff)

P-A-05 Policies and Procedures (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Policies and procedures address each applicable standard in the *Standards for Health Services in Prisons*.	X		
2. Health care policies and procedures are site specific.	X		
3. Health care policies and procedures are reviewed at least annually by the RHA and responsible physician.		X	

4. Documentation of this review includes signatures of the RHA and responsible physician and the date of the review.		X	
5. Health staff review policies and procedures any time they are revised or new policies are introduced.		X	
6. Other policies, such as those for custody, kitchen, industries, and health care vendor or other contractors, do not conflict with health care policies.	X		
7. The manual or compilation is accessible to health staff.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.		X	
Comments:			
There was no documentation of past policy reviews except for 2023. New policies may be signed throughout the year but there was no documented review of policies with health care staff.			
Corrective action:			
The facility is to submit corrective action to NCCHC for Compliance Indicators #3-#5 and #8. Acceptable documentation and evidence of compliance includes: • A plan by the RHA that addresses: o How policies and procedures will be reviewed and approved annually by the RHA and responsible physician, with documentation of the review and approval maintained going forward o How health staff will review new or revised policies going forward			

P-A-06 Continuous Quality Improvement Program (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The responsible health authority establishes a continuous quality improvement program that includes a *quality improvement committee* with representatives from the major program areas. The committee meets as required but no less than quarterly. The committee:			
a. Identifies aspects of health care to be monitored and establishes *thresholds*		X	
b. Designs quality improvement monitoring activities		X	
c. Analyzes the results for factors that may have contributed to below threshold performance		X	
d. Designs and implements improvement strategies to correct the identified health care concern		X	
e. Monitors the performance after implementation of the improvement strategies		X	

2. CQI meeting minutes or summaries are made and retained for reference, and copies are available and reviewed by all appropriate personnel.		X	
3. *Health record reviews* are done under the guidance of the responsible physician or designee to ensure that appropriate care is ordered and implemented and that care is coordinated by all health staff, including medical, dental, mental health, and nursing.		X	
4. Beyond chart reviews, the responsible physician is involved in the CQI process.		X	
5. When the committee identifies a site-specific health care concern from its monitoring, a *process* and/or *outcome quality improvement study* is initiated and documented.	X		
6. At least one process and/or outcome quality improvement study is completed per year.	X		
7. The committee documents a written annual review of the effectiveness of the CQI program by reviewing CQI studies and minutes of CQI, administrative, and/or staff meetings, or other pertinent written materials.			X
8. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

There is CQI documentation for only one year: 2023. It was stated that no prior CQI was done.

The responsible physician does not actively participate in the CQI process; he recently conducted a one-time chart review of providers. There was no signature of review of CQI studies or summaries to indicate that site specific health care concerns are addressed by the responsible physician. An excellent dental CQI was performed which resulted in the addition of more dentists.

No annual reviews were completed for the past three years.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #1 - #4, #7, and #8. Acceptable documentation and evidence of compliance includes:

- A plan by the RHA that addresses:
    - How a quality improvement committee will be established to represent staff from all required disciplines per the standard, meeting no less than quarterly, going forward
    - How health care aspects will be identified for monitoring purposes, including involvement of both process and outcome studies, going forward
    - How thresholds will be established when monitoring health care aspects going forward
    - How CQI study results will be analyzed, reviewing factors that may have contributed to less than threshold performance, going forward

- How improvement strategies will be designed and implemented to correct the identified health care problems going forward
- How continued monitoring of performance will occur when improvement strategies have been implemented going forward
- How health records reviews by the responsible physician will be completed going forward
- What role (explain how this role is included / what do they do in relation to the CQI program) the responsible physician plays in relation to the CQI program
- How the annual review of the effectiveness of the CQI program specific to this facility will be completed going forward

- Evidence of health record reviews being completed (i.e. a copy of the standardized tool template document (a blank form) used to complete these tasks and some form of evidence, like a log sheet of which charts were reviewed)
- A copy of an annual review of the CQI program's effectiveness for 2023, along with evidence of its review during a CQI meeting (i.e., copy of meeting agenda and sign in sheets)

P-A-07 Privacy of Care (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Discussions of protected patient health information and *clinical encounters* are conducted in private.	X		
2. Privacy (e.g., privacy screen, curtain, private area) should be afforded during physical exams, with special considerations for pelvic, rectal, breast, or other genital exams.	X		
3. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

P-A-08 Health Records (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The method of recording entries in the health record and the *health record contents* and format are approved by the responsible health authority (RHA) or designee.	X		
2. If electronic health records are used, procedures address integration of health information in electronic and paper forms.	N/A		

3. Where mental health or dental records are separate from medical records:			
a. A process ensures that pertinent information is shared	N/A		
b. At a minimum, a listing of current problems, allergies, and medications is common to all medical, dental, and mental health records of an inmate	N/A		
4. Evidence exists that the health record is available to health staff and health encounters are documented.	X		
5. Criminal justice information that is pertinent to clinical decisions is available to qualified health care professionals.	X		
6. Health records stored in the facility are maintained under secure conditions separate from correctional records.	X		
7. Access to health records and health information is controlled by the RHA.	X		
8. Evidence exists that health staff receive instruction in maintaining confidentiality.	X		
9. If records are transported by nonhealth staff, the records are sealed.	X		
10. When an inmate is transferred to another correctional facility:			
a. A copy of the current health record or a *comprehensive health summary* accompanies the inmate	X		
b. The transfer and sharing of health records complies with state and federal law	X		
11. There is a system for the reactivation of records when requested by health staff.	X		
12. The jurisdiction's legal requirements regarding records retention and release are followed.	X		
13. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
Health records are entirely manual. Implementation of an electronic medical record was planned to occur later this year. For a system this size, one medical records clerk is not sufficient and manual filing into the record is not timely.			
Corrective action:			
None			

P-A-09 Procedure in the Event of an Inmate Death (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. A *clinical mortality review* is conducted within 30 days.		X	
2. An *administrative review* is conducted in conjunction with custody staff.		X	
3. A *psychological autopsy* is performed on all deaths by suicide within 30 days.	N/A		
4. Treating staff are informed of pertinent findings of all reviews.		X	
5. A log is maintained that includes:			
a. Patient name or identification number	X		
b. Age at time of death			X
c. Date of death	X		
d. Date of clinical mortality review		X	
e. Date of administrative review		X	
f. Cause of death (e.g., hanging, respiratory failure)			X
g. Manner of death (e.g., natural, suicide, homicide, accident)			X
h. Date pertinent findings of review(s) shared with staff			X
i. Date of psychological autopsy, if applicable	N/A		
6. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

Since the last survey there were seven inmate deaths; while the causes of death were not available, we confirmed that none were due to suicide.

The mortality log is deficient in recording required data. There is no grid or routine tracking of deaths. No suicides were indicated but the cause of deaths and other various information was not obtainable. Mortality and administrative reviews were mostly inconsistent, with very scant documentation. No documentation was provided to show evidence that findings from any reviews were shared with treating staff.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #1, #2, #4, #5b,and d-h and #6. Acceptable documentation and evidence of compliance includes:

- A plan by the RHA that addresses:
  - How clinical mortality reviews will be conducted within 30 days on all in custody deaths going forward

- How administrative reviews in conjunction with custody staff will be conducted on all in custody deaths going forward
- How treating staff will be informed of pertinent findings of clinical and administrative reviews going forward
- How a log incorporating all required components of tracking in custody deaths will be appropriately maintained in compliance with the standard going forward

- Submission of any applicable policy and procedure changes made (with changes highlighted for easy identification by NCCHC staff)
- Submission of a copy of a revised log format to be used to track all future in custody deaths.

P-A-10 Grievance Process for Health Care Complaints (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. A grievance process is in place.	X		
2. The grievance policy includes:			
a. A time frame for response	X		
b. The process for appeal	X		
3. Responses to inmate grievances are:			
a. Timely	X		
b. Based on principles of adequate medical care	X		
c. Include documentation of response	X		
4. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

B. HEALTH PROMOTION, SAFETY, AND DISEASE PREVENTION

Standards in this section address the need to optimize education, safety, and preventive care. Policies and procedures related to these standards require involvement by all facility staff.

Standard Specific Findings

P-B-01 Healthy Lifestyle Promotion (I)			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Health staff document that patients receive individual *health education* and instruction in *self-care* for their health conditions.	X		
2. General health education (e.g., pamphlets, news articles, video, classes) is accessible to all inmates.	X		
3. The facility provides a *nutritionally adequate* diet to the general population.	X		
4. A *registered dietitian nutritionist* (RDN), or other licensed qualified nutrition professional, as authorized by state scope of practice laws, documents a review of the regular diet for nutritional adequacy at least annually.	X		
5. The facility has a procedure in place to notify the RDN whenever the regular diet menu is changed.	X		
6. Health staff promote and provide education on exercise and physical activity options in the facility.	X		
7. Smoking is prohibited indoors. If the facility allows smoking outside, specific areas are designated.	X		
8. Information on the health hazards of tobacco is available to inmates.	X		
9. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

P-B-02 Infectious Disease Prevention and Control (E)			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The facility has a written *exposure control plan* that is approved by the responsible physician. The plan is reviewed and updated annually.		X	
2. The responsible health authority ensures that:			
a. Medical, dental, and laboratory equipment and instruments are appropriately cleaned, decontaminated, and sterilized per applicable recommendations and/or regulations	X		
b. Sharps and biohazardous wastes are disposed of properly	X		
c. Surveillance to detect inmates with infectious and communicable disease is effective	X		
d. Inmates with contagious diseases are identified and, if indicated, *medically isolated* in a timely fashion	X		
e. Infected patients receive medically indicated care	X		
3. *Standard precautions* are always used by health staff to minimize the risk of exposure to blood and body fluids.	X		
4. Inmate workers, if used, are trained in appropriate methods for handling and disposing of biohazardous materials and spills.	X		
5. Patients requiring respiratory isolation are housed in a functional negative pressure room.	X		
6. Inmates who are released with communicable or infectious diseases have documented community referrals, as medically indicated.			X
7. The facility completes and files all reports as required by local, state, and federal laws and regulations.			X
8. Effective *ectoparasite* control procedures are used to treat infected inmates and to disinfect bedding and clothing.			
a. Inmates, bedding, and clothing infected with ectoparasites are disinfected.	X		
b. Prescribed treatment considers all conditions (such as pregnancy, open sores, or rashes) and is ordered only by *providers*.	X		

c. If the facility routinely delouses inmates, only over-the-counter medications, such as those containing pyrethrins, are used.	X		
9. An environmental inspection of health services areas is conducted monthly to verify that:			
a. Equipment is inspected and maintained		X	
b. The unit is clean and sanitary		X	
c. Measures are taken to ensure the unit is occupationally and environmentally safe		X	
10. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

There is no annual update or review of the infection control plan, documented with signature and dates by the RHA or responsible physician. It is contained within their full set of policies and procedures.

Inmate workers reportedly handle biohazardous waste; supervision and training is managed by custody.

There are four negative pressure rooms and two positive pressure rooms. The rooms each have a gauge that shows a green light when they are functioning properly. The practice is to notify custody if the green light goes out, which indicates malfunction. We could not determine if proper inspections have been completed other than staff paying attention to the green lights.

There was no documentation to confirm any community referrals are being done or that required reports are filed with the local or state agencies. The infection control nurse indicated that no external reporting is done. He stated that reports are not filed with local or state agencies that require notification and no documentation was available.

Immunizations have been appropriate and timely, and included HPV, Shingrix and others.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #1, #6 - #7, #9 and #10. Acceptable documentation and evidence of compliance includes:

- A plan by the RHA that addresses:
  - How a written exposure control plan will be implemented, and reviewed and approved by the responsible physician, with annual review and approval going forward
  - How all inmates who are released with communicable or infectious diseases have documented community referrals as clinically indicated
  - How the facility will consistently complete, document, and file all reports as required by local, state, and federal laws and regulations
  - How monthly environmental inspections of health services areas will be completed and documented going forward
- Evidence that the exposure control plan has been recently reviewed by the responsible physician

- Evidence of staff training, including course materials (i.e. a copy of the presentation or instructional handouts) and attendance (i.e., sign in sheets showing names and titles of those present) for the following topics:
    - Documenting community referrals, as medically indicated, for patients released with communicable or infectious diseases
    - Procedures for completing and filing of all reports as required by local, state, and federal laws and regulations
- Evidence of two consecutive monthly environmental inspections documenting the items in the standard have been verified as being completed and any concerns requiring further attention or repair have been properly addressed (i.e., a copy of a completed monthly inspection report / checklist used to ensure all areas are being consistently checked each month, copies of maintenance work orders being submitted and completed, evidence item requiring attention has been corrected (i.e., photos if paper documentation is not applicable)
- Submission of any applicable policy and procedure changes made (with changes highlighted for easy identification by NCCHC staff)

P-B-03 Clinical Preventive Services (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The responsible physician determines the medical necessity and/or timing of screenings and other preventive services (e.g., mammograms, colorectal screening, prostate screening, Pap smears).		X	
2. The responsible physician determines the frequency and content of periodic health assessments.		X	
3. The dentist determines the frequency and content of periodic dental evaluations.	X		
4. The responsible physician determines the medical necessity and/or timing of screening for communicable diseases (e.g., HIV, syphilis, gonorrhea, chlamydia), to include laboratory confirmation, treatment, and follow-up as clinically indicated.		X	
5. Immunizations are administered to patients as clinically indicated.	X		
6. All aspects of the standard are addressed by written policy and defined procedures.		X	
Comments:			
A policy makes a vague reference to the standard but there is no identified schedule or guideline for preventive services. Policy references US Preventive Health Care but provides no definitive services, screening, or timelines. Multiple services and appropriate age-related testing and screening such as Well Women examinations (backlog of more than 120 patients) and Pap smear per ACOG guidelines, are			

extremely backlogged. A total of 594 appointments, including annual examinations and appropriate age-related testing and screening, are not being completed or are significantly delayed.

Mammography and colorectal cancer screens are reasonably up to date, although some mammograms are not conducted on a timely schedule. Screening and monitoring by mental health staff, including for psychotropic medications, was timely, based on our review.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #1, #2, #4, and #6. Acceptable documentation and evidence of compliance includes:

- A joint plan by the RHA and responsible physician that addresses:
  - The medical necessity and/or timing of screenings and other preventive services
  - The frequency and content of periodic health assessments
  - The medical necessity and/or timing of screening for communicable diseases, including laboratory confirmation, treatment, and follow-up as clinically indicated
- Submission of any applicable policy and procedure changes made (with changes highlighted for easy identification by NCCHC staff)
- Submission of any applicable clinical protocols regarding the timing of preventive services screenings, other preventive services, periodic health assessments, and screening for communicable diseases (with changes highlighted for easy identification by NCCHC staff)
- Results of the following 30-day CQI studies that evaluate the effectiveness of the corrective action plan for each individual topic, including any additional corrective action that may be identified for follow-up studies (*Note: the CQI study should include a sufficient number of examples to demonstrate compliance with the standard*).
  - Preventive services and screenings being completed
  - Periodic health assessments being completed
  - Communicable disease screenings being completed

P-B-04 Medical Surveillance of Inmate Workers (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. There is an institutional committee or equivalent body that identifies and oversees inmate occupational-associated risks through a *medical surveillance* program			X
2. An initial *medical screening* of an inmate for contraindications to a work program, based on job risk factors and patient condition, is conducted prior to enrollment in the program.			X
3. Ongoing medical screening of inmates in work programs is conducted in a way that affords the same health protections as medical screening of employee workers in equivalent jobs.			X
4. The responsible physician reviews and approves the health aspects of the medical surveillance program.			X

5. Inmate illness or injury potentially related to occupational exposure or with occupational implications is identified and the information provided to the quality improvement committee for review.			X
6. All aspects of the standard are addressed by written policy and defined procedures.			X

Comments:

There is no program in place, although policy states otherwise. Inmates do not receive an initial medical clearance to work in the kitchen and other areas. The only clearance is a classification issued by custody staff. Upon an inmate's request due to injury or other problem, medical staff may conduct a screening to determine if the inmate can continue in the job.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #1 - #6. Acceptable documentation and evidence of compliance includes:

- A plan by the RHA that addresses:
  - How an institutional committee or equivalent body will be created, that identifies and oversees inmate occupational-associated risks through a medical surveillance program going forward
  - How an initial *medical screening* of an inmate for contraindications to a work program, based on job risk factors and patient condition will be conducted and documented in their health record prior to enrollment in the program going forward
  - How ongoing medical screening of inmates in work programs will be conducted in a way that affords the same health protections as medical screening of employee workers in equivalent jobs going forward
  - How the responsible physician will review and approve the health aspects of the medical surveillance program
  - How inmate illnesses or injuries potentially related to occupational exposure or with occupational implications will be identified and the information provided to the quality improvement committee for review going forward
- Evidence a medical surveillance program has been implemented (i.e., copies of CQI meetings where inmate occupational-associated risks, illnesses and injuries have been discussed, as well as sign in sheets showing who was in attendance)
- Evidence the responsible physician has reviewed and approved the health aspects of the medical surveillance program
- Submission of any applicable policy and procedures changes made (with changes highlighted for easy identification by NCCHC staff)

P-B-05 Suicide Prevention and Intervention (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The responsible health authority and facility administrator approve the facility's suicide prevention program.	X		
2. A suicide prevention program includes the following:			

a. Facility staff identify suicidal inmates and immediately initiate precautions.	X		
b. Suicidal inmates are evaluated promptly by the designated health professional, who directs the intervention and ensures follow-up as needed.	X		
c. *Acutely suicidal* inmates are monitored by facility staff via constant observation.	X		
d. *Nonacutely suicidal* inmates are monitored by facility staff at unpredictable intervals with no more than 15 minutes between checks.	X		
3. The use of other inmates in any way (e.g., companions, suicide-prevention aides) is not a substitute for staff supervision.	X		
4. Treatment plans addressing suicidal ideation and its reoccurrence are developed.	X		
5. Patient follow-up occurs as clinically indicated.	X		
6. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

P-B-06 Contraception (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Emergency contraception is available to women at intake.	X		
2. For planned releases to the community, arrangements are made to initiate contraception for women, upon request.	X		
3. Information about contraceptive methods and community resources is available.	X		
4. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

P-B-07 Communication on Patients' Health Needs (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Correctional staff are advised of inmates' special health needs that may affect:			
a. Housing	X		
b. Work assignments	X		
c. Program assignments or selection	X		
d. Disciplinary measures	X		
e. Transport to and from outside appointments	X		
f. Admissions to and transfers from facilities	X		
g. Clothing or appearance	X		
h. Activities of daily living	X		
2. Communication of health needs is documented.	X		
3. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
Two additional meetings are held regularly to discuss case management of special needs inmates; these meetings are attended by health care, behavioral health and custody staff.			
Corrective action:			
None			

P-B-08 Patient Safety (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Facility staff implement *patient safety systems* to prevent *adverse* and *near-miss* clinical events.	X		
2. The responsible health authority (RHA) implements a reporting system for health staff to voluntarily report, in a nonpunitive environment, adverse and near-miss events that affect patient safety.	X		
3. All aspects of the standard are addressed by written policy and defined procedures.	X		

Comments:
The RHA has recently implemented an improved process (based on CQI efforts) that tracks any medication errors and works with staff to encourage disclosure in order to retrain if necessary.
Corrective action:
None

P-B-09 Staff Safety (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Methods of communication (e.g., radio, panic button, voice proximity) between health staff and custody staff are available.	X		
2. When a safety concern arises, custody staff are requested and readily available to health staff.	X		
3. On each shift where health staff are present, inventories are maintained on items subject to abuse (e.g., needles, scissors, other sharp instruments) and discrepancies are immediately reported to the custody staff.	X		
4. As in the community, health staff identify and use contemporary equipment during the course of their duties (e.g., personal protective equipment, needle safety devices such as self-sheathing needles or needleless systems).	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

C. PERSONNEL AND TRAINING

Standards in this section ensure that appropriately trained personnel are in place to deliver health care to the inmate population and that qualified health care professionals are evaluated for continuing competency.

Standard Specific Findings

P-C-01 Credentials (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. All qualified health care professionals have credentials and provide services consistent with the licensure, certification, and registration requirements of the jurisdiction.	X		
2. The responsible health authority (RHA) ensures that new hires undergo a credential verification process that confirms current licensure, certification, or registration.	X		
3. The credential verification process includes inquiry regarding sanctions or disciplinary actions of state boards and, for *prescribers*, the National Practitioner Data Bank (NPDB).			X
4. Qualified health care professionals do not perform tasks beyond those permitted by their credentials.	X		
5. The RHA maintains verification of current credentials for all qualified health care professionals at a readily accessible location.	X		
6. A license that limits practice to only correctional health care is not in compliance with this standard.	X		
7. Specialists providing on-site or telehealth care services have appropriate licenses and certifications on file.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.		X	
Comments:			
We reviewed the licenses for both medical and behavioral health staff. However, there was no evidence of NPDB inquiries.			
Corrective action:			
The facility is to submit corrective action to NCCHC for Compliance Indicators #3 and #8. Acceptable documentation and evidence of compliance includes: • A plan by the RHA that addresses how the credentialing process will include inquiries with the NPDB for all prescribers going forward • Evidence of NPDB inquiry being completed for all current prescribers (including nurse practitioners, physician assistants, physicians, dentists, and optometrists)			

- *Note – please do not submit the actual NPDB report, merely the NPDB provided receipt notification a report was run on the applicable prescriber(s). A memo on your / facility letterhead is not sufficient, as verification of evidence must be generated from the NPDB account in which the inquiry was requested.*

P-C-02 Clinical Performance Enhancement (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Clinical performance enhancement reviews are conducted, at a minimum, on all full-time, part-time, or per diem:			
a. Providers		X	
b. RNs		X	
c. LPNs		X	
d. Psychologists	N/A		
e. Licensed clinical social workers	X		
f. Dentists	X		
2. The clinical performance enhancement review is conducted annually.		X	
3. Clinical performance enhancement reviews are kept confidential and incorporate at least the following elements:			
a. The name and credentials of the individual being reviewed	X		
b. The date of the review	X		
c. The name and credentials of the reviewer	X		
d. A summary of the findings and corrective action, if any	X		
e. Confirmation that the review was shared with the individual being reviewed		X	
4. A log or other written record listing the names of the individuals reviewed and the dates of their most recent reviews is available.		X	
5. The responsible health authority (RHA) implements an *independent review* when there is concern about any individual's competence.		X	
6. The RHA implements procedures to improve an individual's competence when such action is necessary.		X	

7. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

Documentation was available indicating that behavioral health provided clinical performance enhancement reviews in 2023, except for their six psychiatric nurse practitioners. Medical recently completed clinical performance enhancement reviews for four providers, although only two had been reviewed with the provider as of the time of the survey. There was no evidence of review in 2021 and 2022. Nurses had no clinical performance enhancement reviews available for any years in the survey cycle.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #1a-c, #2, #3e, #4 - #7. Acceptable documentation and evidence of compliance includes:

- A plan by the RHA that addresses:
    - How annual clinical performance enhancement reviews will be conducted on all full-time, part-time, or per diem Providers, RNs, LPNs, and psychiatric nurse practitioners going forward
    - How all clinical performance enhancement reviews will be documented going forward to include at least the following information:
        - The name and credentials of the individual being reviewed
        - The date of the review
        - The name and credentials of the reviewer
        - A summary of the findings and corrective action, if any
        - Confirmation the review was shared with the individual being reviewed
    - How a log or other written record listing the names of the individuals reviewed and the dates of their most recent review will be maintained going forward
    - How the RHA will implement an independent review when there is concern about any individual's competence when necessary going forward
    - How the RHA will implement procedures to improve an individual's competence when such action is necessary
- Submission of any applicable policy and procedure changes made (with any changes made highlighted for reference by NCCHC staff)
- A log or other written record providing evidence of:
    - The names of the providers, RNs, LPNs, and dentist
    - The dates of their most recent annual clinical performance enhancement reviews
    - The name and credential of the reviewer
    - Confirmation the review was shared with the individual being reviewed
- Evidence of any independent reviews that may be implemented as a result concern of an individual's competence.
- Evidence of steps taken to for any procedures implemented to improve and individual's competence when necessary.

P-C-03 Professional Development (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. All qualified health care professionals obtain at least 12 hours of continuing education per year or have proof of a valid license in states where continuing education is required for licensure.	X		
2. The responsible health authority (RHA) documents compliance with continuing education requirements.	X		
3. The RHA maintains a list of the state's continuing education requirements for each category of licensure of all qualified health care professionals.	X		
4. All qualified health care professionals who have patient contact are current in cardiopulmonary resuscitation technique.	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

P-C-04 Health Training for Correctional Officers (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. A training program is established and approved by the responsible health authority in cooperation with the facility administrator.	X		
2. An outline of the training, including course content and length, is kept on file.		X	
3. Correctional officers who work with inmates receive health-related training at least every 2 years. This training includes, at a minimum:			
a. Administration of first aid		X	
b. Cardiopulmonary resuscitation including the use of an automated external defibrillator		X	

c. Acute manifestations of certain chronic illnesses (e.g., asthma, seizures, diabetes)		X	
d. Intoxication and withdrawal		X	
e. Adverse reactions to medications		X	
f. Signs and symptoms of mental illness		X	
g. Dental emergencies		X	
h. Procedures for suicide prevention		X	
i. Procedures for appropriate referral of inmates with medical, dental, and mental health complaints to health staff		X	
j. Precautions and procedures with respect to infectious and communicable diseases		X	
k. Maintaining patient confidentiality		X	
4. A certificate or other evidence of attendance is kept on-site for each employee.			X
5. While it is expected that 100% of the correctional staff who work with inmates are trained in all of these areas, compliance with the standard requires that at least 75% of the staff present on each shift are current in their health-related training.			X
6. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

It is evident that officers have received training; certain topics such as suicide prevention and PREA are offered annually. The officers we interviewed were knowledgeable and supportive of health care efforts.

However, there was no documentation, electronic tracking or manual logs provided to substantiate that officers receive this training including any documentation of CPR and first aid.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #2 - #6. Acceptable documentation and evidence of compliance includes:

- A joint plan by the RHA and Facility Administrator that addresses how all required health-related training will be conducted and documented at least every 2 years
- An outline of the courses, including documentation reporting all topics required in Compliance Indicator #3
- Certificates or other evidence of training attendance for each of the above-mentioned topics, documenting at least 75% of correctional staff on each shift who work with inmates. *Note: This documentation must include a complete listing of correctional officers assigned to each shift, so that cross-referencing the completed training will verify the 75% on each shift threshold requirement.*

P-C-05 Medication Administration Training (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Correctional or health staff who administer or deliver prescription medication to inmates must be permitted by state law to do so.	X		
2. Staff who administer or deliver prescription medications are trained in matters of:			
a. Security		X	
b. Accountability		X	
c. Common side effects		X	
d. Documentation of administration of medicines		X	
3. The training is approved by the responsible physician or designee and facility administrator or designee.		X	
4. Documentation of completed training and testing is kept on file for staff who administer or deliver medications.		X	
5. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

Certified medication aides are utilized along with nurses. Many of the nurses (approximately 20%) are agency nurses. We could not verify medication administration training for either permanent or agency staff. Training documentation was very sporadic and not systematically filed.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #2 - #5. Acceptable documentation and evidence of compliance includes:

- A plan by the RHA that addresses:
  - How all staff who administer or deliver prescription medications will have documented training incorporating all required elements in compliance indicator #2 going forward
  - How the medication administration will be approved by the responsible physician or designee and facility administrator
- Evidence of medication administration training compliant with the standard has been completed, including a copy of the medication administration training course description that covers security, accountability, common side effects, and documentation of administration of medicines, and proof of completed training (i.e., sign in sheets)
- Evidence the medication administration training has been approved by the responsible physician and facility administrator, or their designees.

P-C-06 Inmate Workers (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Inmates do not make treatment decisions or provide patient care.	X		
2. Inmates are not substitutes for health staff, but may be involved in appropriate peer health-related programs or *reentry health care training programs*.	X		
3. Other than those in a reentry health care training program, inmates are not permitted to:			
a. Distribute or collect sick-call slips	X		
b. Schedule appointments	X		
c. Transport or view health records	X		
d. Handle or administer medications	X		
e. Handle surgical instruments and sharps	X		
4. Inmates in peer-health related programs are permitted to:			
a. Assist patients in *activities of daily living* (except for infirmary-level care patients)	X		
b. Participate in a buddy system for nonacutely suicidal inmates after documented training	X		
c. Participate in hospice programs after documented training (see F-07 Care for the Terminally Ill)	X		
5. Patients have the right to refuse care delivered by inmates who are in a reentry health care training program (e.g., dental assistant, nursing assistant).	N/A		
6. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
There was no hospice patient on site at the time of the survey; however, there is a training program for inmates to assist within acceptable roles and duties.			
Corrective action:			
None			

P-C-07 Staffing (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The RHA approves the staffing plan.			X
2. Prescriber and nursing time must be sufficient to fulfill clinical responsibilities.	X		
3. Responsible physician time must be sufficient to fulfill administrative responsibilities.		X	
4. A documented plan is in place for custody staff to follow when a health situation arises and health staff are not present.		X	
5. The adequacy and effectiveness of the staffing plan are assessed by the facility's ability to meet the health needs of the inmate population.		X	
6. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

Staffing below is based on verbally reported positions and FTEs were not available. There was no formal staffing plan for us to review and confirm accuracy. The RHA stated she could not obtain a formal staffing plan or FTE allotment and possibly, one does not exist.

The facility significantly relies on agency nursing; we also noted significant staff transition, including replacement of several RHAs. Due to the extreme backlogs for patient care in many areas, an overall medical staffing review is needed. Nursing coverage is mostly 24 hours a day, seven days a week for two areas, and behavioral health care is provided during daytime only (and supplemented with on-call). Similar to having no official staffing plan for medical staff, there was not any evidence of a written behavioral health staffing plan provided to us.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #1 and #3-#6. Acceptable documentation and evidence of compliance includes:

- A joint plan by the RHA and Facility Administrator that addresses:
    - A review of the current staffing plan and identification of what strategies will be taken to address a more adequate representation of health services available at the facility, including:
        - A short-term staffing plan to immediately address lack of health staff coverage to ensure health care is offered and being made available to the patient population at the facility
        - A long-term staffing plan to address lack of health staff coverage to ensure health care is offered and being made available to the patient population
    - A review of the current staffing plan and identification of what strategies will be taken to address a more adequate representation of health services available at the facility, including:

- A short-term staffing plan to immediately address the health care needs of the patient population, providing necessary staffing adjustments needed to ensure health care is offered and being made available to the patient population at the facility, specifically focusing on any backlog of patient care needs within the facility
- A long-term staffing plan to address the lack of assigned health staff coverage of the current staffing plan, ensuring adequate health care is offered and being made available to the patient population and their health care needs

- Evidence of the plan's implementation (i.e., proof of any job posting, hiring, staffing plan changes made)

When writing the plan, below are some items to consider:
The RHA could review health care processes and services, identifying staffing assigned to each task to ensure patient care needs are being addressed timely. This could include a review of health assessments, mental health assessment, oral screenings, sick call, doctor call, etc., identify and address cross-training needs that may be warranted to ensure care is provided in a safe/timely manner, create a task/assignment matrix illustrating how tasks will be accomplished with the current staffing plan. The creation of this plan may require working with custody staff to ensure adequate availability for the inmate population.

Staffing Plan

Number of On-Site Health Staff (Full-Time Equivalents) *Someone working a regular 40 hour week is considered 1.0 FTE. To calculate FTEs, take the total number of hours by employee category and divide by 40 (or the jurisdiction's equivalent of a full-time workweek). For example, someone working 16 hours would be a .40 FTE (16/40 = .40); 5 part-time LPNs working a total of 60 hours would be 1/5 FTE (60/40 = 1.5).*

Employee Category	Main Unit	Satellites		Vacant
		1	2	
Administrator (HSA)	1			
Administrative Assistant	1			
Physician	1			
Psych Nurse Practitioner	3			1
Nurse Managers	2			
Registered Nurse	29			9
Licensed Practical Nurse				5
Psychiatrist	1			
Psychologist				1
Mental Health Worker	10			2
Health Records Personnel	1			
CMA	9			1
Office staff	5			1
Psychiatric office staff	4			
Behavioral Health Managers	2			

P-C-08 Health Care Liaison (I).			
X NOT APPLICABLE	*The compliance indicator is:*		
	Fully Met	**Partially Met**	**Not Met**
1. A designated, trained *health care liaison* coordinates health services delivery in the facility and satellite(s) on days when no qualified health care professionals are on-site for a continuous 24-hour period.	N/A		
2. The health care liaison is instructed in the role and responsibilities by the responsible physician or designee.	N/A		
3. The health care liaison should have a plan that includes contact information for the on-call health staff, ambulance, and other emergency community contacts.	N/A		
4. The health care liaison receives instruction in reviewing patient information.	N/A		
5. The health care liaison maintains confidentiality of patient information.	N/A		
6. Duties assigned to the health care liaison post are appropriately carried out.	N/A		
7. All aspects of the standard are addressed by written policy and defined procedures.	N/A		
Comments:			
The facility does not require a health care liaison			
Corrective action:			
None			

P-C-09 Orientation for Health Staff (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The orientation program is approved by the responsible health authority and the facility administrator.			X
2. The orientation lesson plan is reviewed annually or more frequently, as needed.			X
3. All health staff receive a *basic orientation* on or before the first day of on-site service.	X		
4. Within 90 days of employment, all health staff complete an *in-depth orientation*.		X	

5. Completion of the orientation program is documented and kept on file.		X	
6. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

We could not verify that all new employees received an orientation. There was no evidence that the plan had been reviewed and approved, nor a formalized orientation package with a checklist and signed dates of completion. We did review an outdated blank manual, we could not determine if a formal process was in place for all new hires, of which there were many. Nor did new provider hires have a formal plan, organized goals, or documented orientation.

There was no documentation or tracking available such as checklists, new employee signatures and dates or supervisor signatures to document that orientation was provided.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #1, #2 and #4-#6. Acceptable documentation and evidence of compliance includes:

- A plan by the RHA that addresses:
  - How the orientation lesson plan will be developed and then reviewed annually or more frequently, and approved by the RHA and facility administrator going forward
  - How the in-depth orientation will be documented and kept on file for all current and new hires going forward
- Evidence the orientation program has been approved by the responsible physician and facility administrator
- Evidence of completion of the in-depth orientation program for any new hires within the last 6 months of the date of this report (i.e., copies of an orientation checklist used to track all orientation components)

D. ANCILLARY HEALTH CARE SERVICES

Standards in this section address the establishment and maintenance of all necessary procedures for the provision of ancillary health care services.

Standard Specific Findings

P-D-01 Pharmaceutical Operations (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The facility complies with all applicable state and federal regulations regarding prescribing, *dispensing*, *administering*, *procuring,* and *disposing* of pharmaceuticals.		X	
2. The facility maintains procedures for the timely procurement, dispensing, *distribution*, *accounting*, and disposal of pharmaceuticals.	X		

3. The facility maintains records as necessary to ensure adequate control and accountability for all medications, except those that may be purchased over the counter.	X		
4. The facility maintains maximum security storage of, and accountability by use for, Drug Enforcement Agency *(DEA)-controlled substances*.	X		
5. Drug storage and medication areas are devoid of outdated, discontinued, or recalled medications, except in a designated area for disposal.	X		
6. A staff or consulting pharmacist documents inspections and consultations of all sites, including satellites, at least quarterly.	X		
7. All medications are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.	X		
8. Antiseptics, other medications for external use, and disinfectants are stored separately from internal and injectable medications. Medications requiring special storage (e.g., refrigeration) for stability are so stored.	X		
9. An adequate and proper supply of antidotes and other emergency medications (e.g., naloxone, epinephrine) and related information are readily available to the staff.	X		
10. The poison control telephone number is posted in areas where overdoses or toxicologic emergencies are likely.	X		
11. All aspects of the standard are addressed by written policy and defined procedures.	X		

Comments:

Designated prescription medications are included in the nursing assessment protocols, reportedly in accordance with state laws (medications such as antibiotics, Prilosec, Septra, Zofran, Naprosyn Pyridium, and others). Evidence this practice of standing orders being allowable under state law was not provided. The physician reviews and signs them the next business day.

The KOP (keep-on-person) program is liberal, and allows some psychotropic medications as well as antibiotics, etc. Pharmacy audits were well documented for the past three years.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicator #1. Acceptable documentation and evidence of compliance includes:

- A plan by the RHA that addresses:
    - How the RHA will ensure current practices for medication preparation and pass are appropriate to the allowable scope of practice authorized within the state
    - How the facility will comply with all applicable state and federal regulations regarding *dispensing and administering* pharmaceuticals going forward

- Submission of evidence (i.e., from state nursing and/or pharmacy regulatory authority) authorizing the use of standing orders
- Submission of any applicable policy and procedure changes made (with changes highlighted for easy identification by NCCHC staff)

P-D-02 Medication Services (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Medications are administered or delivered to the patient in a timely and safe manner.	X		
2. Prescription medications are given only by order of a physician, dentist, or other legally authorized individual.	X		
3. A policy identifies the expected time frames from ordering to administration or delivery to the patient and a backup plan if the time frames cannot be met.	X		
4. The responsible physician determines prescribing practices in the facility.	X		
5. If the facility maintains a *formulary*, there should be a documented process for obtaining nonformulary medications in a timely manner.	X		
6. Medications are prescribed only when clinically indicated.	X		
7. Medications are kept under the control of appropriate staff members, except for *self-medication programs* approved by the facility administrator and responsible physician.	X		
8. Inmates are permitted to carry medications necessary for the emergency management of a condition when ordered by a prescriber.	X		
9. Inmates entering the facility on verifiable prescription medication continue to receive the medication in a timely fashion, or justification for an alternate treatment plan is documented.	X		
10. The ordering prescriber is notified of the impending expiration of an order so that the prescriber can determine whether the drug administration is to be continued or altered.	X		
11. All aspects of the standard are addressed by written policy and defined procedures.	X		

Comments:
None
Corrective action:
None

P-D-03 Clinic Space, Equipment, and Supplies (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Examination and treatment rooms for medical, dental, and mental health care are available and equipped to meet the needs of the patient population.	X		
2. Pharmaceuticals, medical supplies, and mobile emergency equipment are available and checked in accordance with policy.	X		
3. There is adequate office space with administrative files, secure storage of health records, and writing desks.	X		
4. When laboratory, radiological, or other ancillary services are provided on-site, the designated area is adequate to hold equipment and records.	X		
5. When patients are placed in a waiting area for more than a brief period, the waiting area has seats and access to drinking water and toilets.	X		
6. The facility has, at a minimum, the following equipment, supplies, and materials for the examination and treatment of patients:			
a. Hand-washing facilities or alternate means of hand sanitization	X		
b. Examination table	X		
c. A light capable of providing direct illumination	X		
d. Scale	X		
e. Thermometers	X		
f. Blood pressure monitoring equipment	X		
g. Stethoscope	X		
h. Ophthalmoscope	X		
i. Otoscope	X		
j. Transportation equipment (e.g., wheelchair, stretcher)	X		

k. Trash containers for biohazardous materials and sharps	X		
l. Sterilizer for non-disposable medical or dental equipment	X		
m. Appropriate space, equipment, and supplies for pelvic examinations if the facility houses females.	X		
n. Oxygen	X		
o. Automated external defibrillator	X		
p. Pulse oximeter	X		
q. Personal protective equipment (e.g., gloves, eye protection, gowns, masks)	X		
7. Basic equipment required for on-site dental examinations includes, at a minimum:			
a. Hand-washing facilities or alternate means of hand sanitization	X		
b. Dental examination chair	X		
c. Examination light	X		
d. Instruments	X		
e. Trash containers for biohazardous materials and sharps	X		
f. A dentist's stool	X		
g. Personal protective equipment	X		
8. The presence of a dental operatory requires the addition of at least:			
a. An X-ray unit with developing capability	X		
b. Blood pressure monitoring equipment	X		
c. Oxygen	X		
9. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

P-D-04 On-Site Diagnostic Services (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The responsible health authority maintains documentation that on-site diagnostic services (e.g., laboratory, radiology) are certified or licensed to provide that service.	X		
2. There is a procedure manual for each on-site diagnostic service, including protocols for the calibration of testing devices to ensure accuracy.	X		
3. Facilities have, at a minimum, multiple-test dipstick urinalysis, finger-stick blood glucose tests, peak flow meters (handheld or other), stool blood-testing material, and in facilities housing women, pregnancy test kits.	X		
4. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

P-D-05 Medical Diets (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Medical diets are provided per prescriber order and documented in the health record.	X		
2. Orders for medical diets are communicated in writing to dietary staff and include the type of diet, the duration for which it is to be provided, and special instructions, if any.	X		
3. A registered dietitian nutritionist (RDN) or other licensed qualified nutrition professionals, as authorized by state scope of practice laws, documents a review of all medical diets for nutritional adequacy at least annually.	X		
4. The facility has a procedure in place to notify the RDN whenever the medical diet menu is changed.	X		
5. Written documentation of menu reviews includes the date, signature, and title of the dietitian.	X		
6. Workers who prepare medical diets are supervised in diet preparation.	X		

7. When inmates refuse prescribed diets, follow-up nutritional counseling is provided.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
At the time of the survey, 484 medical diets had been ordered.			
Corrective action:			
None			

P-D-06 Patient Escort (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Patients are transported safely and in a timely manner for medical, dental, and mental health clinic appointments both inside and outside the facility.	X		
2. Patient confidentiality is maintained during transport.	X		
3. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

P-D-07 Emergency Services and Response Plan (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The facility provides 24-hour emergency medical, dental, and mental health services.	X		
2. Facility staff provide emergency services until qualified health care professionals arrive.	X		
3. The health aspects of the documented emergency response plan are approved by the responsible health authority and facility administrator, and include, at a minimum:			
a. Responsibilities of health staff	X		
b. Procedures for triage for multiple casualties	X		
c. Predetermination of the site for care	X		

d. Emergency transport of the patient(s) from the facility	X		
e. Use of an emergency vehicle	X		
f. Telephone numbers and procedures for calling health staff and the community emergency response system (e.g., hospitals, ambulances)	X		
g. Use of one or more designated hospital emergency departments or other appropriate facilities	X		
h. Emergency on-call physician, dental, and mental health services when the emergency health care facility is not nearby	X		
i. Security procedures for the immediate transfer of patients for emergency care	X		
j. Procedures for evacuating patients in a mass disaster	X		
k. Alternate backups for each of the plan's elements	X		
l. Time frames for response	X		
m. Notification to the person legally responsible for the facility	X		
4. *Mass disaster drills* are conducted so that each shift has participated over a 3-year period, including satellites.			X
5. A health emergency *man-down drill* is practiced once a year on each shift where health staff are regularly assigned, including satellites.			X
6. The mass disaster and man-down drills are *critiqued,* the results are shared with all health staff, and recommendations for health staff are acted upon.			X
7. All aspects of the standard are addressed by written policy and defined procedures.		X	
Comments:			
There was no evidence of an emergency drill or actual event in the past three years. One drill (a unit fire) occurred in 2023. However, custody did not coordinate it with the RHA, nor were medical responses critiqued or shared with staff. Additionally, there were no man down drills documented for the past three years.			
Corrective action:			
The facility is to submit corrective action to NCCHC for Compliance Indicators #4 - #7. Acceptable documentation and evidence of compliance includes: • A plan by the RHA that addresses: o How mass disaster drills will be conducted in the future so that each shift has participated in a mass disaster drill / event over a 3-year period going forward o How man-down drills will be conducted in the future so that a man-down drill / event is practiced at least once a year on each shift where health staff are present going forward			

- How mass disaster drills and man-down drills (or actual events) will be critiqued in compliance with the standard going forward
- How results of the mass disaster drills (or actual events that may have occurred) and man-down drills (or actual events that may have occurred) will be shared with health staff and recommendations acted upon going forward

- Evidence at least one mass disaster drill has occurred, and a critique has been completed in compliance with this standard
- Evidence at least one qualifying man-down has occurred, and a critique has been completed in compliance with this standard
- Evidence that the critique results were shared with health staff, including evidence of any recommendations being acted upon (e.g., copy of health staff meeting agenda/notes documenting when such information was discussed with health staff and sign in rosters to reflect such training occurred)

P-D-08 Hospital and Specialty Care (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Evidence demonstrates that there is appropriate and timely access to hospital and specialist care when necessary.	X		
2. When patients are referred for outside care, written or verbal information about the patient and the specific problem to be addressed must be communicated to the outside entity.	X		
3. The health record contains results and recommendations from off-site visits, or attempts by health staff to obtain these results.	X		
4. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

E. PATIENT CARE AND TREATMENT

Standards in this section ensure the delivery of health care from arrival through discharge for health care issues. All care is timely and appropriate, and continues until resolution of the problem or until discharge.

Standard Specific Findings

P-E-01 Information on Health Services (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. A sign explaining how to access health services is posted in the intake/processing area.	X		
2. Within 24 hours of their arrival, inmates are provided with written, electronic, or video information about:			
a. How to access emergency and routine medical, dental, and mental health services	X		
b. The fee-for-service program, if one exists	N/A		
c. The grievance process for health-related complaints	X		
3. Procedures ensure that inmates who have difficulty communicating (e.g., foreign speaking, developmentally disabled, illiterate, mentally ill, deaf) understand how to access health services.	X		
4. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

P-E-02 Receiving Screening (E)			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Reception personnel ensure that persons who are unconscious, semiconscious, bleeding, mentally unstable, severely intoxicated, exhibiting symptoms of alcohol or drug withdrawal, or otherwise urgently in need of medical attention are referred immediately for care and *medical clearance* into the facility.	X		
a. If they are referred to a community hospital and then returned, admission to the facility is predicated on written medical clearance from the hospital.	X		
2. A *receiving screening* by a qualified health care professional takes place as soon as possible upon acceptance into custody.	X		
3. The receiving screening form is approved by the responsible health authority and inquires as to the inmate's:			
a. Current and past illnesses, health conditions, or special health requirements (e.g., hearing impairment, visual impairment, wheelchair, walker, sleep apnea machine dietary)	X		
b. Past infectious disease	X		
c. Recent communicable illness symptoms (e.g., chronic cough, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever, night sweats)	X		
d. Past or current mental illness, including hospitalizations	X		
e. History of or current suicidal ideation	X		
f. Dental problems (decay, gum disease, abscess)	X		
g. Allergies	X		
h. Dietary needs	X		
i. Prescription medications (including type, amount, and time of last use)	X		
j. Legal and illegal drug use (including type, amount, and time of last use)	X		
k. Current or prior withdrawal symptoms	X		
l. Possible, current, or recent pregnancy	X		

m. Other health problems as designated by the responsible physician	X		
4. The form also records reception personnel's observations of the inmate's:			
a. Appearance (e.g., sweating, tremors, anxious, disheveled)	X		
b. Behavior (e.g., disorderly, appropriate, insensible)	X		
c. State of consciousness (e.g., alert, responsive, lethargic)	X		
d. Ease of movement (e.g., body deformities, gait)	X		
e. Breathing (e.g., persistent cough, hyperventilation)	X		
f. Skin (including lesions, jaundice, rashes, infestations, bruises, scars, tattoos, and needle marks or other indications of drug abuse)	X		
5. The disposition of the inmate (e.g., immediate referral to an appropriate health care service, placement in the general population) is appropriate to the findings of the receiving screening and is indicated on the receiving screening form.	X		
6. Receiving screening forms are dated and timed immediately on completion and include the name, signature and title of the person completing the form.	X		
7. All immediate health needs are identified through the screening and properly addressed by qualified health care professionals.	X		
8. A screening test for latent tuberculosis is completed (e.g., PPD, chest x-ray, laboratory test).	X		
9. Potentially infectious inmates are isolated from the general inmate population	X		
10. If a woman is pregnant, an opiate history is obtained.	X		
11. If a woman reports current opiate use, she is immediately offered a test for pregnancy to avoid opiate withdrawal risks to fetus.	X		
12. Health staff regularly monitor receiving screenings to determine the safety and effectiveness of this process.	X		
13. All aspects of the standard are addressed by written policy and defined procedures.	X		

Comments:
There are intake processes for both males and females. RNs conduct the prison intakes and they are done promptly.
Corrective action:
None

P-E-03 Transfer Screening (E).			
X NOT APPLICABLE	*The compliance indicator is:*		
	Fully Met	**Partially Met**	**Not Met**
1. Qualified health care professionals review each transferred inmate's health record or summary to ensure continuity of care and medications.	N/A		
2. When transferred from an intake facility, inmates who do not have initial medical, dental, or mental health assessments are to be evaluated at the receiving facility in a timely manner.	N/A		
3. Documentation in the health record demonstrates continuity of health care and medication administration.	N/A		
4. All aspects of the standard are addressed by written policy and defined procedures.	N/A		
Comments:			
A receiving screening is completed for all inmates entering the facility.			
Corrective action:			
None			

P-E-04 Initial Health Assessment (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Receiving screening results are reviewed within 7 days.		X	
2. All inmates receive an initial health assessment as soon as possible, but no later than 7 calendar days after admission to the facility.		X	
3. The responsible physician determines the components of an initial health assessment.	X		
4. Initial health assessments includes, at a minimum:			

a. A qualified health care professional collecting additional data to complete the medical, dental, and mental health histories, including any follow-up from positive findings obtained during the receiving screening and subsequent encounters	X		
b. A qualified health care professional recording of vital signs (including height and weight)	X		
c. A *physical examination* (as indicated by the patient's gender, age, and risk factors) performed by a physician, physician assistant, nurse practitioner, or RN.	X		
d. When clinically indicated, a pelvic exam, or referral for a pelvic exam, with or without a pap smear.	X		
5. All abnormal findings (i.e., history and physical, screening, and laboratory) are reviewed by the provider.	X		
6. Specific problems are integrated into an initial problem list.		X	
7. Diagnostic and therapeutic plans for each problem are developed as clinically indicated.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

Health assessments are behind (by approximately 300). Nurse practitioners conduct the assessments and many of the males who arrive at intake here are transferred to another facility for permanent housing, but without having had an assessment. We reviewed 21 health assessments and found 14 (66%) were out of compliance, generally from 9 days to six months. Most health assessments are performed 20-30 days after arrival.

Problem lists observed in charts were incomplete and with a backlog in health assessments, these are not being reviewed or updated timely when utilizing the health assessment encounter as another opportunity to ensure information is captured and updated.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #1, #2, #6 and #8. Acceptable documentation and evidence of compliance, includes:

- A joint plan by the RHA and facility administrator that addresses:
  - How a review of the receiving screening results and an initial health assessment will be completed as soon as possible, but no later than 7 days after admission to the facility going forward
  - A short-term and a long-term operational plan to address timeliness of completing the health assessments within 7 days of admission
  - How the current backlog of initial health assessments within 7 days of admission to the facility will be addressed in the short-term, near future
  - How any identified problems will be integrated into the problem list going forward
- Submission of any policy and procedure changes made (with changes highlighted for easy identification by NCCHC staff)

- A 60-day log of all health assessment related encounters including:
  - Inmate number
  - Date inmate was admitted to the facility
  - Date inmate's receiving screen was reviewed
  - Number of days between date of admission and date receiving screen was completed
  - Date health assessment was completed
  - Date problem list was reviewed and updated as necessary
  - Number of days between date of admission and date health assessment was completed
- Submission of verification the current backlog of initial health assessments are being addressed, which includes documentation showing backlog numbers for both the number of outstanding initial health assessments at the time of the survey and at the time of the corrective action being submitted to NCCHC

P-E-05 Mental Health Screening and Evaluation (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Mental health screening is performed as soon as possible but no later than 14 calendar days after admission.	X		
2. Mental health screening may be conducted by *qualified mental health professionals* or qualified health care professionals who have received documented training.	X		
3. The initial mental health screening includes a structured interview with inquiries into:			
a. A history of:			
i. Psychiatric hospitalization and outpatient treatment	X		
ii. Substance use hospitalization	X		
iii. Withdrawal seizures	X		
iv. Detoxification and outpatient treatment	X		
v. Suicidal behavior	X		
vi. Violent behavior	X		
vii. Victimization	X		
viii. Special education placement	X		
ix. Cerebral trauma	X		
x. Sexual abuse	X		
xi. Sex offenses	X		

b. The current status of:			
i. Psychotropic medications	X		
ii. Suicidal ideation	X		
iii. Drug or alcohol use	X		
iv. Drug or alcohol withdrawal or intoxication	X		
v. Orientation to person, place, and time	X		
c. Emotional response to incarceration	X		
d. A *screening for intellectual functioning* (i.e., mental retardation, developmental disability, learning disability)	X		
4. The patient's health record contains results of the initial screening.	X		
5. Inmates who screen positive for mental health problems are referred to *qualified mental health professionals* for further evaluation.	X		
6. Mental health evaluations of patients with positive screens should be completed within 30 days or sooner if clinically indicated.	X		
7. Patients who require acute mental health services beyond those available on-site are transferred to an appropriate facility.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
Screenings and evaluations were timely and well documented.			
Corrective action:			
None			

P-E-06 Oral Care (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. *Oral care* under the direction and supervision of a licensed dentist is provided to each inmate.	X		
2. Care is timely and includes immediate access for urgent conditions.	X		
3. *Oral screening* is performed as soon as possible but no later than 7 calendar days from admission.		X	

4. Oral screening may be done by the dentist or qualified health care professional who has received documented training approved or provided by the dentist.	X		
5. Instruction in oral hygiene and preventive oral education are given within 30 days of admission.		X	
6. An *oral examination* is performed by a dentist within 30 days of admission.	X		
7. *Oral treatment*, not limited to extractions, is provided according to a treatment plan based on a system of established priorities for care when, in the dentist's judgment, the patient's health would otherwise be adversely affected.	X		
8. Radiographs are used in the development of the treatment plan.	X		
9. Consultation through referral to oral health care specialists is available as needed.	X		
10. Each inmate has access to the preventive benefits of fluorides in a form determined by the dentist to be appropriate for the individual's needs.	X		
11. Extractions are performed in a manner consistent with community standards of care.	X		
12. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

Oral care was found to be very good with excellent, prompt care provided for requested service. The oral examination consistently took place within 30 days of arrival. Dental requests are typically seen in less than two weeks, with no backlog or wait time. There is an array of prioritized care that is provided, including orthodontic treatment.

Oral screens did not comply with the seven-day timeline as the nurse practitioner conducts them during the health assessment. Oral instruction is also given at that time. which was found to be routinely outside of the 30-day timelines.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #3, #5, and #12. Acceptable documentation and evidence of compliance includes:

- A plan by the RHA that addresses:
    - How proper oral screenings (visual observation of the teeth and gums, and notation of any obvious or gross abnormalities requiring immediate referral to a dentist) will be completed within seven days going forward
    - How instruction in oral hygiene and preventive oral education will be given to all inmates within 7 days of admission, including how this will be documented in the patient's health record going forward

- Submission of any applicable policy and procedure changes made (with changes highlighted for easy identification by NCCHC staff)

P-E-07 Nonemergency Health Care Requests and Services (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. All inmates, regardless of housing assignment, are given the opportunity to submit oral or written *health care requests* at least *daily*.	X		
2. The health care requests are picked up daily by health staff.	X		
3. Health care requests are reviewed and prioritized daily by qualified health care professionals, or the health care liaison if applicable.	X		
4. A face-to-face encounter for a health care request is conducted by a qualified health care professional, or the health care liaison (if applicable), within 24 hours of receipt by health staff.	X		
5. Patients are evaluated in a *clinical setting* as indicated.	X		
6. All aspects of the health care request process, from review and prioritization to subsequent encounter, are documented, dated, and timed.		X	
7. The frequency and duration of response to health services requests is sufficient to meet the health needs of the inmate population.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
Sick call requests are paper-based and there is no tracking system. Although 24-hour face-to-face is not formally tracked, random reviews indicated that behavioral health meets close to 100% of responses to health care requests; medical responses were also prompt. But without consistent date stamping of the requests, we could not determine what percentage of medical face-to-face encounters were timely. (Medical and behavioral health responses were found consistently to be within one day.)			
Corrective action:			
The facility is to submit corrective action to NCCHC for Compliance Indicator #6. Acceptable documentation and evidence of compliance includes: • A plan by the RHA that addresses how all aspects of the health care request process, from review and prioritization to subsequent encounter, will be documented, dated, and timed going forward • Submission of any applicable policy and procedure changes made (with changes highlighted for easy identification by NCCHC staff)			

• Evidence of staff training on the procedures for properly documenting all aspects of the health care request process in the involved patient's health record for nonemergent medical, dental, and mental health requests, including course content and attendance records (i.e., sign in sheets)

P-E-08 Nursing Assessment Protocols and Procedures (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Nursing assessment protocols and nursing procedures:			
a. Are used by nursing personnel	X		
b. Are appropriate to the level of competency and preparation of the nurses who will carry them out	X		
c. Comply with the state practice act in the facility's jurisdiction		X	
2. Protocols and procedures are developed and reviewed annually by the nursing administrator and responsible physician based on the level of care provided in the facility.	X		
3. The protocols and procedures are accessible to all nursing staff.	X		
4. There is documentation of nurses' training in use of nursing assessment protocols and nursing procedures based on the level of care provided by the nurse. Documentation includes:			
a. Evidence that new nursing staff are trained and demonstrate knowledge and competency for the protocols and procedures that are applicable to their scope of practice		X	
b. Evidence of annual review of competency			X
c. Evidence of retraining when protocols or procedures are introduced or revised			X
5. Nursing assessment protocols for nonemergency health care requests include over-the-counter medications only.		X	
6. Approved assessment protocols pertaining to emergency life-threatening conditions (e.g., chest pain, shortness of breath) may contain prescription medications and must include immediate communication with a provider.	X		

7. Emergency administration of prescription medications requires a provider's order before or immediately after administration.		X	
8. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

There was no documented evidence of annual training or initial competency demonstration.

Designated prescription medications are included in the protocols, reportedly in accordance with state laws (medications such as antibiotics, Prilosec, Septra, Zofran, Naprosyn Pyridium, and others). Evidence this practice of standing orders being allowable under state law was not provided. The physician reviews and signs them the next business day.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #1c, #4, #5, #7 and #8. Acceptable documentation and evidence of compliance includes:

- A joint plan by the RHA and responsible physician that addresses:
    - The applicable training required of all nursing staff, including how their demonstration of knowledge and competency for the protocols and procedures applicable to their scope of practice will be conducted and documented at least annually, or more frequently when new protocols or procedures are introduced or revised
    - How the RHA will ensure current practices for administering prescription medications without prior authorization for the order are appropriate to the allowable scope of practice authorized within the state
- Evidence (i.e., from state nursing or pharmacy regulatory authority) authorizing the specific staff assigned to sick call can administer medications based on standing orders as noted during the survey are sufficient to meet applicable state laws and pharmacy regulations in the event practices observed during the survey are continued throughout the facility
- Evidence of staff training on any medication administration procedures that may require adjustment based on what is allowable in the state for all involved in administering pharmaceuticals
- Evidence of completed staff training and documented competency verification for those involved in utilizing the nursing assessment protocols, including course content and attendance records (i.e., sign in sheets)
- Evidence the nursing assessment protocols and procedures have been revised to reflect use of a) over the counter medication only, and b) provider communication in the event any medication is administered in life-threatening situations, as well as have been reviewed and approved by the nursing administrator and responsible physician
- Submission of any applicable policy and procedure changes made (with changes highlighted for easy identification by NCCHC staff)

P-E-09 Continuity, Coordination, and Quality of Care During Incarceration (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Patients receive medical, dental, and mental health services from admission to discharge per prescribers' recommendations, orders, and evidence-based practices.		X	
2. Prescriber orders are implemented in a timely manner.		X	
3. If deviations from evidence-based practices are indicated, clinical justification for the alternative treatment plan while in custody is documented.		X	
4. Diagnostic tests are reviewed by the provider in a timely manner.		X	
5. Treatment plans are modified as clinically indicated by diagnostic tests and treatment results.	X		
6. Treatment plans, including test results, are shared with patients.	X		
7. For hospitalization, urgent care, emergency department, or specialty visits:			
a. Patients are seen by a qualified health care professional or health care liaison (if appropriate) upon return	X		
b. Recommendations are reviewed for appropriateness of use in the correctional environment	X		
c. A provider is contacted in a timely manner to ensure proper implementation of any orders and to arrange appropriate follow-up	X		
8. All aspects of the standard are addressed by written policy and defined procedures.		X	
Comments:			
Specialty consultations / radiology procedures (CT scans, MRI's and PET scans) are very problematic. We reviewed a recent aging report for January 2024 that listed specialty services that had been ordered since June 2023. The report indicated that 76 orders have not yet been scheduled. Two had been waiting to be scheduled since October 2022. Nine appointments labeled as "priority" (within 4-14 days) were delayed up to seven months scheduled. Urgent scheduling is defined as 1–3-day scheduling, and one was also out of compliance with their written policies.			

Diagnostic testing that is ordered are not being monitored for scheduling and/or review purposes, as some were noted as being done upwards of six months after initially being ordered. There is no follow-up process in place to ensure they are being scheduled and completed as ordered, nor applicable follow-up once completed.

This significant backlog impacts provider review and follow up, appropriate patient care and quality services. Many of these provider orders have not been implemented. It was described that all outside scheduling must be done statewide by the headquarters and is not within the control of individual facilities.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #1 - #4, and #8. Acceptable documentation and evidence of compliance includes:

- A short-term and a long-term operational plan to address timeliness of scheduling diagnostic testing, off-site specialty care and radiology testing as reported on the "specialty services aging report" shared during the survey
- A plan by the RHA that addresses:
    - How patients will receive medical, dental, and mental health services from admission to discharge per prescribers' recommendations, orders, and evidence-based practices going forward, incorporating applicable documentation into the patient's health record going forward
    - How prescriber orders will be implemented in a timely manner going forward
    - If deviations from evidence-based practices are indicated, clinical justification for the alternative treatment plan while in custody will be documented going forward
    - How diagnostic tests will be reviewed by the provider in a timely manner going forward
- Submission of any applicable policy and procedure changes made (with changes highlighted for easy identification by NCCHC staff)
- Evidence the off-site specialty services are being scheduled and completed in a timely manner (i.e., summary review of the aging report results in relation to results available during the survey)
- Results of two consecutive 30-day CQI studies that evaluates compliance with ordering / scheduling, completion, and applicable follow-up of diagnostic testing, off-site specialty appointments, and radiology testing, including any additional corrective action that may be identified for follow-up studies (*Note: the CQI study should include a sufficient number of examples to demonstrate compliance with the standard*).

P-E-10 Discharge Planning (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. For planned discharges, health staff arrange for a *reasonable supply* of current medications.	X		
2. For patients with serious medical, dental, or mental health needs, arrangements or referrals are made for follow-up services with community prescribers, including exchange of clinically relevant information.	X		

3. The facility has a process to assist inmates with health insurance application prior to release.	X		
4. All aspects of discharge planning are documented in the health record.	X		
Comments:			
None			
Corrective action:			
None			

F. SPECIAL NEEDS AND SERVICES

Standards in this section address patients with special health care needs and establish compliance requirements specific to each health care issue

Standard Specific Findings

P-F-01 Patients with Chronic Disease and Other Special Needs (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Patients with chronic diseases and other *special needs* are identified.	X		
2. The responsible physician establishes and annually approves clinical protocols.		X	
3. Clinical protocols are consistent with *national clinical practice guidelines*.		X	
4. Clinical protocols for the identification and management of chronic diseases or other special needs include, but are not limited to, the following:			
a. Asthma	X		
b. Diabetes	X		
c. HIV	X		
d. Hyperlipidemia	X		
e. Hypertension	X		
f. Mood Disorders	X		
g. Psychotic disorders	X		

5. Individualized *treatment plans* are developed by a physician or other qualified provider at the time the condition is identified and updated when warranted.	X		
6. Documentation in the health record confirms that providers are following chronic disease protocols and special needs treatment plans as clinically indicated by:			
a. Determining the frequency of follow-up for medical evaluation based on disease control	X		
b. Monitoring the patient's condition (e.g., poor, fair, good) and status (e.g., stable, improving, deteriorating) and taking appropriate action to improve patient outcome	X		
c. Indicating the type and frequency of diagnostic testing and therapeutic regimens (e.g., diet, exercise, medication)	X		
d. Documenting patient education (e.g., diet, exercise, medication)	X		
e. Clinically justifying any deviation from the protocol		X	
7. Chronic illnesses and other special needs requiring a treatment plan are listed on the master problem list.	X		
8. Medical and dental orthoses, prostheses, and other *aids to reduce effects of impairment* are supplied in a timely manner when patient health would otherwise be adversely affected, as determined by the responsible physician or dentist.	X		
9. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

Chronic care visits are behind schedule for medical care but timely and up to date for behavioral health.

Clinical protocols are outdated and were last signed in 2017. There is a lack of timely follow up regarding medical chronic care patients. As an example, chronic care guidelines for diabetes mellitus are seven to eight years out of date and does not reflect current standard of evidence-based medical care. Although it was stated that drafts were being developed, none were produced.

Providers generally are not practicing evidence-based medical care as found in English language peer review medical literature. There is no documentation justifying this in their health records. An example is Metformin being prescribed for weight loss for patients without PCOS (polycystic ovary syndrome) with no documentation of monitoring of HGB A1C's or watching for hypoglycemia and other noted side effects of this medication. We reviewed charts for chronic care, specialist consults, ER visits and hospital stays. Chronic care scheduling and follow up is also not conducted in a timely manner.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #2, #3, #6e and #9. Acceptable documentation and evidence of compliance, includes:
• A plan by the RHA and Responsible Physician that addresses:
  ○ How the clinical protocols will be reviewed and approved by the responsible physician annually in the future, ensuring they are consistent with national clinical practice guidelines
  ○ How clinical justifications for deviation from identified protocols will be determined and documented in the health record
  ○ How the backlog in chronic care visits will be addressed to ensure chronic care treatment is timely
• Submission of any applicable policy and procedure and chronic care clinical guidelines changes made (with changes highlighted for easy identification by NCCHC staff)
• Evidence the clinical protocols, consistent with current national clinical practice guidelines, have been reviewed and approved annually by the responsible physician
• Results of two consecutive 30-day CQI studies that assess the justification for clinical deviations from clinical protocols and applicable documentation of such justification, including any additional corrective action that may be identified for follow-up studies (*Note: the CQI study should include a sufficient number of examples to demonstrate compliance with the standard*).
• Submission of verification the current backlog of chronic care visits is being addressed, which includes documentation showing backlog numbers for both the number of outstanding chronic care appointments at the time of the survey and at the time of the corrective action being submitted to NCCHC

P-F-02 Infirmary-Level Care (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Policy defines the scope of medical, psychiatric, and nursing care available on-site to patients who need infirmary-level care.	X		
2. Patients who need infirmary-level care are always within sight or hearing of a facility staff member, and a qualified health care professional can respond in a timely manner.	X		
3. The number of qualified health care professionals providing infirmary level care is based on the number of patients, the severity of their illnesses, and the level of care required for each.	X		
4. At least daily, a supervising RN ensures that care is being provided as ordered. Initiation and discontinuation of infirmary-level care is by provider order.	X		
5. The frequency of provider and nursing rounds for patients who need infirmary-level care is specified based on clinical acuity and the categories of care provided.	X		

6. Health records for patients who need infirmary-level care include:			
a. Initial clinical note that documents the reason for infirmary-level care and outlines the treatment and monitoring plan	X		
b. Complete documentation of the care and treatment given	X		
7. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
There are two wings of infirmaries that comprise a 14-bed medical unit and 10 bed behavioral health unit.			
Corrective action:			
None			

P-F-03 Mental Health Services (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Patients' mental health needs are addressed on-site or by referral to appropriate alternative facilities.	X		
2. Outpatient services include, at a minimum:			
a. Identification and referral of inmates with mental health needs	X		
b. Crisis intervention services	X		
c. Psychotropic medication management, when indicated	X		
d. Individual counseling	X		
e. Group counseling and/or psychosocial/psychoeducational programs	X		
f. Treatment documentation and follow-up	X		
3. When commitment or transfer to an inpatient psychiatric setting is clinically indicated:			
a. Required procedures are followed	X		
b. The transfer occurs in a timely manner	X		
c. The patient is safely housed and adequately monitored until the transfer occurs	X		

4. Outpatients receiving mental health services are seen as clinically indicated and as prescribed in their individual treatment plans.	X		
5. Mental health, medical, and substance abuse services are sufficiently coordinated such that patient management is appropriately integrated, medical and mental health needs are met, and the impact of these conditions on each other is adequately addressed.	X		
6. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

P-F-04 Medically Supervised Withdrawal and Treatment (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Protocols exist for managing inmates under the influence of or undergoing withdrawal from alcohol, sedatives, opioids, and/or other substances.	X		
2. Protocols for intoxication and withdrawal are approved by the responsible physician annually and are consistent with nationally accepted treatment guidelines.		X	
3. Individuals showing signs of intoxication or withdrawal are monitored by qualified health care professionals using approved protocols as clinically indicated until symptoms have resolved.		X	
4. Individuals being monitored are housed in a safe location that allows for effective monitoring.	X		
5. If the findings from patient monitoring meet the national guidelines to begin prescription medications, *medically supervised withdrawal* is implemented.		X	
6. Medically supervised withdrawal is done under provider supervision.	X		
7. Inmates experiencing severe or progressive intoxication (overdose) or severe alcohol/sedative withdrawal are transferred immediately to a licensed acute care facility.	X		

8. The facility has a policy that addresses the management of inmates on medication-assisted treatment (MAT).	X		
9. Inmates entering the facility on MAT have their medication continued, or a plan for medically supervised withdrawal is initiated.	X		
10. Disorders associated with alcohol and other drugs (e.g., HIV, liver disease) are recognized and treated.	X		
11. All aspects of the standard are addressed by written policy and defined procedures.		X	

Comments:

Although an outside entity has been contracted to assist with patients on Methadone, this entity is reportedly unresponsive and does not provide services to both pregnant and non-pregnant women who arrive here on Methadone. These women have their Methadone stopped and are given oral morphine in the infirmary until their COWS scores elevate and are then started on Buprenorphine. This is not current evidence-based medical care, potentially creating risk for both the inmate and the fetus.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #2, #3, #5, and #11. Acceptable documentation and evidence of compliance includes:

- A joint plan by the RHA and responsible physician that addresses:
  - How protocols for intoxication and withdrawal will be consistent with nationally accepted treatment guidelines and approved by the responsible physician going forward
  - How individuals showing signs of intoxication or withdrawal will be monitored by qualified health care professionals using approved protocols as clinically indicated going forward
  - How medically supervised withdrawal will be implemented if the findings from patient monitoring meets the national guidelines to begin prescription medications going forward
- Submission of the intoxication and withdrawal protocols, including evidence they are consistent with nationally accepted treatment guidelines and have been approved by the responsible physician
- Submission of any applicable policy and procedure changes made (with changes highlighted for easy identification by NCCHC staff)
- Evidence of staff training for all clinical staff involved in patient care related to the medically supervised withdrawal, including course content and attendance records (i.e., sign in sheets)

P-F-05 Counseling and Care of the Pregnant Inmate (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Counseling and assistance are provided and documented in accordance with the pregnant inmate's expressed desires regarding her pregnancy, whether she elects to keep the child, use adoptive services, or have an abortion.	X		

2. Prenatal care includes:			
a. Medical examinations by a provider qualified to provide prenatal care	X		
b. Prenatal laboratory and diagnostic tests in accordance with national guidelines	X		
c. Orders and treatment plans documenting clinically indicated levels of activity, nutrition, medications, housing, and safety precautions	X		
d. Counseling and administering recommended vaccines in accordance with national guidelines	X		
3. Pregnant patients with active opioid use disorder receive evaluation upon intake, including offering and providing medication-assisted treatment (MAT) with methadone or buprenorphine.	X		
4. Emergency delivery kits are available in the facility.	X		
5. Custody restraints are not used during labor and delivery.	X		
6. Custody restraints, if used, at other points of pregnancy and the postpartum period shall be limited to handcuffs in front of the body.	X		
7. *Postpartum care* is provided and documented.	X		
8. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
There were four pregnant females during the survey and 20 births in the past three years.			
Corrective action:			
None			

P-F-06 Response to Sexual Abuse (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The facility has guidelines or protocols regarding the detection, prevention, and reduction of sexual abuse.	X		
2. Health staff are trained in how to:			
a. Detect, assess, and respond to signs of sexual abuse and sexual harassment	X		
b. Preserve physical evidence of sexual abuse	X		

3. Emergency contraception is available to female victims of sexual assault.	X		
4. Recent sexual assault is either referred to a community facility for treatment and gathering of evidence, or if these procedures are performed in-house, the following guidelines are used:	X		
a. A history is taken and qualified health care professionals conduct an examination to document the extent of physical injury and to determine whether referral to another medical facility is indicated. N/A if referred to community facility	X		
b. Personnel trained in examination of sexual abuse victims will conduct the exam. N/A if referred to community facility	N/A		
c. Whenever possible, the examiner will not have a therapeutic relationship with individuals involved in the incident. N/A if referred to community facility	N/A		
d. With the victim's consent, the examination includes collection of evidence from the victim, using a kit approved by the local legal authority. N/A if referred to community facility	N/A		
5. In all cases, whether the victim is treated in-house or referred to an outside facility, the following activities occur:			
a. Prophylactic treatment and follow-up care for sexually transmitted infections or other communicable diseases (e.g., HIV, hepatitis B) are offered to all victims, as appropriate.	X		
b. There is an evaluation by a qualified mental health professional for crisis intervention counseling and follow-up.	X		
c. A report is made to the correctional authorities to effect a separation of the victim from the abuser in their housing assignments.	X		
6. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

P-F-07 Care for the Terminally Ill (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. A program to address the needs of terminally ill inmates includes *palliative care*.	X		
2. When the responsible physician determines that care in a community setting is medically preferable, a recommendation is made to the appropriate legal authority regarding the patient's transfer or *early release*.	X		
3. If there is an on-site palliative care program:			
a. Enrollment is a patient's informed choice	X		
b. Qualified health care professionals working in the program have received training in palliative care techniques	X		
c. Inmate workers or volunteers providing services in the program are properly trained and supervised	X		
4. *Advance directives*, health care proxies, and "do not resuscitate" (DNR) orders are available when medically appropriate.	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
Long-term care patients may be housed in the infirmary			
Corrective action:			
None			

G. MEDICAL – LEGAL ISSUES

The standards in this section ensure that health services comply with legal requirements.

Standard Specific Findings

P-G-01 Restraint and Seclusion (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. With regard to *clinically ordered restraint* and *seclusion*:			
a. Policies and procedures specify:			

i. The types of restraints or conditions of seclusion that may be used	N/A		
ii. When, where, how, and for how long restraints or seclusion may be used	N/A		
iii. How proper peripheral circulation is maintained when restraints are used	N/A		
iv. That proper nutrition, hydration, and toileting are provided	N/A		
b. In each case, use is authorized by a physician or other qualified health care professional where permitted by law, after reaching the conclusion that no other less restrictive treatment is appropriate.	N/A		
c. Unless otherwise specified by a physician or other qualified health care professional, health-trained personnel or health staff evaluate any patient placed in clinically ordered restraints or seclusion at an interval of no greater than every 15 minutes and document their findings.	N/A		
d. The treatment plan provides for removing patients from restraints or seclusion as soon as possible.	N/A		
e. The same types of restraints that would be appropriate for individuals treated in the community are used in the facility.	N/A		
f. Patients are not restrained in a position that could jeopardize their health.	N/A		
2. With regard to *custody-ordered restraints*:			
a. When restraints are used by custody staff for security reasons, a qualified health care professional is notified immediately in order to:	X		
i. Review the health record for any contraindications or accommodations required, which, if present, are immediately communicated to appropriate custody staff	X		
ii. Initiate health monitoring, which continues at medically appropriate intervals as long as the inmate is restrained. If the inmate's health is at risk, this is immediately communicated to appropriate custody staff.	X		
iii. If health staff are not on duty when custody-ordered restraints are initiated, it is expected that health staff review the health record and initiate monitoring upon arrival	X		

b. If the restrained inmate has or develops a medical or mental health condition, the provider is notified immediately so that appropriate orders can be given.	X		
c. When health staff note use of restraints that may be jeopardizing an inmate's health, this is communicated to custody staff immediately.	X		
3. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
Chair restraints are used very rarely; there was physical evidence of wall restraints, which are reportedly being phased out. Seclusion is practiced when needed and the patient is seen by a behavioral health provider with custody staff at the time of the incident. Medical monitoring is also provided.			
Corrective action:			
None			

P-G-02 Segregated Inmates (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Upon notification that an inmate has been placed in segregation:			
a. A qualified health care professional reviews the inmate's health record		X	
b. If existing medical, dental, or mental health needs require accommodation, custody staff are notified		X	
c. The review and notification, if applicable, are documented in the health record		X	
2. The health professional's monitoring of a segregated inmate is based on the degree of isolation:			
a. Inmates in *solitary confinement* with little or no contact with other individuals are monitored daily by medical staff and at least once a week by mental health staff.	N/A		
b. Inmates who are segregated and have limited contact with staff or other inmates are monitored 3 days a week by medical or mental health staff.		X	
3. Documentation of segregation rounds is made on individual logs or cell cards, or in an inmate's health record, and includes:	X		

a. The date and time of the contact	X		
b. The signature or initials of the health staff member making the rounds	X		
4. Significant health findings are documented in the inmate's health record.	X		
5. Health staff promptly identify and inform custody officials of inmates who are physically or psychologically deteriorating and those exhibiting other signs or symptoms of failing health.	X		
6. All aspects of the standard are addressed by written policy and defined procedures		X	

Comments:

There are several areas throughout the facility designated as restricted housing. Any area that is locked down for the majority of the day is considered segregation, including some behavioral health units. However, staff notification of placement and initiation of monitoring at least three times a week are inconsistent. Behavioral health staff makes at least weekly rounds. There are various and undetermined housing areas; all restricted housing areas need to be defined for both medical and behavioral health staff. We observed there were logs in some restricted areas and not others. Health and welfare checks should be standardized to include consistent documentation, which can be included it in the new electronic record.

Corrective action:

The facility is to submit corrective action to NCCHC for Compliance Indicators #1, #2b and #6. Acceptable documentation and evidence of compliance includes:

- A joint plan by the RHA and Facility Administrator that addresses
    - When and how qualified health care professionals will be notified an inmate has been placed in segregation status in alignment with the definitions within this standard going forward
    - When and how a qualified health care professional ~~has~~ will review~~ed~~ the inmate's health record once an inmate has been placed in segregation going forward
    - When and how custody staff will be notified if any existing medical, dental, or mental health needs require accommodation going forward
    - How inmates who are segregated and have limited contact with staff or other inmates will be monitored 3 days a week by medical or mental health staff going forward, with these segregation rounds being documented pursuant to the standard
    - How documentation of these tasks will be incorporated into the patient's health care record as required within the standard
- Results of two consecutive 30-day CQI studies that assess the consistency in completion and documentation of segregation rounds, including any additional corrective action that may be identified for follow-up studies (*Note: The CQI study should include sufficient numbers / examples to demonstrate compliance with the standard)*

P-G-03 Emergency Psychotropic Medication (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. The policies on *emergency forced psychotropic medication*:			
a. Require licensed provider authorization prior to use	X		
b. Specify when, where, and how the psychotropic medication may be forced	X		
2. When a provider orders psychotropic medication to be forced, he or she documents in the patient's record:			
a. The patient's condition	X		
b. The threat posed	X		
c. The reason for forcing the medication	X		
d. Other treatment modalities attempted, if any	X		
e. Treatment plan goals for less restrictive treatment alternatives as soon as possible	X		
3. Appropriate follow-up care is provided when medication is forced.	X		
4. Follow-up documentation is made by nursing staff at least once within the first 15 minutes, then every 30 minutes until transfer to an inpatient setting or the patient no longer requires monitoring.	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
Emergency medication is rarely utilized and there is a process in place to allow for evaluation and referral including involuntary medication.			
Corrective action:			
None			

P-G-04 Therapeutic Relationship, Forensic Information, and Disciplinary Actions (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. Health staff are not involved in the collection of *forensic information*.	X		

2. Health staff do not participate in disciplinary action nor are compelled to provide clinical information solely for the purposes of discipline.	X		
3. Treatments and medications are never withheld as a form of punishment.	X		
4. Segregation and restraints are never clinically implemented as disciplinary action.	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

P-G-05 Informed Consent and Right to Refuse (I).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
1. All examinations, treatments, and procedures are governed by *informed consent* practices applicable in the jurisdiction.	X		
2. For procedures and medications that in the community setting would require informed consent, written documentation of informed consent is required.	X		
3. Any health evaluation and treatment refusal is documented and must include the following:			
a. Description of the service being refused	X		
b. Evidence that the inmate has been informed of any adverse health consequences that may occur because of the refusal	X		
c. The signature of the patient	X		
d. The signature of a health staff witness	X		
4. If the patient does not sign the refusal form, it is to be noted on the form by a second health or custody staff witness.	X		
5. All aspects of the standard are addressed by written policy and defined procedures.	X		
Comments:			
None			
Corrective action:			
None			

P-G-06 Medical and Other Research (I).			
X NOT APPLICABLE	*The compliance indicator is:*		
	Fully Met	**Partially Met**	**Not Met**
1. Guidelines are in place that specify:			
a. The process for obtaining approval to conduct the research	N/A		
b. The steps to be taken to preserve the subject's rights	N/A		
2. When inmates who are participants in a community-based research protocol are admitted to the facility, procedures provide for:			
a. Continuation of participation	N/A		
b. Consultation with community researchers so that withdrawal from the research protocol is done without harming the health of the inmate	N/A		
3. All aspects of the standard are addressed by written policy and defined procedures.	N/A		
Comments:			
Medical related research is not authorized at this facility at all.			
Corrective action:			
None			

P-G-07 Executions (I).			
X NOT APPLICABLE	*The compliance indicator is:*		
	Fully Met	**Partially Met**	**Not Met**
1. Executions do not occur in the medical unit or area.	N/A		
2. Health staff do not assist, supervise, or contribute to the ability of another individual to directly cause the death of an inmate	N/A		
3. Health staff do not participate in determinations of competency to be executed.	N/A		
4. Health staff do not pronounce death in an execution.	N/A		
5. All aspects of the standard are addressed by written policy and defined procedures.	N/A		
Comments:			
Executions do not occur at this facility.			
Corrective action:			
None			