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NATIONAL COMMISSION
ON CORRECTIONAL HEALTH CARE

Health Services Accreditation Focused Survey Report

El Paso County Criminal Justice Center
Colorado Springs, Colorado

Survey Date: August 31, 2021

Report Date: October 31, 2021

This accreditation report, including any attachments, is intended solely for the use of the recipient facility and contains confidential information which may be legally protected from disclosure.

El Paso County Criminal Justice Center, CO
Focused Survey Report
October 31, 2021

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.

On March 15-16, 2021 NCCHC conducted its virtual review for continuing accreditation of the El Paso County Criminal Justice Center under the NCCHC *2018 Standards for Health Services in Jails*. On April 30, 2021, NCCHC placed the facility on probation, and directed that compliance be determined through a focused survey; this virtual survey occurred on August 31, 2021. This report focuses primarily on issues that required corrective action for compliance with the standards and is most effective when read in conjunction with NCCHC's April 30, 2021 report.

Essential Standards

There are 39 essential standards, 38 are applicable to this facility and 38 (100%) were found to be in full compliance. One hundred percent (100%) of the applicable essential standards must be met for to achieve accreditation. ***The El Paso County Criminal Justice Center has now met this condition.***

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:
None

Standard number and name not applicable:
J-F-02 Infirmary Level Care

Important Standards

There are 20 important standards; 19 are applicable to this facility and 19 (100%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. **The El Paso County Criminal Justice Center has met this condition.**

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:
None

Standard number and name not applicable:
J-C-08 Health Care Liaison

Decision: On October 31, 2021, NCCHC's Accreditation and Standards Committee voted to continue to accredit the El Paso County Criminal Justice Center.

J-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 Professional Counselors	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:	X		
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		

	Fully Met	Partially Met	Not Met
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:

Out of 58 licensed staff, 17 staff had no peer review after one year. This included licensed counselors and nurses (both RNs and LPNs).

The following corrective action is required for Compliance Indicators #1b, c, and e, #2, 4 and 7:

Acceptable documentation includes:

- A log or other written record providing:
  - The names of the RNs, LPNs, and licensed professional counselors
  - The dates of their most recent clinical performance enhancement reviews in accordance with the standard (including the name and credentials of the reviewer)
- Verification that the reviews were shared with the individuals being reviewed
- A plan for how the reviews will be conducted in accordance with the standard in the future

Focused Survey Results:

The nurse educator and mental health director developed and maintain tracking logs that include date of hire, review date, signed review date, and next due date. Specifically, LPNs, RNs and counselors were up to date at the time of the focused survey; we reviewed a random selection of reviews, which were appropriately signed and dated, to verify compliance. (A recent change in vendor contributed to lack of data. Many staff were also newly hired and not yet employed for a full year.) An electronic tracker now monitors all performance enhancement review due dates to ensure they are conducted in a timely manner. **The standard is now met.**

J-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:

Although the state does not require continuing education for nurses, physicians, and mid-level providers in this state, the standard requires at least 12 hours of CEU each year. Out of 58 licensed staff, 21 staff had less than 12 hours of annual training for the past year. Additionally, pro-rated training hours for PRN staff was not documented. Both medical and mental health services utilize PRN staff.

The following corrective action is required for Compliance Indictors #1-5:

Acceptable documentation includes:

- A plan by the RHA on how this standard will be corrected and maintained on an annual basis
- Any policy and procedure changes
- A list of all current qualified health care professionals should be submitted along with the continuing education that each employee has received for 2020, including pro-rated hours for PRN staff.
- Verification that all qualified health care professionals who have patient contact are current in cardiopulmonary resuscitation technique

Focused Survey Results:

During the March survey, state licensing CEU requirements were not provided for all professionals. Since then, subsequent documentation was accumulated to show that mental health professionals exceed the required 40 CEU hours every two years. Spread sheets were also developed and completed with the names and training credits for all staff, including pro-rated PRN staff. We verified that all staff had appropriate CEUs completed for 2020, and were also current in CPR and first aid. The HSA or her designee will monitor twice-a-month mandatory training to ensure at least 12 hours are completed annually by all staff. In addition to the nurse educator's tracking efforts, staff at the corporate office maintains its own data. **The standard is now met.**

J-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:
The intent of this standard is to ensure that inmates who need immediate/emergent medications, such as an inhaler, have access to the medications without delay. The current process at the facility is that any required medication such as an inhaler, is brought to the housing unit by the nurse as needed, or the inmate comes to the clinic. Security prohibits the use of KOP medications. The process as described seems to cause delays in getting access to emergent medications.
The following corrective action is required for Compliance Indicator #8:
Acceptable documentation includes: • A plan for how inmates will be able to carry medications as necessary for the emergency management of a condition when ordered by a provider or gain access to prescribed medications in a timely manner, with no delays, and when it is medically necessary. The key for emergent medication is to ensure immediate access.
Focused Survey Results:
KOP medications were implemented on July 1, 2021. This was documented by a memo to all staff; custody staff completed a power point slide presentation for training. We reviewed the curricula and training documentation to verify compliance, and confirmed officers now support of a new process that now allows albuterol inhalers and other KOP medications as needed. Patient KOP medication needs are reviewed on a case-by-case basis. Narcan is kept in a first aid kit in each housing unit and elsewhere for accessibility. **The standard is now met.**

J-E-02 Receiving Screening (E)			
☐ **NOT APPLICABLE** This facility receives inmates only from other facilities within the same correctional system. There are no inmates that arrive directly from the community or a facility outside of the correctional system.	*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* 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:	X		
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. Potentially infectious inmates are isolated from the general inmate population	X		
9. If a woman is pregnant, an opiate history is obtained.	X		
10. If a woman reports current opiate use, she is immediately offered a test for pregnancy to avoid opiate withdrawal risks to fetus.	X		
11. When health-trained correctional personnel perform the receiving screening, they have documented training by the responsible physician or designee in early recognition of medical, dental, and mental health conditions requiring clinical attention.	N/A		
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 is a process in place for nurses to screen inmates as soon as they enter and prior to any delays by custody staff. However, we found that 17% of receiving screenings were completed more than four hours (industry standard) after inmates' arrival. The late screenings are not tracked nor identified for reasons that would cause delay.
The following corrective action is required for Compliance Indicator #2:
Acceptable documentation includes: • A plan from the RHA that ensures screening as soon as possible when inmates arrive at the facility • Any policy and procedure changes • Evidence of necessary staff training • A CQI study on the timeliness of the intake process including an analysis regarding why the screenings are delayed. • The CQI study should include a sufficient number of examples to demonstrate compliance with the standard
Focused Survey Results:
A CQI study dated May through July 2021 found several clarifications and corrective actions. During the May study, it was revealed that the wrong booking time was used. Arresting officers can electronically input pre-booking data prior to bringing the inmate to the facility. When actual arrival times were tracked for June and July, the following improved compliance was noted: 75% were booked within four hours in June and 72% in July. Booking times reflect that the remaining 25% were booked two hours later, not to exceed a total of six hours. Continued monitoring of screenings will be on-going. In practice, all inmates are seen by a nurse or EMT while in the patrol car or sallyport immediately upon arrival. The sheriff, in partnership with local public health officials, has implemented an additional process due to increases in Covid. Initial Covid screening now takes place prior to inmates entering the jail. It includes a symptoms check, rapid Covid testing, and recording of vital signs. Any immediate medical and mental health issues are also assessed at that time. This two-step screening process has caused some delay in the electronic input of the screening data; however, all inmates are medically screened as they arrive without exception. (The delay is primarily entering data electronically and completing the rest of the screening.) Due to the priority status of Covid screening and increased precautions, the extended intake process is understandable. Data and other documentation support that intake screening is paramount in this facility and the intent of the standard is met. Our review of 20 records showed 100% of receiving screenings were completed, with some delays as described. The HSA discussed possibly implementing the use of tablets in the sallyport to document immediately as inmates arrive rather than risk delayed data input. The HSA also indicated that CQI monitoring will continue to ensure ongoing compliance. **The standard is now met.**

J-E-04 Initial Health Assessment (E).			
	The compliance indicator is:		
	Fully Met	**Partially Met**	**Not Met**
Compliance Indicators: Full Population Assessment (1-9) ☐ **NOT APPLICABLE** The facility has implemented option #2, Individual Assessment When Clinically Indicated.			
1. Receiving screening results are reviewed within 14 days.	X		
2. All inmates receive an initial health assessment as soon as possible, but no later than 14 calendar days after admission to the facility.	X		
3. If the health assessment is deferred because of a documented health assessment within the last 12 months, documentation in the health record must confirm that the new receiving screening shows no change in health status.	X		
a. If the receiving screening shows a change in health status, the initial health assessment is repeated.	X		
4. The responsible physician determines the components of an initial health assessment.	X		
5. 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. A screening test for latent tuberculosis (e.g., PPD, chest X-ray, laboratory test), unless completed prior to the initial health assessment.	X		
6. All abnormal findings (i.e., history and physical, screening, and laboratory) are reviewed by the provider.	X		

7. Specific problems are integrated into an initial problem list.	X		
8. Diagnostic and therapeutic plans for each problem are developed as clinically indicated.	X		
9. All aspects of the standard are addressed by written policy and defined procedures.	X		
Compliance Indicators: Individual Assessment When Clinically Indicated (10-16) **X□ NOT APPLICABLE** The facility has implemented option #1, Full Population Assessment			
10. Inmates identified with *clinically significant findings* as the result of a comprehensive receiving screening receive an initial health assessment as soon as possible, but no later than 2 working days after admission. To qualify for this option, an institution:			
a. Has 24-hour, 7-day on-site health staff coverage			
b. Allows only licensed health care personnel to conduct a comprehensive receiving screening on all inmates			
c. Includes in its comprehensive receiving screening all elements of the receiving screening standard plus:			
i. Further inquiry into past history and symptoms of chronic diseases			
ii. Finger stick on individuals with diabetes			
iii. Vital signs (including pulse, respirations, blood pressure, and temperature)			
iv. Further inquiry into medication and dosages where possible			
v. A screening test for latent tuberculosis (e.g., PPD, chest X-ray, laboratory test.			
11. If the health assessment is deferred because of a documented health assessment within the last 12 months, documentation must confirm that the new receiving screening shows no change in health status.			

a. If the comprehensive receiving screening shows a change in health status, the initial health assessment is repeated.			
12. The responsible physician determines the components of an initial health assessment.			
13. Individual health assessments include, at a minimum:			
a. A review of comprehensive receiving screening results			
b. 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			
c. A qualified health care professional recording of vital signs (including height and weight)			
d. A physical examination (as indicated by the patient's gender, age, and risk factors) performed by a provider.			
e. Laboratory and/or diagnostic tests for disease, such as peak flow for asthma patients and blood work for diabetes patients.			
14. Specific problems are integrated into an initial problem list.			
15. Diagnostic and therapeutic plans for each problem are developed as clinically indicated.			
16. All aspects of the standard are addressed by written policy and defined procedures.			

Comments:

We reviewed 18 health records and found the health assessment was late in four cases. The CQI committee also noted compliance issues in 2020.

The following corrective action is required for Compliance Indicators #1 and 2:

The RHA may submit a copy of a CQI process study assessing

- the timeliness of health assessments *and*
- the documentation of the review of receiving screening results during the health assessment.

Focused Survey Results:

CQI studies and tracking was completed for May through August 2021. Results showed a compliance rate as follows:

May-84%, June-68%, July-92% and August-93%. Two additional nurses were trained in health assessments and these positions were dedicated to performing timely assessments, despite current vacancies. All the RNs were retrained in order to provide additional support as needed. We reviewed 22 health records during the focused survey and found four health assessments that were beyond 14 days (several being late due to lack of inmate cooperation). The receiving screening review during the health assessment was also documented. **The standard is now met.**

J-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:

The percentage of face-to-face encounters that are completed within 24 hours is 100% for medical requests, but only 83% for mental health requests. The kiosk system allows inmates to make requests with prompt medical triage and response. Mental health staff, however, conduct their own triage and assignment. Inmates with mental health issues do not receive a face-to-face for clinical issues unless it is an urgent issue.

The following corrective action is required for Compliance Indicator #4:
Acceptable documentation includes: • a plan by the RHA on how this standard will be corrected including any policy and procedure changes and • staff training if necessary. In addition, • a 60-day log for **all mental health requests** with the following columns: inmate number, date of request, date/time request received, nature of complaint, date/time of face-to-face encounter by qualified health care professional or health care liaison (if applicable).
Focused Survey Results:
A CQI study tracked mental health 24-hour face-to-face responses for May through July 2021. Tracking included the mental health request, time and date, reason, and documented response with time and date. Out of 142 mental health requests, 11% required a 24-hour response, and all but two were seen in a timely manner. (The remaining two were a few hours later.) The HSA indicated that monitoring for ongoing compliance would continue. Additionally, mental health staff assignments were assessed, and priorities given to these response assignments. Staff were trained and documented in the April, June and August staff meetings. The mental health director will continue to review data, staff allocation and resources for any post intervention required. **The standard is now met.**

J-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:	X		
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 is no annual review of competency testing of protocols, nor subsequent testing if retraining is required.

The following corrective action is required for Compliance Indicators #4b and c, #5-8:

Acceptable documentation includes:

- A signature page containing the signatures of the responsible physician and nursing administrator attesting to their current review and approval of the protocols
- A plan by the RHA on how the protocols will be reviewed annually in the future as required by the standard
- A plan for how nurses will be trained when protocols or procedures are introduced or revised

Focused Survey Results:

Signature pages documenting review by the responsible physician and nursing administrator were documented for June 25, 2020, and July 14, 2021. All nurses are trained in protocols during orientation and all nurses were retrained in March 2021. The nurse educator follows up monthly with any needed retaining or when protocols or

procedures are introduced or revised. The corporate office also provides quarterly protocol training by Zoom. We verified compliance by reviewing the training documentation, to include competency testing and on-the-job mentoring for 2020 and 2021. (Nurses receive an average of 70 hours training annually. **The standard is now met.**

J-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	N/A		
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:

Only custody restraints are used, and monitoring is consistently documented by the nurses. However, documentation of the health record review when an inmate is placed in restraints is not consistent.

The following corrective action is required for Compliance Indicator #2ai and ii, and #3:

Acceptable documentation includes:

- A plan by the RHA on how this standard will be corrected
- Any policy and procedure changes
- Evidence of staff training
- A CQI study that assesses the effectiveness of the corrective action plan

Focused Survey Results:

A CQI study and monitoring was conducted from May through August 2021. During these months, 43 inmates were placed in restrictive housing. We reviewed a total of 10 health records, and found the documentation to be consistent regarding custody notification, nurse chart review (including mental health alerts) and rounds at least

three times a week by mental health and medical staff. We also recommended periodic monitoring of the notification and documentation processes. Custody staff were also reminded (during meetings) to provide consistent notification to medical staff. A policy was already in place, so no further action was needed; all staff were redirected to comply with existing policy. An EMR form was modified to include specific documentation of initial review for easier access. This electronic improvement was made nationally by the corporate leadership for improved documentation and information access. **The standard is now met.**

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