National Commission on Correctional Health Care

ACCREDITATION UPDATE REPORT OF

THE HEALTH CARE SERVICES AT

EL PASO COUNTY CRIMINAL JUSTICE CENTER

Colorado Springs, CO

April 22, 2018

National Commission on Correctional Health Care
1145 W. Diversey Pkwy.
Chicago, IL 60614-1318
(773) 880-1460

El Paso County Criminal Justice Center, CO
April 22, 2018
UPDATE REPORT

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 October 2-3, 2017 NCCHC conducted its review for continuing accreditation of the El Paso County Criminal Justice Center under the NCCHC *2014 Standards for Health Services in Jails*. On December 8, 2017, NCCHC placed the facility on probation. Subsequently, the RHA has submitted corrective action, which brought the facility into compliance with applicable essential and important standards. 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 December 8, 2017 report.

There are 40 essential standards; 39 are applicable to this facility and 39 (100%) were found to be in compliance. One hundred percent of the applicable essential standards must be met. ***The El Paso County Criminal Justice Center has now met this condition.***

Essential Standards Not in Compliance
None

Essential Standard Not Applicable
J-G-03 Infirmary Care

There are 27 important standards; 26 are applicable to this facility and 25 (96%) 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.**

Important Standard Not in Compliance
J-C-02 Clinical Performance Enhancement

Important Standard Not Applicable
J-C-08 Health Care Liaison

Decision: On April 22, 2018, NCCHC's Accreditation Committee voted to continue to accredit the El Paso County Criminal Justice Center.

J-C-02 Clinical Performance Enhancement (I). A clinical performance enhancement process evaluates the appropriateness of services delivered by all direct patient care clinicians, registered nurses (RN) and licensed practical nurses (LPN). A professional of at least equal training in the same general discipline completes the reviews annually. We reviewed a log from former vendor that listed the names of the individuals who had been reviewed and the date of their most recent review, which included required elements.

However, the log was incomplete, included only the previous year, and did not include all staff. The current vendor had been on site for a very limited time (approximately three months) and had not yet completed any clinical performance enhancement reviews. The standard is not met.

> Corrective action is required for Compliance Indicators #1. The clinical performance of the facility's direct patient care clinicians and RNs and LPNs should be reviewed at least annually. Clinical performance enhancement review processes are designed to enhance competence and address areas in need of improvement. Ultimately, honing the practitioner's clinical skills positively impacts patient care. The following is acceptable documentation for compliance: a log or other written record providing the names of the direct patient care clinicians, RNs and LPNs, the dates of their most recent clinical performance enhancement reviews in accordance with the standard (including the name and credentials of the reviewer), and the signatures of the individuals being reviewed to attest that the results were shared. Corrective action is required in order to meet this standard.

In March 2018, the RHA submitted sample peer review logs (which include signature blocks for both parties), and a log of employees documenting that those who had been employed for a year or longer had a review completed (generally in the last few weeks of 2017, or the first few weeks of 2018). The log also indicated that the results had been signed by reviewer and reviewee, but verification of the reviewer's name and credentials is also required. Further corrective action is required. **The standard is not met.**

J-C-09 Orientation for Health Staff (I). We reviewed an outline of a new employee orientation, but it did not include several components of the standard, nor was it approved by the responsible health authority and the facility administrator. The standard is not met.

> Corrective action is required for Compliance Indicators #1, #3 and #4. The orientation program should be approved by the responsible health authority and the facility administrator. All health staff should receive a basic orientation on the first day of on-site service. At a minimum, this addresses relevant security and health services policies and procedures, response to facility emergency situations, the staff member's functional position description, and inmate-staff relationships. Within 90 days of employment, all full-time health staff should complete an in-depth orientation. At a minimum, this includes all health services policies and procedures not addressed in the basic orientation, health and age-specific needs of the inmate population, infection control including use of standard precautions, and confidentiality of records and health information. The content may vary depending upon the roles and responsibilities of the newly hired staff member. Acceptable documentation includes a plan by the RHA on how orientation of new employees will be competed in the future. In addition, an outline of the orientation program, approved by the responsible health authority and facility administrator that contains all

requirements of the standard should be included. Corrective action is required in order to meet this standard.

In March 2018, the RHA indicated the orientation plan had been reviewed and signed by the RHA and facility administrator and included a copy verifying review and approval in September 2017. A "Day 1" security packet was developed, and the nurse educator, director of nursing, and administrative assistant were trained to provide the "day 1" orientation packet to all new employees. The submission included the revised orientation agenda and the respective modules (which appeared to address the first day requirements). The RHA further indicated that as of October 9, 2017, all newly hired staff had received the "day 1" orientation packet and signed acknowledgement form. **The standard is now met.**

J-E-04 Initial Health Assessment (E). The full population initial health assessment has been implemented at this facility. The RN completes the hands-on portion of the health assessment and was trained to do so by the responsible physician. We verified that the assessments consists of the required elements, including a review of the receiving screening results. Initial health assessments with positive findings are referred to the responsible physician for review. Specific health problems are integrated into an initial problem list. Diagnostic and therapeutic plans are developed as clinically indicated for each identified medical problem. According to the RHA, at the time that the vendor took over care of this facility, there were over 1600 health assessments that had not been completed. The RHA stated that they had been able to get that number down to approximately 380 by the time of this survey. The RHA provides influenza immunization and Hepatitis B vaccine when clinically necessary.

However, our review of the electronic health records indicated that a significant number of an initial health assessments (more than 50) were significantly past the 14 day expectation. The diagnostic assessments component of the initial health assessment includes laboratory or diagnostic tests for communicable diseases when the patient is symptomatic or requests it. Individuals age 23 or younger will have a urine test and if it tests positive for bacteria, the urine will be tested for chlamydia and gonorrhea. Otherwise, there was no routine testing for communicable diseases, nor was there verification from the health department that the prevalence rate does not warrant testing. The standard is not met.

Corrective action is required for Compliance Indicator #1. All inmates should receive an initial health assessment as soon as possible, but no later than 14 calendar days after admission to the facility, to ensure that individuals with serious medical or mental health needs are identified. Deterioration in their level of functioning may be prevented and necessary treatment can be given in a timely fashion if these inmates are identified quickly. Documentation of corrective action is required in order to verify that initial health assessments are conducted in this 14-day time frame. 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 CQI study that assesses the effectiveness of the corrective action plan should also be included. The CQI study should also include a sufficient number of examples of charts to demonstrate compliance with the standard. In order to receive accreditation, verification that this standard has been met is required.

> Corrective action is required for Compliance Indicator #2e. The initial health assessment should include laboratory and/or diagnostic tests for communicable diseases. All inmates should be tested for communicable disease (including sexually transmitted disease and tuberculosis) unless the health department determines this is not necessary. Acceptable documentation includes a plan by the RHA on how the standard will be corrected, including policy and procedure changes and staff training if necessary. Alternatively, the RHA may submit documentation from the health department indicating that testing for tuberculosis and sexually transmitted diseases is not necessary because the prevalence rate does not warrant testing. In order to receive accreditation, verification that this standard has been met is required.

In March 2018, the RHA indicated that the nurse's time management has been improved, and that additional RN staff have been trained to complete the health assessment (verification of training was included). The RHA also submitted logs from November 2017 through January 2018 indicating health assessments are completed within 14 days, as required.

The RHA also submitted a letter from the local health department indicating that while mandatory testing was not yet indicated, rates in the area were rising and voluntary testing was encouraged. To that degree, the submission included a revised (February 2018) policy and procedure that specifies the parameters of gonorrhea and Chlamydia testing, and evidence of staff training (staff meeting minutes of October 2017, and revised policy and procedure acknowledgements from February 2018).

A CQI study (spanning November 2017 through January 2018) found the following: The ADP was 1566; 1850 initial health assessments were completed; 1654 tuberculin tests were completed, with 131 patients as past positive reactors (who received a chest x-ray, while 65 were released prior to the test's reading). A random sample of 30 lab tests found that all had received STD screening and tuberculin testing for communicable disease, and 25 (83%) had accepted and completed STD testing, while 24 (80%) accepted and completed syphilis testing.

After receiving the public health department's communication, a further CQI study (spanning February 7 through March 7, 2017) gathered a sample of: women aged 35 or younger, men aged 30 or younger, and men who have sex with men. Their charts were reviewed to ensure Chlamydia and gonorrhea testing was completed and those with positive results were then tested for syphilis. The results indicated that 24 (80%) had received the first testing and 22 (73%) had accepted and completed the second testing. (One person in the sample tested positive for gonorrhea/Chlamydia, and subsequently refused syphilis testing.) **The standard is now met.**

J-E-06 Oral Care (E). A trained registered nurse completes the oral screening during the initial health assessment. We reviewed the training material and found it to be extensive and clinically appropriate. The dentist completes an oral examination within 12 months of inmates' admission. Routine oral care was timely and it included immediate access for urgent or painful conditions. The dentist has a system of establishing priorities for oral treatment that was not limited to extractions.

However, many of the oral screenings were not completed within 14 days, based on our health record review. Nor are inmates consistently instructed on oral hygiene and preventative oral education. The standard is not met.

Corrective action is required for Compliance Indicator #1. Oral screening should be conducted by the dentist or qualified health care professionals trained by the dentist within 14 days of admission. Acceptable documentation includes a plan by the RHA on how this standard will be corrected including any policy and procedure changes and staff training. In addition, the results of a CQI study assessing the timeliness of oral screening should be submitted. In order to receive accreditation, verification that this standard has been met is required.

Corrective action is required for Compliance Indicator #2. Instruction in oral hygiene and preventive oral education should be given within 30 days of admission. Acceptable documentation includes: (a) a plan that addresses how such education is being provided (e.g., handouts or other written materials or verbal instruction documented during the oral screening); and (b) results of a CQI process study assessing the timeliness of how instruction in oral hygiene and preventive oral hygiene is provided and documented. In order to receive accreditation, verification that this standard has been met is required.

In March 2018, the RHA indicated that the RN's time management has been enhanced, and additional RN staff have been trained to provide the oral screening, which is part of the health assessment. See J-E-04 Initial Health Assessment for further corrective action on the 14-day time line.

The RHA further indicated that the training addressed instructing patients (verbally and in writing) on oral care as part of the screening, and submitted sample handouts. CQI studies were also submitted as requested. **The standard is now met.**

J-E-07 Nonemergency Health Care Requests and Services (E). All inmates, regardless of housing assignment, have access to regularly scheduled times for routine health care.

However, the frequency and duration of response to requests for health services does not appear sufficient for the inmate population. Nonemergency sick call is scheduled seven out of fourteen shifts every two weeks; Sunday through Tuesday one week and Sunday through Wednesday the following week. A single nurse was assigned to sick call, and this is her work rotation. Sick call requests are entered through an electronic "kiosk' located in each housing unit and go directly to the medical section for triage and review. According the nurse assigned to this task, she does not triaged sick call requests. Inmates requiring a face-to-face encounter are not seen within 48 to 72 hours. In a majority of the logs provided for review, it is seven days or more before the sick call request is evaluated and a response given. At the time of the survey, there was a significant back log of patients waiting to be seen. The standard is not met.

Corrective action is required for Compliance Indicator #1, #2 and #4. Oral or written requests for health care must be picked up daily by qualified health care professionals and triaged within 24 hours to ensure that inmates' routine health needs are met. When a request describes a clinical symptom, a face-to-face encounter between the patient and qualified health care professional occurs within the next 24 hours (72 on the weekends). When responding to health services requests, qualified health care professionals should make timely assessments in a clinical setting. Qualified health care professionals should provide treatment according to clinical priorities or, when indicated, schedule patients as

clinically appropriate. The frequency and duration of response to health services requests must be sufficient to meet the health needs of the inmate population. Acceptable documentation includes a plan by the RHA on how this standard will be corrected, including policy and procedure change and staff training. In addition, a 60-day log with the following columns should be included: inmate number, date of request, nature of complaint, date of triage, and date of face-to-face assessment by qualified health care professional. In order to receive accreditation, verification that this standard has been met is required.

In March 2018, the RHA submitted evidence of staff training on sick call triage in October 2017 (via staff meeting minutes and attendance roster, and the procedural flow chart). Further corrective action included enhancing/reallocating RN resources to decrease the backlog and ensure the response is adequate to the patients' needs; ensuring daily nurses' sick call was scheduled to accommodate the time lines of 24, 48 and 72 hours (on weekends); and updating the kiosk to remove released patients from the system. The RHA also submitted the requested log (consisting of the required elements), and confirming the dates of triage and face-to-face assessment are in accordance with the standard. **The standard is now met.**

J-E-08 Emergency Services (E). The local EMS system is called when an inmate needs to be transferred in a life-threatening situation. The responsible physician, nurse practitioner, director of mental health and dentist are on-call 24 hours a day, and there were 10 automated external defibrillators (AED) at the time of the survey.

We verified that adequate supplies of emergency equipment, drugs and supplies were available, although the emergency bags were not checked consistently. The standard is not met.

Corrective action is required for Compliance Indicator #2. Emergency drugs, supplies, and medical equipment should be regularly maintained. Acceptable documentation includes a plan by the RHA on how this standard will be corrected. In addition, documentation of regular checks for emergency drugs, supplies and medical equipment should be submitted. In order to receive accreditation, verification that this standard has been met is required.

In March 2018, the RHA submitted the following: evidence of staff training on checking the bags each shift (October 2017 staff meeting minutes and attendance roster); and evidence of compliance via complete emergency equipment logs from November 2017 through January 2018. **The standard is now met.**

J-E-11 Nursing Assessment Protocols (I). The nursing staff utilizes nursing protocols. The protocols do not include any prescription medication other than those required to handle emergency life-threatening situations. In such cases, it is followed by a practitioner's review and written order. The protocols have been reviewed and approved annually by both the physician and HSA, most recently on July 15, 2017.

However, we were unable to confirm that the nurses are trained to use them upon hire. As the vendor recently assumed responsibility at this facility, there has been no opportunity for an annual review of competency. The standard is not met.

Corrective action is required for Compliance Indicator #2a-#2d. There should be evidence that all new nursing staff are trained; demonstration of knowledge and competency; evidence of annual review of competency as it relates to nurses' training in protocol use; and evidence of retraining when protocols are introduced or revised. The standard intends to ensure that nurses who provide clinical services are trained and competent in their use and use the protocols under specified guidelines. Acceptable documentation includes a plan by the RHA on how the standard will be corrected and evidence of implementation. Corrective action is required in order to meet this standard.

In March 2018, the RHA indicated that all health staff had completed the orientation process, and nursing staff had completed part C (nursing assessment protocols) as well as emergency readiness training, and submitted a summary verifying that both components were completed within a few months of hire; as current contract staff began on July 15, 2017, an annual review of competency was not yet indicated but would be completed at the appropriate time. The submission also included the orientation agenda, and checklists. **The standard is now met.**

J-E-12 Continuity and Coordination of Care During Incarceration (E). The clinical orders were found to be evidenced-based and that deviations were clinically justified, documented and shared with the patient. The clinician reviews diagnostic tests in a timely manner, discusses the need for these tests with the patient, and modifies treatment plans as clinically indicated.

When a patient returns from the emergency room, urgent care or hospitalization, protocols are followed in accordance with the standard, and a medical provider evaluates the patient. If a provider is not available when a patient returns, the next level provider evaluates the patient and consults the on-call provider if necessary. The responsible physician determines the frequency of periodic health assessments on the basis of protocols promulgated by nationally recognized professional health organizations. The responsible physician reviews medical records to assure that clinically appropriate care is ordered and implemented.

However, the clinicians reported that specimens were frequently not being collected as ordered. All abnormal diagnostic test findings are shared with the patient, but normal results are only shared with those patients in chronic care clinics. There was no mechanism in place to share normal diagnostic findings with other patients. Because of a delay in scanning paper communications from an outside health care provider, recommendations from specialty consultations are not always reviewed and acted upon by the clinician in a timely manner. The standard is not met.

Corrective action is required for Compliance Indicators #1, #5, and #7. All aspects of care should be coordinated and monitored from admission to discharge. Clinician orders should be evidence-based and *implemented in a timely manner*. Treatment plans, including test results should be shared and discussed with patients. Recommendations from specialty consultations should be reviewed and acted upon by clinicians in a timely manner. Acceptable documentation includes a plan by the RHA on how all aspects of this standard will be corrected. The plan should include necessary policy and procedure changes as well as evidence of training for appropriate staff. In addition, a CQI process study that evaluates the continuity and coordination of care following the implementation of the corrective action plan should be included. The CQI study should include a sufficient

number of examples to demonstrate compliance with the standard. In order to receive accreditation, verification that this standard has been met is required.

In March 2018, the RHA indicated the following corrective action: training of medical assistants and nursing staff to obtain lab specimens and to use the lab software program (attendance roster included); implementing a new process to obtain lab specimens daily, after medication administration on both shifts, with monthly monitoring by the HSA and medical director; counseling staff as needed; and activating the LabCorp interface with the electronic health record so that the results appear immediately in the providers' approval queue.

An initial CQI study of 60 chronic care patient charts (spanning December 2017 and January 2018) measured timely completion of clinical laboratory order labs. In December 2017, 30 patients had labs ordered, and all were drawn within a week; 11 were drawn within 24 hours, and 18 within 72 hours. In January 2018, a review of 30 patients who had labs ordered found that all were drawn within a week, and 13 within 24 hours, and 28 within 72 hours.

Corrective action taken to improve communication of normal lab results to patients included developing a communication document (sample included), to be given to medication pass staff to deliver directly, and monthly monitoring for compliance by the HSA and medical director.

CQI studies spanning December 2017 through February 2018 found that of the 751 labs ordered, 524 were completed, 101 were patient-refused, and 126 patients were discharged before the sample could be collected. Of 30 randomly selected lab tests, 29 were either discussed with the patient, or the results (if normal) communicated to them in writing (one patient had been released before either process could be completed).

Further corrective action regarding the backlog of documentation to be scanned into the electronic health record included adding a scanner, training additional staff to scan (completed in January 2018), and hiring staff as medical records. A CQI study found that of 38 offsite specialty appointments (December 2017 through February 2018), the provider had reviewed the documentation the same day or next except in two cases (one in which the paperwork was not received until approximately 10 days later, and the other in which the review occurred three days later). **The standard is now met.**

J-G-05 Suicide Prevention Program (E). The suicide prevention program addresses each of the 11 key components as described by the standard. The RHA has approved the training curriculum for staff. Treatment plans address suicidal ideation and recurrence. Patient follow-up occurs as clinically indicated. There have not been any suicides at this facility since the last on-site accreditation visit.

However, all suicidal inmates are placed on 15-minute staggered observation. Those patients that are considered acutely suicidal have a 'red' tag on their door and are housed in a 'high observation, suicide prevention cell' directly across from the nurse's station in the medical housing unit. A member of security documents rounds at least every 15 minutes. Non-acutely suicidal inmates have a 'yellow tag' on their door and are on an unpredictable (staggered) schedule not exceeding 15 minutes. There is also a high observation dormitory for the non-acute suicidal inmate. A correctional officer is assigned to this housing unit to observe inmates housed here. The

RHA indicated that by having a suicide 'safe' cell located in a high observation area, the staff was providing coverage for patient safety. The standard is not met.

> Corrective action is required for Compliance Indicator #1c. Acutely suicidal inmates should be placed on constant observation. The RHA should submit a plan addressing how acutely suicidal inmates will be monitored in accordance with the standard including necessary changes in policy and training of staff. In addition, the results of a 30-day CQI study assessing the monitoring of acutely suicidal inmates should also be submitted. In order to receive accreditation, verification that this standard has been met is required.

In March 2018, the RHA submitted a revised (January 2018) policy and procedure that requires acutely suicidal inmates to be monitored continuously; a redesigned mental health intake form to allow a more expeditious manner of referral and precaution referral system to ensure housing decisions are also efficient for security staff; and evidence of staff training in January 2018 on the new "purple sheet" system implemented to identify the acutely suicidal (meeting minutes and attendance roster included). The RHA further indicated that such patients are not common at this facility, and none had been identified during the 64-day period that ended on March 23, 2018. **The standard is now met.**

J-H-01 Health Record Format and Contents (E). Inmates' medical and mental health records are integrated in a combined format. By policy, all paper documents are scanned into the individual patient's electronic health record, but at the time of the survey, there was a significant delay in this process. Consequently, the clinicians often do not have timely access to consent and refusals forms; results of specialty consultations and off-site referral documents; and discharge summaries of hospitalizations and other inpatient stays. The standard is not met.

> Corrective action is required for Compliance Indicator #2. If electronic records are used, procedures should address integration of health information in electronic and paper forms. Acceptable documentation includes a plan by the RHA on how this standard will be corrected and proper integration of the records will occur, with evidence of the plan's implementation. In order to receive accreditation, verification that this standard has been met is required.

See J-E-12 Continuity and Coordination of Care During Incarceration for corrective action taken regarding the backlog of documents to be scanned into the health record; a random sample of 30 records indicated the necessary documents had been scanned and were present. The RHA also indicated the backlog had been brought current by January 23, 2018, and at the time of the submission, remained current. **The standard is now met.**