



(Centurion Indiana) CQI MANUAL

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(Centurion Indiana)
COMPREHENSIVE CQI PROGRAM SUMMARY

Continuous quality improvement (CQI) is important to correctional healthcare because of the tremendous medical and mental health needs of the incarcerated population and the competition for resources that influence the process of care.

The primary goals of our CQI program are:

- Improved inmate healthcare outcomes
- Effective and efficient healthcare service processes
- Patient and employee safety
- Effective utilization of resources
- Identifying and providing patients and staff education
- Enhanced client satisfaction

CQI helps us understand what we are doing and how to do it better. The CQI process is important to correctional healthcare staffs because the process empowers staff to become invested in identifying safety and care issues, participate in problem solving, as well as finding and implementing solutions. The benefits of staff participation in the CQI process include improved staff satisfaction, increased staff knowledge, increased understanding of processes, and development of skills necessary to affect change and achieve improvement.

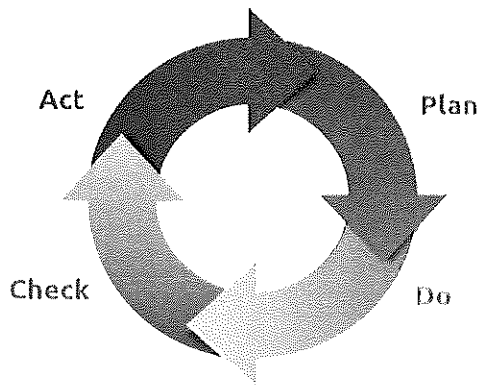
Although all Centurion contracts are monitored/audited by the client and/or other outside auditing bodies as a means to monitor/track our **compliance with the contract** or national standards, our CQI program provides a systematic way of auditing not only for compliance but to ensure we are **providing quality care**. The Centurion CQI program is a "proactive" way to systematically review whole processes, identify our opportunities for improvement, and to work as a team to improve the quality and outcomes of our processes

Centurion's CQI Program provides the tools and resources to establish a meaningful, sustaining way to improve processes and ensure the site(s) are prepared when auditing bodies come to review our medical/ mental health/dental/staffing programs. Our CQI program is collaborative, multidisciplinary, and fully integrated with the Indiana Department of Corrections (IDOC) contractual requirements and collaborates with the County's monitoring activities.

Specifically, Centurion's CQI program includes staff training, audit tool templates, process assessments and root cause analysis tools and Corrective Action Plan templates.

Centurion CQI program

Centurion uses the *PDCA* model in the CQI program for assessing and improving processes and enhancing outcomes:



Step 1: Plan - Plan for change

Step 2: Do - Implement change

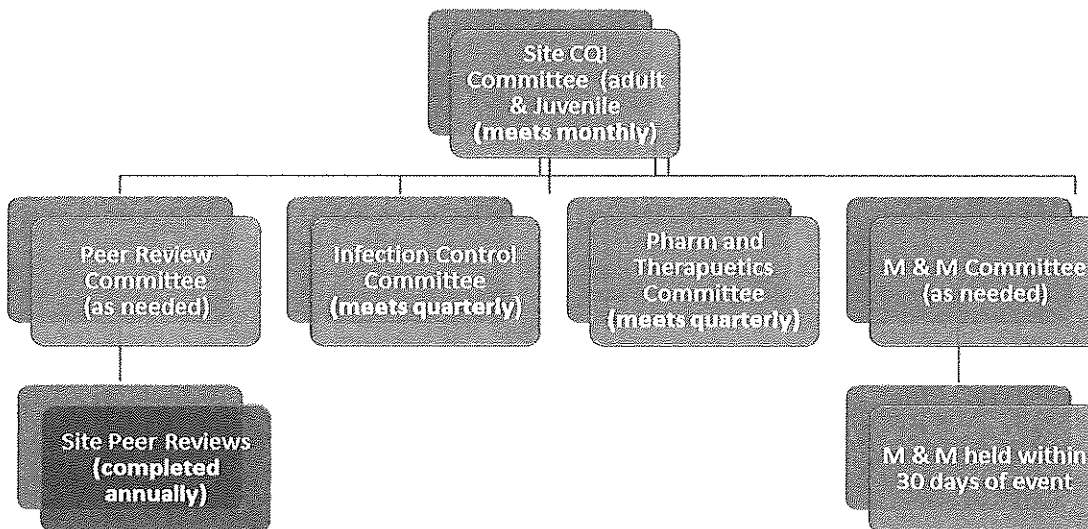
Step 3: Check - Monitor results of change

Step 4: Act - Modify change if needed

Centurion CQI Program Mission

- Make our CQI program a proactive, systematically reviewed, quality-driven program
- Make sustained changes that improve the whole process

CQI COMMITTEES AND ORGANIZATIONAL CHART (EXAMPLE – is contract specific)



CQI Framework: Major Service areas & Quality Performance Measures

The Centurion Quality Improvement Program follows the (Indiana) DOC policy, NCCHC (*Standard P-A-06*) and ACA (*5-ACI-6D-2 and/or Healthcare Standards 1-HC-4A-03 & 1-HC-7A-02*) requirements. Our CQI program measures each **major service area** at least once a year, and incorporates one or more **Quality performance measures**. Our CQI program particularly focuses on high-volume; high-risk, problem-prone issues. Centurion's monthly CQI audit tools, time studies, log reviews, and/or process/outcome studies incorporate these requirements.

Major Service areas reviewed at least annually include:

- Intake processing
- Primary care (sick call for both general population and segregation housing)
- Medication services
- Chronic care services
- Intrasystem transfer services
- Scheduled off-site services (consultations and procedures)
- Unscheduled on-site and off-site services (urgent/emergent care)
- Mental health services
- Dental services
- Ancillary services (lab and X-ray)
- Dietary services
- Infirmary services

Centurion will also monitor the following **CQI indicators** as often as deemed necessary:

- Risk assessment/accident/injury monitoring
- Health maintenance
- Suicide prevention
- Appropriateness of chronic disease management
- Peer review process
- Inpatient care
- Therapeutic diets
- Pharmacological therapies
- Institutional specific studies
- Medication Assisted Treatment (MAT)

Quality performance measures are used when evaluating health care programs and are addressed on audit tools and outcome studies:

- Accessibility
- Appropriateness of clinical decision making
- Continuity
- Timeliness
- Effectiveness(outcomes)
- Efficiency
- Quality of clinician-patient interaction
- Safety

Additionally, Centurion CQI program includes:

- **Annual CQI calendar** - The CQI Calendar is fluid and is subject to additions/edits throughout the year to incorporate needs for specific studies. The calendar addresses major service areas and contracted quality performance measures.
- **Grievances monitoring** - Monitoring grievances trends to identify opportunities for improving care via *Centurion's Daily site log* and *monthly grievance roll up report*
- **oSEL Sentinel events dashboard** - Monitoring morbidity and mortality trends to identify opportunities for improving care and to ensure timeliness of M & M reviews
- **Peer review** – CQI coordinated and monitors the peer review process
- **CQI Annual Review** – This summarizes the CQI program activities for the year and includes progress toward achievement of goals, program effectiveness, and recommendations
- **Process and Outcome Studies** – Each year, each site will complete 1 process and 1 outcome study. Typically, these studies are a result of a review of audit results that require a more in-depth analysis.
- **Corrective Action Plans (CAP)** - When any audit/study criteria result falls below 90%, the institution may perform a **process assessment and root cause analysis** to identify the issues. By taking the time to review each step of a process and analyze the root cause of a non-compliant criteria, their CAPS will be more meaningful and their action steps will help ensure sustained improvements. The CQI committee is responsible for ensuring an appropriate CAP is developed, implemented and monitored until the criteria has sustained goal threshold.
- **CQI Meetings, Agendas and Meeting Minutes** - There will be a (monthly) interdisciplinary CQI meeting at each facility. The template includes review of all required topics, to include updates on current studies, analysis of data, CAP activities, and evaluation of CQI studies. Additionally, (IDOC) and Centurion Regional leadership will meet quarterly to review overall CQI data, activities and CAPS.
- **Centurion CQI auditing monthly reports.** The sites will complete their monthly Centurion audit tools and upload onto a Shared file. The CQI Coordinator will then collate/aggregate the data into the ***Centurion monthly CQI roll-up***. This report will allow (IDOC) and Centurion to note/monitor trends for each process audit result. In order to quickly track and trend audit results we have also devised a ***CQI Scorecard***.

Differences between QA and CQI

QUALITY ASSURANCE

Frequently, the clients' monitoring tools, studies, or audit tools hone in on only a few, specific criteria rather than monitoring the WHOLE of each process:

- QA program is driven by contract requirements - The QA program may be looking at specific criteria that are currently under court requirements, or criteria that has a history of non-compliance

- The client uses the QA monitoring results to validate our **compliance** to the contract requirements, and may use these results to report to other governmental agencies
- Non-compliance may be attached to Pay for Performance or Liquidated Damages

"Quality assurance is about monitoring a particular procedure or a process in order to ensure that they are up to the expected levels of quality standards. Quality assurance is used to identify the mistakes, errors, defects in the processes. Quality assurance is a reactive approach." <http://www.differencebetween.com/difference-between-quality-assurance-and-vs-quality-improvement/>

"With quality assurance, thresholds are determined, and exceptions to the thresholds are reported. Consequently, quality assurance becomes a report of exceptions to the established thresholds." <https://www.ncbi.nlm.nih.gov/pubmed/7970386>

CONTINUOUS QUALITY IMPROVEMENT

CQI is proactive, systematic review of WHOLE process to ensure each step of the process is reviewed and areas that may need improvement and/or further research are identified:

- CQI encompasses the client's policy and procedures, as well as the contract's and NCCHC/ACA requirements
- CQI proactively schedules monthly, quarterly and annual reviews/studies/audits of each major process to either confirm compliance or identify non-compliance
- CQI is based on global audits/review and facilitates further studies to become site-specific process/outcome studies

"QI involves both prospective and retrospective reviews. It is aimed at improvement -- measuring where you are and figuring out ways to make things better. It specifically attempts to avoid attributing blame and to create systems to prevent errors from happening." http://patientsafetyed.duhs.duke.edu/module_a/introduction/contrasting_qi_qa.html

"In CQI, goals are established and measurements of consistent improvement toward the goals are reported. Thus, the goals become synonymous with the accepted standards of care." <https://www.ncbi.nlm.nih.gov/pubmed/7970386>

"Quality improvement refers to the techniques used by the organizations for continuous quality improvements. Quality improvement is concerned with continuously increasing the quality standards. Quality improvement is a proactive approach." <http://www.differencebetween.com/difference-between-quality-assurance-and-vs-quality-improvement/>

Quality Assurance vs. Quality Improvement

	QA	QI
Model	Monitor and correct performance <i>outliers</i>	Monitor processes/systems of care delivery
Program Scope	Organizational <i>mistakes</i>	Organizational outcomes and processes
Population	<i>Problem</i> prone areas	High-risk, high-volume, problem prone areas
Data Collection	<i>Retrospective</i> data collection	Concurrent data collection Proactive risk reduction

In summary:

- Quality Assurance primarily focuses on identifying and correcting adverse events
- Quality Improvement seeks to foster continuous improvement and changes in response to systemic quality events

Resource

- Quality Improvement Basics: *From QA to QI*
https://www.stratishealth.org/documents/QualityImprovementBasics_0409.pdf

Program/Facility

Model Prison Policies and Procedures

Policy Number:
P-A-06

Subject:

Continuous Quality Improvement Program

Related Standards:

NCCHC: P-A-06 (2018)

ACA: 5-6D-4410, 5-6D-4422, 5-6D-4423

Other:

I. Purpose

The Continuous Quality Improvement (CQI) Program addresses the quality of healthcare services provided to inmates by identifying opportunities to improve clinical outcomes; managing utilization of resources associated with providing services; identifying staff educational needs; and enhancing client and inmate satisfaction with healthcare services.

II. Policy

1. The responsible health authority/responsible behavioral 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 healthcare aspects to be monitored and establishes thresholds
 - b. Designs quality improvement monitoring activities
 - c. Analyzes the results for factors that may have contributed to less than threshold performance
 - d. Designs and implements improvement strategies to correct the identified healthcare problem
 - e. Re-monitors the performance after implementation of the improvement strategies.
2. CQI meeting minutes or summaries are made and retained for reference, and copies are available and reviewed by all appropriate personnel.
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, behavioral health, and nursing.
4. Beyond chart reviews, the responsible physician is involved in the CQI process.
5. When the committee identifies a site-specific healthcare concern from its monitoring, a process and/or outcome quality improvement study is initiated and documented.
6. The committee documents a written annual review of the effectiveness of the CQI program by reviewing CQI studies and minutes of CQI, administrative, and staff meetings, or other pertinent written materials.

III. Definitions

1. *Quality Improvement Committee*: consists of health staff from various disciplines (e.g., medicine, nursing, behavioral health, dentistry, health records, pharmacy, laboratory, custody staff). The committee designs quality improvement monitoring activities,

discusses the results, and implements corrective action. Additional participants may be included, depending on the issues being addressed.

2. *Health record reviews* are systematic reviews of the health record using a standardized form or audit tool to determine whether specific elements related to quality of care provided are adequately documented.
3. *Thresholds* are the expected level of performance (of aspects of healthcare) established by the quality improvement committee.
4. *Process quality improvement study*: examines the effectiveness of the healthcare delivery process by:
 - a. Identifying a healthcare system concern, (e.g., delayed sick call appointments, discontinuity of medications, lack of follow up on abnormal lab values)
 - b. Determining a threshold based on the problem identified
 - c. Conducting a baseline study (e.g., task analysis, root cause analysis, staffing plan)
 - d. Developing and implementing a corrective action plan
 - e. Re-studying the problem to assess the effectiveness of the corrective action plan.
5. *Outcome quality improvement studies*: examine whether expected outcomes of patient care were achieved by:

Identifying a patient clinical care problem (e.g., poor asthma control, poor diabetes control, high-volume of off-site visits)

- a. Determining a threshold based on the problem identified
- b. Conducting a baseline study
- c. Developing and implementing a clinical corrective plan
- d. Restudying the problem to assess the effectiveness of the corrective action plan.

IV. Procedures

1. Operation of the CQI Program
 - a. The Medical Director/Psychiatric Medical Director, CQI Manager and Program Manager co-chair the CQI Committee. Representatives of clinical disciplines (medicine, nursing, behavioral health, dentistry) and health records, pharmacy and laboratory participate in the committee. The responsible medical and behavioral health physicians have integral participation in the CQI Committee. Client's administrative and security staff are invited to participate.
 - b. The CQI Committee meets no less than quarterly.
 - c. Primary functions of the CQI Committee are:
 - Establish objective criteria for monitoring quality of care, assuring high-risk, high-volume and problem-prone aspects of care are evaluated
 - Develop or choose tools that effectively evaluate the problem areas identified and establish thresholds as the expected level of performance for aspects of care
 - Assign studies to various staff members for data collection and completion
 - Review results of studies that have been completed and analyze results for factors that contribute to performance that does not meet thresholds

- Develop and implement corrective action plans to correct identified problems
 - Assess effectiveness of corrective action by monitoring the effectiveness of the strategies of the action plan.
- d. The CQI Committee meetings will be structured by an agenda that includes:
- Review of healthcare service delivery statistics and trends
 - Medication and non-formulary medication usage
 - Results of morbidity and mortality reviews
 - Adverse patient outcomes
 - Review of major occurrence reports and related recommendations
 - Results of disaster drills
 - Review of inmate grievance reports
 - Review of progress on action plans related to prior CQI activities
 - Discussion about last quarter's CQI project(s) including development of recommendation(s) for improvement
 - Discussion about implementing CQI project(s) for the next quarter including assigning staff responsibilities
 - Discussion about issues brought to the attention of staff for consideration by the CQI Committee. These issues will be given priority attention in the CQI Program
 - Other business, as necessary

Refer to CQI Meeting Agenda Minutes Template (CQI-010)

- e. All quality improvement documents are marked "Privileged and Confidential Quality Improvement." Discussions held during CQI Committee meetings and the activities documented are confidential; however, a summary of quality improvement activities is distributed to the client. Recommendations for essential service delivery improvements are immediately communicated to all healthcare staff.
- f. The following aspects of care are monitored through the CQI Program.
- Accessibility: How easily an inmate is able to obtain needed services
 - Timeliness: If interventions are provided to inmates at most beneficial or necessary times
 - Effectiveness: If a particular intervention results in the desired outcome
 - Appropriateness: If the care or intervention provided is relevant to the inmate's clinical needs and community standards of care
 - Continuity: If the care or intervention is coordinated among practitioners, between institutions and across time
 - Quality of provider-inmate relationship: The degree the inmate is involved in his/her own care decisions and the degree of sensitivity and respect for inmate's differing needs and expectations shown by service providers
 - Individual inmate clinical outcomes: Increased ability to function while incarcerated; stabilization of chronic health problems, reduced incidents of self-harm or attempts

- Appropriate utilization of resources: Staff and resource distribution; utilization of off-site services, site medications; infirmary and behavioral health unit beds
 - Effectiveness of healthcare delivery system to provide treatment in least restrictive environment
 - Efficiency of the healthcare system; usually measured in terms of cost efficiency (e.g. average cost per patient per year for services provided)
 - Patient and staff safety; both safety of the physical environment and adherence to custody safety and security requirements. Issues of patient safety are also promoted by investigating and performing an analysis of all deaths as well as other adverse events.
 - Key sentinel events (i.e., serious clinical, professional or administrative occurrences requiring investigation)
- g. The CQI Program will routinely review major occurrences related to healthcare issues including inmate deaths/suicides; adverse patient outcomes, medical problems and suicide attempts requiring emergency off-site care; use of emergency forced medication; and use of restraints for medical/behavioral health reasons.
- h. Regional and/or contract specific CQI monitoring can represent a part of the site CQI program but cannot be representative of the entire site quality monitoring program. The site program should additionally include specific outcome and/or process monitoring specific to the individual site/facility.
- i. Minutes of the CQI Committee meetings will be completed and reviewed for accuracy at the following meeting. The Program Manager will maintain minutes and all related CQI information in a confidential file.
2. The CQI Committee will conduct an Annual CQI Review and develop an Annual Plan. The plan will establish specific type of documentation and/or an aspect of care to be investigated during each quarter for the upcoming year. These activities will include the routine monitoring of healthcare services and the review of major occurrences and high-risk interventions.
- a. The annual CQI Review and Plan will include both process and outcome quality improvement studies. The type and number of process and/or outcome studies is not mandated but instead will be specific to aspects of care specific to the individual healthcare delivery program/site. A process improvement study examines the effectiveness of the healthcare delivery process such as sick call or medication administration. A problem is identified, a study is completed, a plan is developed and implemented, results are monitored and tracked, and improvement is demonstrated or the problem is restudied. An outcome improvement study reviews the outcomes of treatment provided to patients.
 - b. CQI Committee meetings during the year may make adjustments to the plan based upon monitoring findings and relevant issues.
 - c. The Annual CQI Review and Plan includes annual peer review process.
 - d. The Annual CQI Review and Plan includes an annual review of the effectiveness of the CQI program through review of CQI studies and minutes of CQI, administrative, and/or staff meetings, and other pertinent written materials. The effectiveness and completeness of all corrective actions are evaluated and follow-up provided as indicated.

Program/Facility

Model Prison Policies and Procedures

Policy Number:
P-A-06

3. Interface of the CQI Program with client's CQI program
 - a. Healthcare staff will actively participate in quality improvement activities and programs conducted by the client
 - b. Documentation of the CQI Program provided to the client will include the monthly submission of healthcare service delivery statistics as well as the quarterly submission of a CQI report summarizing the findings of the CQI Program and the action plans developed to address identified areas for improvement.

Referenced Forms:

CQI Reference Manual
CQI Process Assessment Tool (CQI-004)
CQI Meeting Agenda Minutes Template (CQI-010)
CQI Process Study Report Template and Example (CQI-008)
CQI Outcome Study Report Template and Example (CQI-009)

References:

Clinical Operations Revision Dates:

August 2018
July 2019

Reviewed/ Approved By	Facility	Effective Date	Review Date

(Centurion Indiana)

CQI AUDITING TOOLS AND TEMPLATES SUMMARY

(Centurion Indiana) specific CQI auditing tools/templates are developed to incorporate the Indiana Department of Corrections (IDOC) policies and procedures, Indiana Department of Corrections (IDOC) performance indicators, NCCHC and ACA Healthcare requirements, and Centurion's CQI review of processes. Our program starts with an **Annual Calendar**. A CQI Calendar is a method to assist in organizing and planning annual CQI activities. The calendar is a working document that provides program staff and the client a guide for future CQI projects.

The annual calendar is a living document – updates are made throughout the year depending on the County, Centurion and/or site needs. Sites will supplement the monthly audits with their own process and outcome studies as needed (but one of each is required per year). It is highly recommended that a proposed CQI calendar be prepared by and presented to the CQI Committee and staff at least 30 to 60 days prior to the end of the year to allow for appropriate review, feedback and approval.

CQI reviews are completed by conducting monthly audits, reviewing logs, conducting a time study, completing a process/outcome study, or by reviewing trending data. Centurion audit tools incorporate the Indiana Department of Corrections (IDOC) performance indicators, policies and procedures. Audit tools and process and outcome study templates can be found in the (Centurion Indiana) *CQI audit tool library section* of the Centurion portal page. Additionally, training materials can be found on Centurion's main Portal page under the *CQI section*.

Each month, based on the Annual Calendar, the CQI Coordinator will download the appropriate audit(s) from the portal, complete the auditing, and then upload the results onto the "CQI reporting" folder on the Centurion Portal. Additionally the CQI Coordinator will complete the **Centurion CQI Monthly Scorecard**

Centurion has developed the following standardized audit tools (templates are in the *CQI library section of the portal*):

- Chronic Care – Anticoagulation
- Chronic Care – Asthma
- Chronic Care – Diabetes
- Chronic Care – Seizures
- Crisis Intervention
- Initial Health Assessment
- Receiving Screening
- Nursing Sick Call

(Centurion Indiana) – Additionally, we have the following audit tools specific to contract needs:


- JMH – Initial Psych Medications
- JMH – Medication Adherence
- BH – Use of Restraints in MH
- BH – Care in Mental Health Unit
- Suicide Prevention
- Medication Management
- Pharmacy Operations and Management
- Infirmary/Inpatient Care
- Infection Control
- Preventative Services and Wellness Screening
- Receiving – Continuity of Care
- Dialysis
- Pre/Postnatal Care
- Employee Staffing and Competency
- Chronic Care – HIV
- Chronic Care – Hepatitis C
- Chronic Care – Hypertension
- Chronic Care – Cardiac
- Diagnostic Tests, ER, Hospital and Specialty Care
- Sick Call – Nurse Protocols
- Dental – Access to Care, Prosthetics
- RWI – Screening, Referral and Assessment
- RWI – Clinical Treatment Notes and Treatment Planning
- RWI – Treatment Summaries, Completions and Discharges
- Intoxicate/Overdose
- Transitional Health
- Offender Death/CCI process
- Vision Care

Centurion
CQI Annual Audit Calendar


Audit Topic	1st Qtr 2021			2nd Qtr 2021			3rd Qtr 2021			4th Qtr 2021		
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Chronic Care (TWICE A YEAR)		X						X				
Infirmity - If applicable (TWICE A YEAR)			X						X			
Medication Management (TWICE A YEAR)			X						X			
Receiving Screening - If applicable (TWICE A YEAR)					X						X	
Periodic Screening (ONCE A YEAR)										X		
Intersystem Transfer (TWICE A YEAR)				X						X		
Sick Call (TWICE A YEAR)	X						X					
Off-Site Specialty Care (TWICE A YEAR)							X					X
Discharge/Re-Entry (TWICE A YEAR)	X				X							
Emergency Care (ONCE A YEAR)		X										
Dental (ONCE A YEAR)				X								
Women's Care - If applicable (ONCE A YEAR)											X	
Inpatient Mental Health (QUARTERLY)	X			X			X			X		
Suicide observation (ONCE A YEAR)										X		
Outpatient Mental Health (QUARTERLY)		X			X			X			X	
Inmate Requests (ONCE A YEAR)												X
Psychiatric Emergency Tool (ONCE A YEAR)	X											
Mental Health Discharge/Re-Entry Tool (ONCE A YEAR)									X			
Mental Health Restraint (ONCE A YEAR)			X									
Psychiatric Medication (ONCE A YEAR)				X								
Reception Tool (ONCE A YEAR)					X							
Special Housing (ONCE A YEAR)							X					
Use of Force (ONCE A YEAR)								X				

1	This audit tool workbook/template is for use for one site's audit and results/graphs. The template cannot roll-up information from other sites. If several sites are being audited with the same questions/audit tools, see CQI - 002, Sample Blank Audit Tool - Multi-Sites.
2	Click on " Audit Tool Instructions " tab. For item #1, note where medical records will be randomly pulled and for what timeframe (i.e., "Pull 20 medical records from past 60 days from chronic care log, sick call log, MIARs, etc.)
3	Click on " Audit Tool-Data Entry " tab. This tab is the central tab for the audit. By inputting the audit questions into row 2 , the printable tab and summary/graph tab will automatically have the information inputted into the question sections. This is also the tab in which the site will enter results from the audit . By noting "1" in the appropriate "yes," "no" or "N/A" columns for each question, the score at the bottom of this sheet will be automatically calculated and the Summary and Graph tab will be automatically populated.
4	Click on " Audit Tool-Printable " tab and add the name of the audit tool in the highlighted cells. The rest of the sheet is locked and already formatted to print correctly.
5	" Notes " tab is used for further explanation of a particular question, to refer to appropriate policies/procedures etc., or can be used to make notes about information found during the audit.
6	The " Summary and Graph " tab is locked. The information is automatically populated from the " Audit Tool-Data Entry " tab. However, once the audit results have been entered in the data entry tab, the tab will need to be unlocked to print or distribute the audit report. The site name and audit tool name can be added to the yellow highlighted section. The password for this tab is password . Once the site name and audit tool name have been added, the tab can be re-locked.
7	To print any/all of the tabs of this workbook/audit tool, click the tab to print, go to print and choose which tab/tabs need to be printed. Use "active sheet" to print one single tab or "entire workbook" to print all tabs.


Settings


Print Active Sheets
 Only print the active sheets


Pages: to


Print One Sided
 Only print on one side of th...

Settings


Print Entire Workbook
 Print the entire workbook

Pages: to


Print One Sided
 Only print on one side of th...

Sample Size: 20 Medical Records	
1	Pull a random sample of 20 medical records
2	Print the "Audit Tool Printable" tab. The tab has been formatted to print correctly
3	Print the "Notes" tab if there are any notes. Notes may be needed to help in understanding some of the audit questions
4	Note the patient number in the File Identification column on the "Audit Tool-Printable" tab for each medical record audited
5	Manually record Yes, No or Not Applicable (N/A) response on the "Audit Tool-Printable" document for each medical record reviewed.
6	When the record reviews are completed, manual results should be transcribed onto the "Audit Tool-Data Entry" tab. Note a "1" into the appropriate box for each question.
	The compliance information will automatically be scored and documented on the "Summary and Graph" tab. The average for each question and the overall average score will be calculated. A graph will be provided for the scores.
7	If the results for any question are scored less than 90%, a Process Assessment Tool (CQI -004) must be completed. One Process Assessment Tool can be used for all items of the audit with less than 90% compliance.
8	After completion of the Process Assessment Tool, a 5 Whys Analysis , included in the Process Assessment Tool (CQI-004), should be completed to ensure that the root cause of the problem(s) has been determined.
9	Initiate CAP for the process and begin implementing changes.
10	When ready to re-audit to check for improvements, only use the question(s) that scored less than 90% in developing re-audit tool.
11	Add CAP information to Master CAP Roster (CQI - 007).
12	Print site's tab results, the Process Assessment Tool, the 5 Whys, the CAP, and the re-audit tool(s). File in CQI studies binder. Include completed manual audit tool sheet(s).

[illegible]

Centurion/MHM
Audit Tool

Question # 1				Question # 2				Question #3				Question #4				Question #5			
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AUDIT TOOL NAME PG 1				File Identification	Yes	NO	N/A	Yes	NO	N/A	Yes	NO	N/A	Yes	NO	N/A			
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Centurion/MH/M
Audit Tool

Question #6		Question #7			Question #8			Question #9			Question #10		
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File Identification	Yes	NO	N/A	Yes	NO	N/A	Yes	NO	N/A	Yes	NO	N/A	
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AUDIT TOOL NAME
PG 2

Centurion/MHM
Audit Tool

		Question #11			Question #12			Question #13			Question #14			Question #15		
AUDIT TOOL NAME PG 3		0			0			0			0			0		
	File Identification	Yes	NO	N/A	Yes	NO	N/A	Yes	NO	N/A	Yes	NO	N/A	Yes	N/A	
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Centurion/MHIM
Audit Tool

		Question #16			Question #17			Question #18			Question #19		
AUDIT TOOL NAME PG 4		0			0			0			0		
	File Identification	Yes	NO	N/A	Yes	NO	N/A	Yes	NO	N/A	Yes	NO	N/A
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		Question #20	Question #21		
AUDIT TOOL NAME PG 5		0	0		
	File Identification	Yes	NO	N/A	
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EVALUATION	Threshold for each indicator is 90 % (unless otherwise noted)																				
SITE NAME - AUDIT NAME																					
100%																					
80%																					
60%																					
40%																					
20%																					
0%																					
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	CRITERIA										Results			#DIV/0!	#
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Overall Compliance											#DIV/0!				

PERFORMANCE MEASURES						
	1. Access to Care (HCSD 2.04A)	Quarter	Penalty	Meggs	Riley	Keris/Mays Moore
1.1	All incarcerated individuals will be assigned to the appropriate medical status code during the intake process, as medically indicated and at least annually during the annual health screening process		Y	Y	Y	
1.2	All incarcerated individuals receive information regarding access to care procedures immediately upon arrival at intake and transfer to a new facility.			Y		
1.3	All incarcerated individuals shall have unimpeded access to quality care, regardless of housing assignment or lockdown status.					
1.4	Clinical services must be available at least five days a week for those facilities without 24/7 nursing coverage and seven days a week for those facilities with 24/7 nursing coverage.					
1.5	All incarcerated individuals have access to care that is quality and compassionate, access to a professional medical opinion and access to care and treatment that is prescribed in accordance with time frames established in the Health Care Services Directives (HCSD), American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC) standards, and consistent with contemporary standards of practice.					
1.6	All patients are transported off site for health services in a manner consistent with their clinical condition or consistent with contemporary standards of care.					
2.1	2. Administrative Responsibilities (HCSD 1.11A) All statistics required for contract monitoring will be submitted monthly and as requested. Vendor's staff will complete and forward all responses to inquiries, reports, and other requested documents within the time frames established by IDOC - within 24 hours but not greater than three business days.					
2.2	Vendor's staff will assist or prepare all health-related plans of correction, as necessary.					
2.3	3. Care of Incarcerated individuals in Restricted Housing (HCSD 2.25A and 4.03A)					
3.1	All incarcerated individuals in restricted housing are monitored in accordance with Health Care Services Directive (HCSD) 2.25A.	4		Y		
3.1.1	Documentation supports that health services staff were notified immediately by phone, e-mail, or direct, face to face contact when an incarcerated individual is transferred to a restricted housing unit; supports that when an incarcerated individual has been moved to a restricted housing setting, a nurse has immediately reviewed the incarcerated individual's health record to determine whether restricted housing was contraindicated due to an existing medical, dental, or mental health problem; and that if the nurse determined that restricted housing was contraindicated, the nurse contacted the appropriate provider (e.g. physician, dentist or psychiatrist) for direction and orders and notified the superintendent or designee of the provider's concern or decision.	4				
3.1.2	When an incarcerated individual has had prior contact with mental health, the operations staff or the nurse must contact the Facility's lead mental health professional for advice and direction. Documentation in the incarcerated individual's health record supports that the Mental Health Professional (MHP) reviewed the incarcerated individual's record and determined if restricted housing was contraindicated.	4	Y	Y		

3.1.2.1	At the time of transfer when the mental health professional was on-site; by the next business day when the mental health professional was not on site; an incarcerated individual in restricted housing who is/was receiving medication had no interruption in medication delivery/administration; and a suicide risk assessment as done within 24 hours of the incarcerated individual's admission/transfer to restricted housing.	4	y	y	y			
3.1.3	When an incarcerated individual has mental health code B or greater, the operations staff or the nurse must contact the Facility's lead mental health professional for advice and direction. Documentation in the incarcerated individual's health record supports that restrictive housing was not contraindicated due to serious suicidal intent, psychotic symptoms, or it a danger to self or others:	4	y		y			
3.1.3.2	If no mental health professional is on site, nursing shall contact the on-call mental health professional for consultation and direction and nursing documents as such.	4						
3.1.3.3	A restrictive housing review was conducted within 72 hours to determine if the incarcerated individual qualified as SMI.	4	y					
3.2	Incarcerated individuals in restrictive status housing are completely dependent upon facility staff for all services. Incarcerated individuals shall continue to receive Physical Health and Behavioral Health Services including prescribed medication while in restrictive status housing.	4						
3.3	Documentation of restricted housing rounds supports that the rounds were completed in accordance with HCSD 2.25A and 4.03 and in accordance with American Correctional Association (ACA)/ National Commission on Correctional Health Care (NCCHC) standards as well as with Ipas.	4						
3.3.1	For every incarcerated individual in restricted housing, a licensed nurse must visit each incarcerated individual in restricted housing once each day including weekends and holidays. Nursing rounds should be documented on State Form #46026, "Segregation/Detention Rounds Flow Sheet".	4	y		y			
3.3.2	A mental health professional must complete cell-front mental health rounds no less than every 30 days and document it on the Restrictive Housing Rounds template in the EMR.	4	y		y			
3.4	All incarcerated individuals in restricted housing have the same access to care as those in general population. There shall be no delay in care.	4						
3.5	Behavioral health staff will round on all incarcerated individuals in restricted housing in accordance with the matrix in HCSD 4.03A.	4						
3.6	Incarcerated individuals continue to receive routine healthcare services.	4						
3.6.1	Documentation supports that the incarcerated individual in restricted housing had access to health care within the timeframes established for other incarcerated individuals (e.g. 24 hours for nursing triage, 7-days for a provider appointment, routine mental health evaluations within 7 days; that necessary clinical evaluations (physical exams, mental health evaluation and treatment) were conducted in an appropriate clinical setting and not conducted at the incarcerated individual's cell; and that routine chronic care appointments and annual health screens were not delayed or stopped due to an incarcerated individual's placement in segregation.	4	y				y	

3.6.2	Whenever mental health needs have been identified, all documentation support that the incarcerated individual was referred to a mental health professional and seen immediately when the incarcerated individual presented with serious suicidal intent (e.g. actively engaging in acts of self-harm or active self-harm is imminent or causing serious property damage), or the incarcerated individual is psychotic (If the mental health professional is not on site, the nurse will contact the on call mental health professional for consultation and direction).	4	y				y	
3.6.3	Whenever mental health needs have been identified, all documentation support that the incarcerated individual was referred to a mental health professional and seen within 24 hours when the information on the health care request form is bizarre, disturbing, or incoherent or the information on the form suggests a depressed mood and the incarcerated individual has a previous history of suicide attempt.	4						
3.6.4	Whenever mental health needs have been identified, all documentation support that the incarcerated individual was referred to a mental health professional and seen when mental health needs are routine, the incarcerated individual will be evaluated by a mental health professional in accordance with the parameters of HCSD 2.04, "Access to Care." (within 24 hours of an urgent request and within 7 days for a routine request).	4						
3.6.5	Whenever mental health needs have been identified, all documentation support that the incarcerated individual was referred to a mental health professional and seen when an incarcerated individual is placed in a restrictive status housing unit the list of Chronic Problems and the incarcerated individual's Individualized Treatment Plan should be established or revised; the treatment plan must describe how mental health treatment needs will be met and identify specific time frames for follow-up evaluations which may not exceed 30 days.	4	y					
3.6.6	The updated treatment plan must include the specific services which will be provided while the incarcerated individual is in restrictive housing.	4						
3.6.7	The updated treatment plan must include the frequency of contacts (e.g. every 2 weeks) with the mental health staff. Frequency of MHP contact cannot exceed 30 days.	4						
3.6.8	The updated treatment plan must include the ITP and must be reviewed and revised at a minimum of every six (6) months.	4 y						
3.7	All documentation of restrictive housing rounds for incarcerated individuals with mental illness (and classified Seriously Mentally III) (SMI)) supports that rounds were completed in accordance with HCSD (HCSD) 2.25 and 4.03.	4						
3.7.1	For Mental Health – an MHP must complete weekly cell-front rounds for incarcerated individuals with mental health codes. Contacts must be documented and filed in the paper chart or the RH round chart in the EMR.	4	y				y	
3.7.2	For Mental Health – incarcerated individuals with an identified mental health need must be offered an out-of-cell evaluation which affords the incarcerated individual confidentiality no less than every 30 days and document it on the Restrictive Housing Visit template in the EMR.	4						
3.7.3	For SMI – an MHP must complete twice weekly rounds for incarcerated individuals classified SMI with no more than three (3) non-contact days between contacts. Contacts must be documented and filed in the paper chart or the RH round chart in the EMR.	4					y	

4.5.2.4.5	For incarcerated individuals requesting refills of inhalers “too soon”, an incarcerated individual was seen by a nurse or practitioner to rule out exacerbation or deteriorating condition (e.g. responses to the HCRFs should not be returned with written comments that the incarcerated individual is abusing the inhaler or requesting a refill too early and when an evaluation has occurred, PEAK flows and lung sounds must be documented).	2					
4.5.2.5	For patients experiencing an exacerbation or receiving Nebulizer treatments documentation supports:	2					
4.5.2.5.1	Pulmonary Assessment testing was obtained prior to the initiation of a nebulizer treatment.	2					
4.5.2.5.2	Pulmonary Assessment testing was obtained after the nebulizer treatment.	2					
4.6	All incarcerated individuals with HIV will be managed in accordance with the current guidelines of the Department of Health and Human Services (DHHS), Guidelines for the Use of Anti-retroviral agents in HIV-1-Infected Adults and Adolescents.						
4.6.1	For intake units:						
4.6.1.1	For all patients who are known or report being HIV infected at intake:						
4.6.1.1.1	HIV RNA and CD4 counts were obtained	2			y		
4.6.1.1.2	Completed blood count (CBC)	2					
4.6.1.1.3	Chemistry profile (e.g. liver function tests, glucose, BUN, creatinine etc.)	2		y			
4.6.1.1.4	Lipids	2			y		
4.6.1.1.5	Chest X-Ray	2				y	
4.6.1.2	Newly Diagnosed HIV						
4.6.1.2.1	CD4 counts	2			y		
4.6.1.2.2	Plasma HIV RNA	2					
4.6.1.2.3	CBC	2					
4.6.1.2.4	Chemistry panel (e.g. liver function tests, glucose, BUN, creatinine etc.)	2		y			
4.6.1.2.5	Lipid Panel	2					
4.6.1.2.6	Genotypic resistance testing	2					
4.6.1.2.7	Urinalysis	2				y	
4.6.2	All Other facilities						
4.6.2.1	Chronically ill incarcerated individuals will be seen in chronic care clinic (CCC) at least every 90 days if criteria are met for unstable chronic care health			y		y	
4.6.2.2	Chronically ill incarcerated individuals will be seen in CCC at least every 180 days if criteria are met for stable chronic care health				y		
4.6.2.3	HIV RNA and CD4 counts are obtained 2-8 weeks after treatment is initiated or changed.	2					
4.6.2.4	HIV RNA and CD4 counts are obtained every 3-4 months in patients not on medication or on medication but stable	2					
4.6.2.5	HIV RNA and CD4 counts are obtained prior to the initiation of treatment.	2					
4.6.2.6	When HIV RNA and CD4 counts are obtained, anti-retroviral therapy was initiated in all patients with a CD4 count below 350 (unless the incarcerated individual signed a refusal).	2					
4.6.2.7	When HIV RNA and CD4 counts are obtained, a chemistry panel, CBC, and lipid profile were obtained annually a minimum.	2					
4.6.2.8	When HIV RNA and CD4 counts are obtained, a fundoscopic exam was performed annually.	2					
4.6.2.9	When HIV RNA and CD4 counts are obtained, an annual dental exam is performed.	2					

All incarcerated individuals with hypertension will be managed in accordance with the guidelines of the National Heart, Lung and Blood Institute (NHLBI).

2 y y

4.7
4.7.1

For all adult facilities						
Documentation supports that an incarcerated individual who reported a history of high blood pressure requiring medication received urinalysis (urine dipstick or lab urinalysis).	3					
Documentation supports that an incarcerated individual who reported a history of high blood pressure requiring medication received blood glucose, potassium, creatinine, and calcium.	3					
Documentation supports that an incarcerated individual who reported a history of high blood pressure requiring medication received hematocrit.	3					
Documentation supports that an incarcerated individual who reported a history of high blood pressure requiring medication received lipid profile.	3					

For all other facilities						
Initial CCC appointment is done with the first 3 months of confinement or at the time of diagnosis and an electrocardiogram is given.	3				y	
Initial CCC appointment is done with the first 3 months of confinement or at the time of diagnosis and a urinalysis is performed.	3					
Initial CCC appointment is done with the first 3 months of confinement or at the time of diagnosis and blood glucose, potassium, creatinine, and calcium are given.	3					
Initial CCC appointment is done with the first 3 months of confinement or at the time of diagnosis and hematocrit is given.	3					
Initial CCC appointment is done with the first 3 months of confinement or at the time of diagnosis and a lipid profile is given.	3					
For incarcerated individuals aged 18 to 59 years without major comorbidities (e.g. diabetes, chronic kidney disease), the goal blood pressure level is $\leq 140/90$ mmHg.	3					
For incarcerated individuals aged 60 years or older with diabetes, chronic kidney disease, or both conditions, the goal blood pressure level is $\leq 140/90$ mmHg.	3					
For incarcerated individuals aged 60 years or older who do not have diabetes or chronic kidney disease the goal blood pressure level is $\leq 150/90$ mmHg.	3					
Risk factors have been addressed (e.g. if the incarcerated individual is obese, there is documentation that the provider recommended weight loss; if the incarcerated individual's LDL on the lipid panel is high, the incarcerated individual has been offered/prescribed a lipid lowering agent; the incarcerated individual has been encouraged to get at least 30 minutes of exercise a day)	3					
A lipid profile, glucose, potassium and creatinine were obtained annually.	3					
A funduscopic exam is performed annually.	3					

All incarcerated individuals with cardiac disease will be managed in accordance with guidelines established by the American Heart Association and the American College of Medicine.

4.8

For all adult intake units there was documentation that supports that an incarcerated individual who reported a history of high blood pressure requiring medication received an intake physical exam that included a notation regarding peripheral edema or jugular venous distention.	3					
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4.8.1

4.8.2	For all adult intake units there was documentation that supports that an incarcerated individual who reported a history of high blood pressure requiring medication received a 12-lead EKG within the first 14 days of admission.	3							
4.8.3	For all other facilities								
4.8.3.1	For all cardiac patients (CAD, stable angina, congestive heart failure, history of MI, post PTCA or CABG; for juvenile facilities, it applies to student with Marfan syndrome) there is documentation that supports:	3							
4.8.3.1.1	Chronically ill incarcerated individuals will be seen in chronic care clinic at least every 90 days if criteria are met for unstable chronic care health	3					Y		
4.8.3.1.2	Chronically ill incarcerated individuals will be seen in chronic care clinic at least every 180 days if criteria are met for stable chronic care health	3			Y			Y	
4.8.3.1.3	Patient was questioned about shortness of breath, fatigue, or changes in exercise tolerance at each visit (Give credit if the provider completed the "Constitutional" portion of the physical exam and charted "no apparent distress").	3							
4.8.3.1.4	Physical exam included an assessment of lung sounds. Give credit if the provider charted respiratory assessment was within normal limits in the physical exam section.	3							
4.8.3.1.5	Physical exam included an assessment of heart sounds. Give credit if the provider charted cardiac assessment was within normal limits in the physical exam section.	3							
4.8.3.1.6	Patient was examined for peripheral edema (e.g. swelling at the ankles). Give credit if the provider charted an extremity exam was within normal limits.	3							
4.8.3.1.7	Risk factors (e.g. hypertension, obesity, elevated lipids) have been addressed (e.g. treating HTN, advised on weight reduction, treating elevated lipids).	3							
4.8.3.1.8	Patients receiving a lipid lowering medication have had a lipid profile and liver function tests done at least every 6 months	3							
4.8.3.1.9	For patients not receiving a lipid lowering medication, documentation supports that a lipid profile has been done at least annually.	3							
4.8.3.1.10	Patient who are not diabetic, a serum glucose was obtained at least once each year.								
4.8.3.1.11	For incarcerated individual receiving nitroglycerin there is documentation of a diagnosis of angina (Give a 0 if nitroglycerin has been prescribed and there is no diagnosis documented in the health record which requires its use.	3							
4.8.3.1.12	Patient with angina or previous history of MI are receiving a beta blocker unless contraindicated.	3							
4.8.3.1.13	4.8.3.1.13. Heart patients with diabetes are receiving an ACEI, an ARB, or a calcium channel blocker (e.g. Norvasc) unless contraindicated.	3							
4.9	All incarcerated individuals on dialysis will be managed in accordance with national guidelines and contemporary standards of care.		3	Y			Y		
4.9.1	Documentation supports the delivered dose of hemodialysis is measured and documented using the Urea Reduction Ratio (URR) at least once each month (either the formal urea kinetic modeling (UKM) or the Daugirdas II formula for spKt/V can be used) with a 3 month average being equal to or greater than 1/2 or an average URR of at least 65%.	3							
4.9.2	Documentation supports a patient was monitored monthly for anemia (CBC or Hgb/Hct).	3							
4.9.3	Documentation supports a patient with Hgb below 12 was provided with epoetin alfa (Epogen, Procrit) unless contraindicated (noted on the health record).	3							

4.9.4	Documentation supports a patient on epoetin alfa have a percent transferring saturation and serum ferritin (iron studies) concentration measured at least once every three months.	3						
4.9.5	Documentation supports a patient with transferring saturations equal to or less than 20% and ferritin levels equal to or less than 100ng/ml receive IV iron unless contraindicated (noted on the health record).	3						
4.9.6	Documentation supports serum albumin levels are checked at least once every three months.	3						
4.9.7	Statistics are maintained noting the number of patients who are dialyzed for the prescribed time each week and the number and reason (e.g. patient refusal, hypotension) of patients who failed to dialyze for the prescribed number of hours.	3			y			
4.9.8	Statistics are maintained noting the number of patients who are dialysis through a catheter versus the number dialyzed through an arteriovenous fistula.	3						
4.9.9	Statistics are maintained noting the number of patients with Hgb above and below 12.	3						
4.9.10	Statistics are maintained noting the number of patients with transferring saturations above and below 20%.							
4.9.11	Statistics are maintained noting the number of patients with ferritin levels above and below 100 ng/ml.							
4.9.12	Statistics are maintained noting the number of patients with serum albumin above and below 3.5.							
4.1	Incarcerated individuals with chronic diseases will be provided services consistent with applicable HCSD.							

All incarcerated individuals with HCV will be managed in accordance with the guidelines of the American Association for the Study of Liver Disease (AASLD) or the Federal Bureau of Prison and HCSD 3.09. These guidelines will help determine prioritization in the treatment queue.

2

For intake units

4.11	For all patients who are known or report being HCV infected at intake, their vital signs were obtained at each CCC visit.	2			y			
4.11.1.1	For all patients who are known or report being HCV infected at intake, their weight was obtained at each CCC visit.	2					y	
4.11.1.2								
4.11.2	For all other facilities (annual review)							
4.11.2.1	Chronically ill incarcerated individuals will be seen in CCC at least every 90 days if criteria are met for unstable chronic care health			y			y	
4.11.2.2	Chronically ill incarcerated individuals will be seen in CCC at least every 180 days if criteria are met for stable chronic care health				y			
4.11.2.3	Lipid Panel is taken							
4.11.2.4	Comp Panel + CBC/Plt is taken							
4.11.2.5	LFTs are taken							
4.11.2.6	ALT is taken							

Major illness must be identified and documented in the EMR.

4.12								
4.12.1	Documentation supports that the incarcerated individual's height, weight, and BMI were obtained.		y			y		
4.12.2	Documentation supports that the incarcerated individual's vital signs were obtained.		y			y		
4.12.3	Documentation supports that the physical exam included an evaluation of the incarcerated individual's feet including a monofilament test.							

[illegible]

6.2.1	Documentation supports that for laboratory testing, the results were placed in record within one business day from receiving results.						
6.3	All diagnostic test results are initiated and dated by a provider, indicating review.						
6.3.1	Documentation supports that all diagnostic test results are initiated and dated by a provider or a progress note is available that indicates the results were noted.	y	y	y	y		
6.4	All diagnostic test results will be reported to the incarcerated individual and documented in the EMR.						
6.5	For all diagnostic tests which are abnormal, health record documentation reflects the practitioner's plan to address the result.	y	y	y			
7.1	7. Documentation of Care						
7.2	Health records are maintained in accordance with Health Care Services Directive (HCSD) 1.34A.						
7.3	Consents and refusals are completed in accordance with HCSD 1.30A.						
7.4	Documentation of care shall be completed on same business day.						
	Documentation of care shall fully describe the actions of care taken and the plan of care.						
8.1	8. Emergency Services (HCSD 1.05A)						
8.1.1	For all treatment provided in a local emergency room (ER), all documentation of the care provided is obtained and scanned into the health record within 24 hours.						
	The health record contains all documentation from the local emergency room (TBNA, ER encounter form) of the care and treatment provided.	y	y	y	y		

All health record documentation reflects the nature of the emergency, the assessments and clinical services performed, the time EMS was notified, the time they arrived, and the time they departed.

8.2	Documentation in the health record identifies the nature of the emergency, the clinical condition or the collection of symptoms that required emergency services or referral to an emergency room (e.g. vomiting blood, low blood pressure, chest pain, and rule out MI etc.).	y	y	y	y		
8.2.1	Documentation in the health record identifies the clinical services or treatment provided (e.g. CPR, oxygen, IV therapy, etc.).						
8.2.2	Documentation supports that when an ambulance was called, a progress note reflects the time EMS was notified, the time they arrived, and the time they departed.						
8.2.3	Documentation must support that the discharge instructions were reviewed immediately upon the patients return from the ER by nursing and the provider called for orders if recommended by the ER provider.						
8.3	All scanned documents show signature and date of provider who reviewed the ER orders.						
8.3.1	There is a nursing note included in patients' health records when an incarcerated individual is returned to site.	y	y	y	y		
8.3.2	For all instances of sexual assault, care is provided in accordance with Health Care Services Directive (HCSD) 2.30A, guidelines in the Sexual Assault Manual, and IDOC policy.	y	y	y	y		
8.4	Documentation supports that immediate assessments are made of sexual assault victim.						
8.4.1	Documentation supports that emergency room services are provided if they are required.						
8.4.2	Documentation supports that sexual assault victims were provided with counseling from mental health.						

8.5 All equipment and supplies, such as an AED, naloxone nasal misters, ambu bag-oxygen tanks etc., are in proper working order (and not expired) and immediately available to treat emergencies in all facilities.

y

8.5.1	Inspection, logs, equipment check lists, observation support that the AED is proper working order (battery is charged and in place, pads, wires etc.).								
8.5.2	Inspection, logs, equipment check lists, observation support that the EKG machine, oxygen tanks, IV supplies or other equipment needed in an emergency is proper working order and immediately available for use.								
8.5.3	Logs, procedures, equipment check lists or other documentation supports that equipment needed for emergency care is periodically checked or tested in accordance with the manufacturer's recommendation (e.g. blood pressure cuffs, glucometers - hi, low testing, expiration dates for IV bags).								
8.6	Rescue Bags used in "man down," signal 3000's or other onsite emergencies contain appropriate equipment and supplies and are checked and maintained in accordance the IDOC policy or contemporary standards of practice.								
8.6.1	Inspection of equipment checklist on man down bags is consistent with what is in the bag.								
8.6.2	Inspection confirms there are no outdated or expired items in the bag.								
8.7	For all incarcerated individuals sent to the ER, documentation in the medical record identifies the provider who gave the order to send the incarcerated individual out.								
8.7.1	Documentation supports that a provider gave the order when an incarcerated individual is sent to the emergency room.	y			y				
9.1	9. Hospital Care (HCSD 1.05A)								
9.1.1	For all incarcerated individuals released from the hospital, the orders of the discharging provider are implemented, or if not implemented, documentation in the medical record explains the rationale for not following the recommendations within 2 hours of the patients return or by the next business day.	y			y			y	
9.2	Documentation in medical file shows discharging providers orders are implemented or an explanation for not following the recommendations.								
9.2.1	For all hospital admissions, facility administrative personnel are advised and updated regarding the patient's condition and expected date of release.								
9.3	Documentation shows administrative personnel were advised and updated regarding the patient's condition and expected date of release.								
9.3.1	For all incarcerated individuals released from the hospital, the hospital discharge summary is scanned into the electronic medical record.								
9.4	Documentation from the hospital discharge summary is scanned into the incarcerated individual's medical file.								
9.4.1	For all patients admitted to the hospital, the health record reflects the reason for the admission including diagnosis if known.								
9.5	For all patients admitted to the hospital, the health record contains a progress note or all other documentation which notes the reason for the admission (difficulty breathing, rule out MI, etc.).								
10.1	There shall be a uniform process in place to track daily inpatient days and to provide daily report of condition to IDOC Division of Health Services.								
	10. Infection Control								
	All patients receiving medication for latent TB including INH are monitored for adverse effects as indicated by the current CDC recommendations or contemporary standards of practice.	2	y		y			y	

10.1.1	Specific disease documentation supports that the incarcerated individual on INH (or Rifampin) are seen monthly.	2	y	y				
10.1.2	Specific disease documentation supports that the incarcerated individual was assessed for clinical symptoms suggestive of hepatitis.	2						
10.1.2.1	Nausea		#					
10.1.2.2	Vomiting	2						
10.1.2.3	Abdominal pain	2						
10.1.2.4	Jaundice	2						
10.1.2.5	Yellow or brown urine	2						
10.2	All outbreaks of infectious or communicable diseases are managed in accordance with CDC/ISDH recommendations.	2						
10.2.1	There is an Infection Control Committee that meets at least quarterly which monitors the presence, transmission and control of infections in the facility.	2						
10.2.2	Specific disease documentation supports that statistics are maintained showing the number of incarcerated individuals treated for LTBI.	2						
10.3	Upon notification of suspected TB is reported to the Executive Director of Health Services and IDOC CMO immediately.	2						
10.3.1	Upon notification of any facility with a suspected case of TB is immediately reported to all appropriate IDOC staff.	2						
10.4	Screening for tuberculosis is completed in accordance with the IDOC's TB Control Plan. A symptom screen is done in conjunction with the TB skin test for all incarcerated individuals annually and at reception.	2	y	y	y	y		
10.4.1	Specific disease documentation supports that a symptom screen was done upon arrival.	2						
10.4.2	Specific disease documentation supports that newly admitted incarcerated individuals who report symptoms suggestive of active TB were masked and evaluated immediately by a practitioner.	2						
10.4.3	Specific disease documentation supports that a TB skin test was planted within the first 24 hours of incarceration.	2		y				
10.4.4	Specific disease documentation supports that the TB skin test was read between 48 and 72 hours of administration.	2		y				
10.4.5	For adults only, at the time of the initial TB skin test, all documentation supports that two-step skin testing was completed at least 7 days but no more than 30 days after the first test (does not apply to juveniles and does not apply to parole violators who have already had 2-step testing).	2						
10.4.6	Specific disease documentation supports that the incarcerated individuals had a symptoms screen done annually (e.g. annual health screen) – this applies to every incarcerated individual regardless of previous results of TB skin test.	2	y			y		
10.4.7	For those incarcerated individuals who are skin test negative, all documentation supports that the incarcerated individual received a TB skin test annually.	2						
10.4.8	Incarcerated individuals with history of a positive TB skin test and symptoms suggestive of TB were immediately referred to a practitioner for evaluation.	2						
10.5	All chest x-rays are completed in accordance with the IDOC's TB Control Plan.	2						

10.5.1	Documentation supports that a chest x-ray (CXR) was done within 7 days on an incarcerated individual with a history of a negative TB skin test who is now positive (mm of induration >10 for most incarcerated individuals) who has no symptoms.	2						
10.5.2	Documentation supports that new incarcerated individuals (intake facilities) known to have HIV infection or other severe immunosuppression had a CXR done as part of the initial screening, completed within 7 days, regardless of the results of the incarcerated individual's TB skin test.	2						
10.5.3	Documentation supports that a chest x-ray was done within 24 hours for any incarcerated individual who complained of symptoms suggestive of TB (e.g. at intake or during the annual screen).	2						
10.5.4	Documentation supports CXR was interpreted by a radiologist or radiology service within 48 hours of exposure.	2						
10.5.5	Documentation supports that a written report of a CXR reading by the radiologist or radiology service was forwarded to the facility within 24 hours of interpretation	2						
10.5.6	Documentation (e.g. initials on the report, a provider's encounter notes in the EMR etc.) supports that a provider reviewed the CXR report by the first business day following the receipt of the radiologist's written report.	2						
10.5.7	Documentation supports that the radiologist or designee telephoned to report abnormal results suggestive of TB.	2						
10.5.8	Documentation (e.g. initials, progress note, etc.) support that an abnormal chest x-ray was immediately brought to the attention of the practitioner	2						
10.6	All patients with latent TB are managed in accordance with the TB control plan and the current CDC recommendations.	2						
10.6.1	Documentation supports that the incarcerated individual who convert from negative to positive (>10 mm induration unless in a high-risk group) was evaluated for treatment against LTBI (e.g. INH). For intake facilities a note indicating the incarcerated individual should be evaluated for INH at the parent facility is sufficient to meet criteria.	2	y	y				
10.6.2	If the incarcerated individual was not placed on INH, all documentation must explain the reason why not.	2						
10.6.3	Documentation supports that the results of the chest x-ray were known before INH or Rifampin therapy was initiated.	2						
10.6.4	Documentation supports that the liver function tests were obtained prior to the initiation of treatment against LTBI for any patient with a history of liver disease, patients who used alcohol regularly, and persons at risk for chronic liver disease (e.g. hepatitis C).	2						
10.6.5	Documentation supports that a standard treatment regimen is/was used to treat LTBI (INH 300 mg daily for 9 months, INH 900 twice weekly for 9 months, Rifampin 600 mg daily for 4 months).	2					y	
10.7	All incarcerated individuals who are symptomatic or have chest x-rays suggestive or suspicious of TB are moved to a negative pressure room.	2						
10.7.1	Documentation supports that an incarcerated individual with a chest x-ray suggestive of active TB was moved to a negative pressure room.	2					y	

10.8	For all patients with active TB care and treatment is provided in accordance with the TB control plan or the CDC's recommendations. All contact tracing is conducted in accordance with generally accepted principles of infection control or at the direction of the local or state TB office.	2						
10.8.1	Immediate precautions against transmission are taken.	2						
10.8.2	Isolation status is mandatory.	2						
10.8.3	The Executive Director of Physical Health or designee must be fully informed regarding contact investigation activities and outcome.	2						
10.9	Sharps and hazardous waste are disposed of in accordance with IDOC procedures, the Health Care Services Directives (HCSD) and OSHA regulations.	2						
10.9.1	All records, logs or other documentation shows sharps and hazardous waste are disposed of properly.	2						
10.1	All incarcerated individuals who are symptomatic or have chest x-rays suggestive or suspicious of TB shall	2						
10.11	have sputum smears and cultures obtained.							
10.11.1	All facilities including intake facilities							
10.11.2	Documentation support that health care staff performing TB screening activities have been trained in the following: Proper use of the TB skin test, proper screening of incarcerated individuals at intake and annually, and association between TB and HIV.							
10.11.3	Documentation (state form 45900) supports new employees who will have contact with confined incarcerated individuals received a TB skin test (unless the employee provided a documentation of a previously positive TB skin test).		y		y			
10.11.4	Documentation supports staff were screened annually for the presence of TB, either through a TB skin test or a symptom screen.					y		

		PERFORMANCE MEASURES											
		11. Infirmar/Inpatient Unit						Quarter	Penalty	Meggs	Riley	Keris/Mays	Moore
11.1	All nursing services provided to incarcerated individuals in an infirmar/Inpatient unit are under the direction of a Registered Nurse (RN). An RN must be present in the infirmar 24 hours a day, 7-days a week.							3					
11.1.1.	Observations, logs, schedules, etc. support that a licensed nurse is on the unit 24 hours a day while patients are present.							3					
	For all Infirmar/Inpatient unit patients, the practitioner rounds, and charts on each patient every business day unless the diagnosis or condition of the patient dictates less frequent monitoring. All decisions to see the patient at a frequency less than every business day must be documented in the progress notes and noted in the provider's orders. The frequency of staff interactions must be reasonable and consistent with the diagnosis and acuity level.							3	y	y			
11.2.	Documentation supports that the practitioner visited the patient every business day (unless the diagnosis or condition of the patient dictates less frequent monitoring).							3					
11.2.1.	When the diagnosis or condition of the patient dictates less frequent monitoring, the patient's infirmar chart contains a progress notes that provides clinical rational for the less frequent monitoring.							3					
11.2.2.	For all Infirmar/Inpatient unit patients, nursing staff chart observations of the incarcerated individual, at a minimum, once each shift. (what is a shift)							3		y			
11.3.	All documentation supports that, at a minimum, a nursing progress note is written once each shift (except for the shift with the comprehensive note).							3			y		
11.3.1.	Documentation supports that a comprehensive nursing note addressing pertinent assessments (e.g. respiratory status, peripheral edema, capillary refill, etc.) skin quality, activities of daily living, eating and elimination, and so on, is written once each day.							3			y		
11.3.2.	Documentation supports that when PRN medication is provided, a subsequent nursing progress note is written indicating how the patient responded to the medication.							3					
11.3.3.	Documentation supports that, at a minimum, vital signs were taken and recorded each shift unless otherwise directed by the treatment plan and practitioner orders.							3	y		y		
11.3.4.	All Infirmar/Inpatient records reflect the care and treatment provided.							3					
11.5.	Documentation supports that all infirmar/inpatient records reflect the care and treatment provided.							3					
11.5.1.	All patients are admitted in accordance with guidelines established in Health Care Services Directive (HCSD) 6.01A.							3					
11.6.	The manual has a signature page that is current (annually) and contains the signatures of the HCA, the Medical Director, and the DON.							3					
11.6.1.	Memos, logs, call lists or other documents support that a physician is on call 24 hours a day with a telephone response time of 20 minutes or less. If a nurse practitioner is on a call, there is a physician available for consultation.							3					
11.6.2.	Observation, visual inspection etc. confirms that the inpatient units is clean and sanitary.							3					
11.6.3.	Observation, interviews, inventory sheets support that supplies are sufficient to provide adequate care.							3					
11.6.4.	Observation, preventive maintenance logs, interviews support that equipment is maintained in proper working order.							3					
11.6.5.								3					

11.7.	For all Infirmary/Inpatient unit admissions, a nursing care plan is completed within 8 hours of admission and updated as needed. A nursing care plan initiated by an LPN must be reviewed and co-signed by an RN prior to the end of that shift.	3							
11.7.1.	Admission orders must be written within 8 hours of an incarcerated individual's arrival and at a minimum, contain the following:	3							
11.7.1.1.	Diagnosis and reason for admission.	3							
11.7.1.2.	Medications.	3							
11.7.1.3.	Diet if different than the regular incarcerated individual diet.	3							
11.7.1.4.	Activity restrictions if any.	3							
11.7.1.5.	Vital sign frequency if different from the default	3							
11.7.1.6.	Other appropriate assessments (e.g. neuro checks, intake and output, weights etc.).	3							
11.7.2.	Documentation supports that when the nursing care plan was prepared by an LPN, an RN reviewed, and counter signed it.	3							
11.7.3.	When pre-printed nursing care plans are used, all documentation supports that the plan has been modified or individualized for the patient's specific needs.	3							
11.7.4.	The nursing care plan must be updated, revised or modified as the incarcerated individual's nursing care needs change or as identified problems have resolved.	3							
11.8.	All incarcerated individuals released from an infirmary will be seen by a provider for a follow up evaluation within 7 days of release.	3							
11.8.1.	Documentation supports that an incarcerated individual released from the infirmary was seen for follow up within 7 days of release.	3					y* unless otherwise ordered	y	
11.9.	All incarcerated individuals placed in an infirmary or observation area for a period of less than 24 hours will be provided services and monitored in accordance with the provider's orders.	3							
11.9.1.	For incarcerated individuals in an observation area or admitted to the infirmary on a 23-hour hold, documentation supports that the monitoring, care and treatment prescribed was provided.	3							
11.10.	For all Infirmary/Inpatient unit admissions, a comprehensive nursing assessment is completed immediately.	3							
11.10.1.	Documentation supports that a nursing assessment (e.g. orientation, level of consciousness, respiratory assessment, pertinent information such as rate of O2 delivery, IV-line status, etc.) was completed immediately upon arrival for all Infirmary/Inpatient unit admissions	3						y	
11.10.2.	Documentation supports that vital signs, including pulse oximetry or other pertinent assessments such as PEAK flow or finger stick blood sugar readings were obtained upon arrival.	3							
11.11.	For all Infirmary/Inpatient admissions, a history and physical is completed by the provider by the first business day	3							
11.11.1.	Documentation supports that an admitting history and physical was completed by the admitting or other responsible practitioner by the end of the first business day after admission.	3							y
11.12.	Documentation supports that the patient was admitted on the order of a physician, dentist, or licensed physician extender.	3							
11.13.	All advance directives are obtained by a practitioner.	3						y	
11.13.1	Documentation supports that an advanced directive for a terminally ill incarcerated individual was obtained by the practitioner.	3							

11.14.	All advanced directives are obtained in accordance with the applicable health care services directive and scanned into the EMR.	3							
11.14.1.	Documentation supports that an incarcerated individual who has been admitted to the infirmary or has been diagnosed with a terminal illness was given the opportunity to sign an advanced directive.	3							
11.14.2.	Documentation supports that the advanced directive was signed by the incarcerated individual and witnessed by at least one other person.	3							
11.14.3.	When competency is questionable or there is a history of mental illness, all documentation supports a mental status examination or mini-mental status examination indicating the absence of any thought or mood disorder and completed within 24 hours (before or after) the Advance Directive.	3							
12.1.	12. Inmate Death								
12.2.	Upon notification IDOC central office health services division and the facility's contract monitor are notified of an incarcerated individual's death immediately.								
12.3.	All facility mortality reviews are conducted within 30 days.								
	All plans of correction which are developed in response to a mortality review are submitted within 3 working days of the mortality review and reports noting progress of implementation are submitted monthly.								
13.1.	13. Intoxication and Overdose Data								
13.2.	For all patients who needed medical intervention due to acute intoxication overdose as it relates to the Health Care Services Directive (HCSD) 2.32.	2							
13.3.	Patient shall be seen upon arrival of the unit by medical staff following signal.	2							
	An evaluation will consist of a medical screening to determine if signs and symptoms are related to acute intoxications and/or overdose.	2							
13.4.	If under review for intoxication or overdose (OD) patient received a urinalysis or blood draw to determine drug type used which lead to the need for intervention. Method and results entered into EMR.	2							
13.5.	Patient report of use (if applicable) entered into EMR.	2							
13.6.	Detoxification recommendation followed as indicated by assessment tool (CIWA, COWS) and recorded in the EMR.	2							
13.7.	If Narcan was used, chart indicates number of doses administered and the method of administration (nasal, IV and IM etc.).	2							
13.8.	Chart indicates level of care used (observation or transfer to offsite care).	2							
13.9.	Patient referred to Addiction Recovery Services within 72 hours. Referral documented in EMR.	2							
13.10.	Patient referred to Mental Health Services. Referral documented in EMR.	2							
13.11.	Incarcerated individual seen by medical for intox and referred to ARS seen within 7 days of referral.	2							

14. Medication Administration									
14.1.	All medication administration records are completed in accordance with Health Care Services Directive (HCSD) 2.17A and contemporary standards of practice.	2y						y	
14.1.1.	Training records support that new employees, including officers in level 1 and work release facilities who are responsible for facilitating self-administration, have been trained regarding medication administration and associated documentation.	2							
14.1.2.	Inspection or review of MARs supports that document is completed, approved abbreviations or codes were used, and staff initiating the form have signed full signature and professional title.	2							
14.2.	Documentation on the health record supports that all incarcerated individuals who fail to show up for prescribed medication were counseled and the practitioner was informed, and subsequent action taken (for example, discontinuation of medication) was noted.	2							
14.2.1.	When an incarcerated individual has missed three doses within a month of hand fed medication or three attempts to distribute keep-on-person (KOP) medication, all documentation supports that the provider was notified.	2y							
14.2.2.	When an incarcerated individual has missed three doses within a month of hand fed medication or three attempts to distribute KOP medication, all documentation supports that the incarcerated individual was counseled and/or given a refusal form.	2							
14.2.3.	After the initial counseling, if the incarcerated individual again fails to show up for his/her medication, all documentation supports that the practitioner was notified.	2							
14.2.4.	After the initial counseling, if the incarcerated individual again fails to show up for his/her medication, all documentation supports that the medication was discontinued or the provider explained the rationale for continuing the medication.	2							
14.2.5.	Documentation supports that for students in juvenile facilities, the superintendent (warden) was notified of the students' noncompliance. Documentation needs to show non compliance if there was one (no specific amount).	2y							
14.3.	In the event a medication is discontinued or a request for a non-formulary medication has been given an alternative treatment plan, the provider must inform the incarcerated individual and provide documentation in the EMR.	2							
14.3.1.	An incarcerated individual must be told by the provider that he/she has discontinued a medication or started an ATP.	2							
14.3.2.	An encounter must note that a medication has been discontinued or an ATP for that medication is ordered.	2							
14.4.	Any medication identified by a provider that needs to be started that day is provided the medication from clinic stock, practitioner supply or the local pharmacy.	2							
15.1.	15. Mental Health								
15.1.1.	All incarcerated individuals will be assigned an appropriate mental health status code.	y						y	
15.1.2.	Every completed Suicide and Serious Suicide Attempted shall be reviewed within 30 days.	y						y	
15.2.	A psychological autopsy is conducted for all completed suicides.								
	A psychological autopsy is conducted for all completed suicides.								
15.3.	For all mentally ill patients residing in specialized mental health units (IRT/SNU/NCP) a treatment plan will be initiated and updated as required by Health Care Services Directive (HCSD) 4.03A.	3							y

15.3.1.	ITPs must be unique and specific to the incarcerated individual and include the problem being addressed, a list of goals and objectives specific to the problems, and a description of the specific interventions to be provided. The treatment plan should include the staff responsible for the interventions to be provided and the frequency or interval of follow up encounters.	3					y		
15.3.2.	Treatment plans also must be reviewed and revised at a minimum in Specialized mental health units every three (3) months.	3					y		
15.3.3.	Incarcerated individual was offered the 10 hours of minimum out of cell therapeutic treatment. The list of chronic problems and the incarcerated individual's ITP should be established ore revised in response to the following events: upon diagnosis or when a significant change in clinical status occurs; upon admission or discharge from a specialized mental health unit; and when a course of planned treatment is completed.	3					y		
15.3.4.									
15.4.	Specialized mental health training is provided to all staff working in a specialized mental health treatment unit.	3							
15.4.1.	All documentation supports that mental health staff have assisted in training specialized mental health unit staff as Certified Treatment Specialists by facilitating the Treatment component of the training	3							
15.4.2.	Documentation supports that mental health staff have assisted in recertifying specialized mental health unit staff as Certified Treatment Specialists by facilitating the Suicide Prevention and Behavior Change components of the annual in-service training.	3							
15.5.	All mentally ill incarcerated individuals being released to the community receive medications per policy and are scheduled for wrap around services.	4							
15.6.	All mental health services, including screening, triage, routine referral, emergency care, risk assessment, medication management, and suicide prevention are provided in accordance with all mental HCSD, established treatment guidelines and contemporary standards of care.	4							
15.6.1.	Documentation support that the incarcerated individuals was asked about past or current mental illness and mental health treatment including hospitalizations upon arrival.	4							
15.6.2.	Documentation support that the incarcerated individual was asked about a history of or current suicidal ideation upon arrival.	4							
15.6.3.	Documentation support that, upon arrival, the incarcerated individual was asked about legal and illegal drug use including the time of last use.	4							
15.6.4.	Documentation support that, upon arrival, the incarcerated individual was asked about drug withdrawal symptoms.	4							
15.6.5.	Documentation support that staff doing the arrival screen observed the incarcerated individual for appearance.	4							
15.6.6.	Documentation support that staff doing the arrival screen observed the incarcerated individual for state of consciousness (e.g. alert and oriented).	4							
15.6.7.	Documentation support that staff doing the arrival screen observed the incarcerated individual for appropriate behavior (e.g. activity on the Suicide/BH template).	4							
15.6.8.	Documentation support that patients who require emergency mental health services (especially those at risk of injury to self or others, or of causing serious property damage) were seen immediately or that nursing staff contacted an MHP for direction.	4					y		
15.7.	All treatment plans identify symptoms or behaviors targeted for treatment, risk and crisis management, cognitive and educational strategies and follow up including discharge planning as clinically indicated.	4							

15.7.1.	ITPs must be unique and specific to the incarcerated individual and include the problem being addressed, a list of goals and objectives specific to the problems and a description of the specific interventions to be provided.	4							
15.7.2.	The treatment plan should include the staff responsible for the interventions to be provided and the frequency or interval of follow up encounters.	4							
15.7.3.	The list of Chronic Problems and the incarcerated individual's ITP should be established or revised in response to the following events:	4							
	• Upon diagnosis or when a significant change in clinical status occurs;		#						
	• Upon admission or discharge from a specialized mental health unit;								
	• When a course of planned treatment is completed; and,								
	• If expected outcomes are not realized within an appropriate period of time.					y			
15.7.4.	Treatment plans also must be reviewed and revised at a minimum in general population units, every 6 months.	4							
15.8.	All mental health patients receiving medication are monitored for adherence and adverse effects.		4						
15.8.1.	Documentation support that an incarcerated individual who was referred to a psychiatrist for medication by a mental health professional or staff was seen within 7 days for a psychiatric evaluation	4							
15.8.2.	Documentation support that informed consent for use of medications was signed by the incarcerated individual	4		y					
15.8.3.	Documentation supports that incarcerated individuals receiving psychotropic medication are seen every 90 days unless the psychiatric provider's progress note indicates a different frequency	4		y					
15.8.4.	For incarcerated individuals who are on an antipsychotic agent, all documentation supports a formal abnormal involuntary movement scale (AIMS) assessment was completed before the dose is administered	4		y			y		
15.8.5.	When psychotropic medication is discontinued, all documentation supports the incarcerated individual was seen within thirty (30) days or within the timeframes established in the updated ITP to determine if a return to treatment with medication is appropriate.	4							
15.9.	For all mentally ill patients residing in specialized mental health units will receive a mental health evaluation and psychiatric assessment in accordance with HCSD 4.0.3.		4						
15.9.1.	Patient shall be seen within one working day of arrival of the unit by mental health staff.	4		y			y		
15.9.2.	An evaluation will consist of a mental status examination for mental health needs within 24 hours of arrival.	4							
15.9.3.	An evaluation of mental health status examination will be conducted weekly for the first 3 months.	4							
15.9.4.	An evaluation of mental health status examination will be conducted once per month from the third to the sixth month.	4							
15.9.5.	An evaluation of mental health status examination will be conducted once every 90 days after 6 months.	4							
15.9.6.	Incarcerated individuals receiving psychotropic medication must be seen within one (1) week by a psychiatric prescriber.	4		y				y	

15.9.7.	An incarcerated individual who is not currently receiving psychotropic medication must be seen by the psychiatric prescriber in accordance with the incarcerated individual's ITP or upon requests that have been found twice unresponsive with Mental Health staff; unless case consultation/staffing with the psychiatric prescriber has taken place, and noted within the EMR, stating that medication management is not indicated.	4					
15.10.	All forced psychotropic medication is provided in accordance with HCSD 4.08 and 4.10.	4	Y				
15.11.	All use of seclusion and restraint adheres to the guidelines established in HCSD 4.02.	4			Y		
15.11.1.	HSA is responsible for reporting the use of restraints and seclusion and forwarding this information to Executive Director of Physical Health or designee.	4					
15.12.	Contractor is to maintain statistics on the number of instances of aggressive, disruptive, or self-injurious behavior in patients with mental illness in general population, and the number of patients placed on Constant and Close Observation.	4					
15.12.1.	Statistics for Mental Health sentinel incidents and number of close and constant observations are included in the Healthcare Service Report.	4					
15.13.	Suicide prevention services are provided in accordance with HCSD 4.06.		3				
15.13.1.	Close or constant observation order was entered within one day of initiation of observation		3				
15.13.2.	At a minimum, once each shift, nursing staff shall obtain vital signs and conduct a mental status assessment for any patient on Constant Watch. The nurse shall document the results of these assessments in the electronic medical record.		3				
15.13.3.	When the MHP is not on site, a Mental Health trained nurse shall complete a mental status assessment once per day.		3				
15.13.4.	Once an incarcerated individual has been released from suicide watch and should receive follow-up assessments by Mental Health staff within 24 hours of the watch being discontinued, unless indicated clearly in a discontinuation note that further follow-up is not clinically needed.		3		Y		
15.13.5.	Assessment by Mental Health staff conducted once a week for 2 weeks after watch was discontinued.		3 Y				
15.13.6.	Assessment by Mental Health staff conducted within 30 days after watch was discontinued.		3 Y		Y		
15.13.7.	Mental Health staff are expected to provide documentation of:		3				
15.13.7.1	1. Date, time, location of situation		3				
15.13.7.2	2. Chronological account of the development and handling of the crisis		3				
15.13.7.3	3. Description of incarcerated individual's behavior and mood		3				
15.13.7.4	4. Information gathered from other staff involved		3				
15.13.7.5	5. Psychiatric history review		3				
15.13.7.6	6. Rationale of the crisis status placement		3				
15.13.7.7	7. Current mental health status		3				
15.13.7.8	8. Individual Treatment Plan with clearly stated and relevant problems, goals, objectives, interventions, time frames, and staff responsibility		3				
15.13.7.9	9. An MHP's orders		3				
15.13.8.	Mental health staff is responsible for assigning the incarcerated individual mental health status code after proper evaluation.		3				
15.14.	All Adult Facilities						

15.14.1.	Documentation support that a mental health appraisal conducted by a mental health professional was completed within 14 days of arrival.	4	y			y	
15.14.2.	Documentation support that the mental health appraisal included an assessment of current mental status (e.g. orientation to person place and time).	4					
15.14.3.	Documentation support that the mental health appraisal included a history of psychiatric hospitalization and outpatient treatment.	4					
15.14.4.	Documentation support that the mental health appraisal included information regarding current and recent suicidal ideation and history of suicidal behavior.	4				y	
15.14.5.	Documentation support that a mental health appraisal included an assessment of violent behavior.	4					
15.14.6.	Documentation support that a mental health appraisal included an assessment of victimization including physical and sexual abuse.	4					
15.14.7.	Documentation support that a mental health appraisal included information regarding special education placement.	4					
15.14.8.	Documentation support that a mental health appraisal included information regarding cerebral trauma or seizures.	4					
15.14.9.	Documentation support that a mental health appraisal included information regarding sex offenses.	4					
15.14.10.	Documentation support that a mental health appraisal included information regarding exposure to traumatic life events and losses.	4					
15.14.11.	Documentation support that a mental health appraisal included information regarding current or past psychotropic medication usage.	4					
15.14.12.	Documentation support that a mental health appraisal included information regarding past psychotherapy.	4					
15.14.13.	Documentation support that a mental health appraisal included information regarding drug and alcohol usage.	4					
15.14.14.	Documentation support that a mental health appraisal included information regarding overall intelligence.	4					
15.14.15.	Documentation support that a mental health appraisal included a comment regarding the incarcerated individual's emotional response to incarceration.	4					
15.14.16.	Documentation support that incarcerated individuals with identified mental health needs received a mental health evaluation within 7 days.	4					
15.14.17.	Health care administrators at those facilities without mental health services on site shall identify a psychologist and psychiatrist from another facility who shall provide leadership and direction as necessary.	4					
15.15.	Triage						
15.15.1.	Documentation support that a health care request form requesting mental health services was screened within 24 hours by a nurse, qualified mental health professional or, in facilities without 7 day per week nursing coverage, an appropriately trained IDOC employee		y			y	
15.15.2.	Documentation support that an incarcerated individual who requires emergency mental health services (e.g. those at risk of injury to self or others or of causing zserious property damage) was seen immediately or that nursing staff contacted an MHP for direction		y			y	

15.15.3.	Documentation support an incarcerated individual was seen face to face within 24 hour of receipt for an urgent problem (e.g. information on the health care request form is bizarre, disturbing, illogical or incoherent, or the information on the form suggests a depressed mood and the incarcerated individual has a previous history of suicide attempt).								
15.15.4.	When the HCRF has been screened by a nurse or other (non-mental health staff) and determined to be non-urgent (routine), all documentation supports that an MHP saw the incarcerated individual face to face within 7 days.	y					y		
15.15.6.	Documentation supports that the initial evaluation for mental health treatment included a mental status exam (EMR template) including appearance, orientation, behavior, speech, affect, mood, memory, intellect, and attitude.								
	16. Mental Health – Juvenile								
	All mental health services including screening, triage, routine referral, emergency care, risk assessment, medication management, and suicide prevention are provided in accordance with all Mental Health Care Services Directives (HCSD), established treatment guidelines and contemporary standards of care. All documentation supports that the student was asked about:	4					y		
16.1.	• past or current mental illness and mental health treatment including hospitalizations upon arrival	4							
16.1.1	• history of or current suicidal ideation upon arrival	4				y			
	• legal and illegal drug use including the time of last use drug withdrawal symptoms	4							
	• Appearance	4							
	• State of consciousness (e.g. alert and oriented)	4							
	• Appropriate behavior (e.g. activity on the Suicide/BH template)	4							
16.1.2.	Students who require emergency mental health services (especially those at risk of injury to self or others, or of causing serious property damage) were seen immediately or that nursing staff contacted an MHP for direction.	4 y					y		
16.1.3.	Students arriving at intake on psychiatric medication documentation supports a provider was contacted for drug orders.	4 y					y		
16.1.4.	Community Records were requested or obtained when the student reported receiving mental health treatment in the community including medication and supportive counseling.	4 y					y		
16.1.5.	The MAYSI-2 was completed within 24 hours of the student's arrival. Only score if MAYSI-2 is done.	4							
16.1.6.	"Limits of Confidentiality" form was completed within 24 hours of arrival.	4 y					y		
16.1.7.	Documentation supports that a mental health appraisal conducted by a mental health professional was completed within 7 days of arrival	4							
16.1.8.	Documentation supports that the mental health appraisal included an assessment of current mental status (e.g. orientation to person place and time)	4							
16.1.9.	Documentation supports that the mental health appraisal included a history of:	4							
	• Psychiatric hospitalization and outpatient treatment.	4							
	• violent behavior	4							
	• current and recent suicidal ideation and history of suicidal behavior	4							
	• victimization including physical and sexual abuse	4							
	• special education placement	4							
	• Psychosocial/family history and assessment of current family circumstances	4							

	• Developmental history	4					
	• Cerebral trauma or seizures	4					
	• Sex offenses	4					
	• Exposure to traumatic life events and losses	4					
	• Drug and alcohol usage.	4					
	• Orientation to person, place and time	4					
	• Orientation to person, place and time	4					
	• Emotional response to incarceration.	4					
16.2.	Juvenile MH Triage	4					
	Documentation support that a health care request form requesting mental health services was screened within 24 hours by a nurse, qualified mental health professional or, in facilities without 7 day per week nursing coverage, an appropriately trained IDOC employee	4				y	
16.2.1.	Documentation support that a student who requires emergency mental health services (e.g. those at risk of injury to self or others or of causing serious property damage) was seen immediately or that nursing staff contacted an MHP for direction.	4 y				y	
16.2.2.	When the HCRF has been screened by a nurse or other (non-mental health staff) and determined to be non-urgent (routine), documentation supports that an MHP saw the incarcerated individual face to face within 7 days.	4					
16.2.3.	Documentation support that a student referred for mental health treatment, from intake screening or sick call from the mental health professional, was seen by a psychologist within 7 days.	4					
16.2.4.	Documentation support that the initial evaluation for mental health treatment included an assessment of educational and vocational skills assessment and family relationship.	4					
16.2.5.	Documentation support that the initial evaluation for mental health treatment included a mental status exam (EMR template) including appearance, orientation, behavior, speech, affect, mood, memory, intellect, and attitude.	4					
16.2.6.	All treatment plans identify symptoms or behaviors targeted for treatment, risk and crisis management, cognitive and educational strategies and follow up including discharge planning as clinically indicated.	4					
16.3.	Problem lists and treatment plans should be reviewed and updated if indicated at least at the following times:	4					
16.3.1.	• Upon admission or transfer to a residential facility.	4					
	• Upon diagnosis or when a significant change in clinical status occurs.	4					
	• When community mental health records are received.	4					
	• A course of planned treatment is completed	4					
	• If expected outcomes are not realized.	4					
16.3.2.	Logs meeting minutes or other documentation supports psychologist and/or MHP participate in regularly scheduled multi-disciplinary meeting (may be monthly in some facilities, weekly in others -- facility must follow their established schedule)	4					
16.3.3.	Documentation support information regarding functional impairment or improvement (school performance, social skills, behavior, etc.) from the multi-disciplinary meeting is integrated into the medical record	4					

16.3.4.	Documentation support that a student who is transferred to another IDOC facility had a discharge summary or "transfer sending" note was generated that described the scope of mental health treatment provided at the sending facility.	4				
16.4.	All mental health patients receiving medications are monitored for adherence and adverse effects.	4 y			y	
16.4.1.	Documentation supports any student who reported taking medication within 60 days prior to arrival were seen by the psychiatrist within 7 days of arrival.	4				
16.4.2.	Documentation supports that a student who was referred to a psychiatrist by the nurse, mental health professional or facility staff for medication was seen within 7 days for an evaluation	4				
16.4.3.	Documentation supports that informed consent for use of medications was signed by the student	4 y			y	
16.4.4.	Documentation supports that informed consent was signed by the superintendent	4 y			y	
16.5.	All forced psychotropic medication is provided in accordance with Juvenile HCSD 4.03.	4			y	
16.5.1.	Documentation supports that students receiving psychotropic medication are seen monthly by the psychiatrist or psychiatric nurse practitioner	4 y				
16.5.2.	Documentation supports that the "Comments/Concerns on Psychiatric Treatment" form was sent to the parent or community caretaker of a student who has been prescribed psychotropic medication	4				
16.5.3.	Documentation supports that a student on psychotropic medication was seen by the mental health professional every 30 days.	4				
16.5.4.	When psychotropic medication is discontinued, all documentation supports the student was seen within 90 days of the last dose of medication to determine if a return to treatment with medication is appropriate	4				
16.5.5.	Documentation supports when medication has been discontinued, follow up evolution is done by the mental health professional in accordance with the juvenile's treatment plan but no later than 90 days	4				
16.6.	All use of seclusion and restraint adheres to the guidelines established in HCSD 4.02.	4			y	
16.6.1.	HSA is responsible for reporting use of restraints and seclusion and forwarding this information to Executive Director of Physical Health or designee.	4				
17.	Pharmacy Services					
17.1.	Documentation show that for all controlled substance counts that are inaccurate will be reported to the quality assurance manager and the Executive Director of Physical Health immediately.	2				
17.2.	All high-profile medication errors/discrepancies will be reported to the quality assurance manager and the ED of Physical Health immediately.	2	y			
17.3.	All quarterly Pharmacy Consultant reports note no deficiencies and are completed quarterly at approximately 90-day intervals.	2				
17.3.1.	Documentation supports that no deficiencies were noted on the last consultant pharmacy visit.	2				
17.3.2.	When deficiencies were noted, all documentation supports that corrective action was implemented and no deficiency was found on the consulting pharmacist's next visit.	2				
17.4.	Medications are stored in accordance with Health Care Service Directive (HCSD) 2.17A.	2				

17.5.	Every site must have an organized system for DOT and KOP medications; a log of FER's, and a system that allows for re-ordering of medications so that no incarcerated individual goes without.	2						
17.5.1.	Documentation shows that medication is organized and ordered on time through a FER log and a renewal binder.	2						
17.6.	Medication storage areas are inspected monthly to ensure that they are free of outdated or expired medications.	2						
17.6.1.	All inspection, interviews, or documentation supports that medication storage areas are inspected monthly.	2						
17.7.	Controlled substances are counted and inventoried at the end of every shift in accordance with HCSD 2.17A.	2						
17.7.1.	Documentation supports that controlled substances are counted at the beginning and end of each shift by two staff members, preferably one staff member from the ending shift and one from the oncoming shift.	2			y		y	
17.7.2.	Inspection, observation or interview confirms that controlled substances (schedules II, III, IV and V medications) are stored in a designated area under two locks.	2						
18.1.	18. Prescriptions							
18.1.1.	All medications, including over-the-counter medications, necessary to treat a serious medical condition are prescribed in accordance with Health Care Services Directive (HCSD) 2.17A.	2						
18.2.	Documentation supports that all verbal and telephone orders were subsequently countersigned or approved by the provider.	2						
18.2.1.	All decisions regarding off formulary requests are noted in the health record.	2						
18.2.2.	Documentation supports that formulary exception request (FER) was generated at the time the prescription was initiated (e.g. there should be no delays of days to weeks in the initiation of medication because the provider did not initiate the FER)	2						
18.2.3.	In facilities with more than 1 provider, a mechanism has been established (tracking calendar, logbook etc.) to track FERs.	2						
18.2.4.	Documentation supports that the disposition of the non-formulary exception request was received by the facility within 3 business days.	2						
18.2.5.	Documentation supports that all non-FERs and the disposition of the request are noted in the health record	2						
18.3.	When the FER was returned with a recommendation for "alternative treatment," documentation supports the provider initiated a suitable alternative OR resubmitted the FER with additional information (e.g. some action was taken by the provider).	2						
18.4.	All routine practitioner orders are addressed and transcribed by 11:59pm of that same day. A 24-hour review/chart check should be completed within the next 24 hours and documented in the EMR.	2						
18.5.	All prescribed medications arrive within 48 hours.	2						
18.6.	There must be a process in place to ensure that chronic medication is not allowed to expire.	2						
18.6.1.	All provider orders for new medications and any changes in an existing prescriptive regimen are accompanied by a progress note which documents the rationale for the prescription.	2						
18.6.2.	Drug therapy is initiated or continued only after an appropriate clinical evaluation has been completed (e.g. for prescriptions like Claritin, Zantac, or Naprosyn or Mobic, there must be a condition on the problem list that warrants this medication).	2						

18.7.	All medications which must be started without delay are provided through stock supplies or through local sources in the community.	2							
18.8.	An adequate supply of urgent/emergent medication must be kept in clinic stock and checked weekly in accordance with HCSD 2.17A.	2							
18.8.1.	Documentation shows adequate amount of clinic stock and that it is inventoried weekly.	2							
18.9.	It is the nursing staff's responsibility to notify provider for new orders before expiration occurs.	2							
	19. Preventive Services and Wellness								
19.1.	All vaccinations are provided in accordance with recommendations of the Advisory Committee on Immunization Practices (ACIP).		y						
19.1.1.	Tetanus-diphtheria (Tdap/Td) was administered at 10-year intervals (age 20, 30, 40, etc.).						y		
19.1.2.	1 dose of Tdap was administered to pregnant female incarcerated individual during each pregnancy (preferred during week 27 to 36 weeks gestation) regardless of the interval since prior Td or Tdap vaccination.							y	
19.1.3.	All incarcerated individuals over age 65 received a pneumococcal polysaccharide vaccine given.							y	
19.1.4.	A single dose of zoster vaccine was administered to an adult incarcerated individual age 70 or older.							y	
19.1.5.	The health record reflects the VIS Material for the current year was provided including the Publication Date (has been a federal law since 1999).								
19.1.6.	Childhood vaccines were administered in accordance with the schedule established by the Vaccines for Children Program.								
19.2.	At a minimum, all services receiving an "A" or "B" recommendation by the US Preventive Services Task Force (USPSTF) are provided.								
19.2.1.	The annual health screen was completed during the incarcerated individual's birth month (For incarcerated individuals who recently received the intake health appraisal during the previous 3 months, the annual screen may be deferred one year.)								
19.2.2.	An incarcerated individual who answered "yes" to questions regarding symptoms was referred to a practitioner for evaluation.								
19.2.3.	Vital signs and weight were recorded in the EMR or on the appropriate section of the state form.								
19.2.4.	For incarcerated individuals with no chronic health problems, a lipid profile was obtained every 5 years for men over age 35 and for women over age 45 (those at increased risk of coronary heart disease (diabetes, HTN, multiple risk factors [tobacco use, HTN, etc.] family history of cardiovascular disease before age 50 in male relatives and age 60 in female relatives). A serum glucose or HgbA1C was done in accordance with the time frames noted on the preventive services grid.					y			y

19.2.5.	For all incarcerated individuals, beginning at age 50 and continuing to age 74, a screening test for colorectal cancer was performed (fecal occult blood testing, flexible sigmoidoscopy, colonoscopy, or double contrast barium enema) at least once every 10 years (score if the procedure was due this contract year. Mark N/A if the incarcerated individual should not have been scheduled for this contract year. incarcerated individuals age 55 to 80, who have a 30 pack-year smoking history and currently smoke or have quit smoking within the past 15 years, a low dose CT scan was done annually. Screening may be discontinued once an incarcerated individual person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.								
19.2.6.	For incarcerated men aged 65-75 who have ever smoked, documentation supports that an ultrasound was done to screen for abdominal aortic aneurysm (AAA) (limited to those inmates with at least 180 days or more to serve).								
19.2.7.	For incarcerated females age 21-65 with a cervix, documentation supports that a PAP smear was done in accordance with the timeframes recommended by HCSD 3.13 and preventive services grid. Score only if the pap smear was due during this contract year. Mark N/A if not due this contract year.								
19.2.8.	A mammogram was done every two years for women age 50 to 74 (score if the audit was during the years due, mark N/A if incarcerated individual is not due this year).					y			
19.2.9.	Woman aged 65 and older were screened for osteoporosis (repeat screening interval is a minimum of 2 years after age 65; to be determined case by case by the facility's provider.								
19.3.	Influenza vaccine is made available, once each year, in accordance with the recommendations of the Centers for Disease Control and Prevention (CDC) and IDOC Influenza Control Program.								
19.3.1.	All documentation in the health record or sign up logs supports that all incarcerated individuals have been offered the influenza vaccine each year during the flu season.								
19.4.	Annual health screening is completed during all adult incarcerated individual's birth months and for juveniles during the intake anniversary month-in accordance with HCSD 2.09A								
19.5.	TB Screening is completed annually for all adult incarcerated individuals during the annual health screening process and for juveniles during the intake anniversary month.								
19.6.	TB Screening is completed annually for all staff members.								
20.1.	20. Prosthetics, Orthotics & Durable Medical Prosthetics, orthotics, durable medical equipment, bottom bunks (not meeting formulary criteria), canes, walkers and provider orders for shoes must be provided only on the approval of a formulary exception request.								

		PERFORMANCE MEASURES						Quarter	Penalty	Maggs	Riley	Keris/Mays	Moore
21. Quality Assurance													
21.1.	All quality assurance (QA) activities are consistent with Health Care Services Directive (HCSD) 1.09A												
21.2.	All plans of correction designed in response to a deficiency noted during a QA activity are submitted to the vendor's Director of QA and the facility's quality assurance manager.												
21.3.	At a minimum, at least one site specific QA monitoring activity is conducted monthly at each facility.												
22. Reception Screening													
22.1.	All incarcerated individuals receive reception screening in accordance with Health Care Services Directive (HCSD) 2.03A (Adult and Juvenile).							y	y	y			
22.2.	All medication that must be continued without interruption such as insulin, cardiac medication, antiretroviral, psychiatric medication is administered at the first medication administration time after the incarcerated individual's arrival.							y	y	y			
22.3.	The Point of Entry (POE) screen is completed in accordance with HCSD 2.03A (Adult and Juvenile).												
22.4.	Community or jail health records are obtained when they are necessary for continuity of care in accordance with HCSD 2.27A.												
22.5.	All incarcerated individuals are screened for alcohol and drug withdrawal in accordance with HCSD 2.03A (Adult and Juvenile)							y	y	y			
23. Safety and Security													
23.1.	All health care staff abide by the security procedures of the facility as established by IDOC policy.												
23.1.1.	Observation, inspection confirms that all staff displayed approved identification cards on their person, in plain view.												
23.1.2.	Observation, inspections confirms that rooms and cabinets that should be locked are locked.												
23.1.3.	Observation, interview or inspection supports that health care staff carrying keys have concealed them in a pocket or fastened them to an approved key holder.												
23.1.4.	Observation or inspection supports that keys were not left unattended, hanging in locks, or left lying on desks, tables or at posts.												
23.1.5.	Observation or inspection supports that keys were not thrown to another staff person or slid from one point to another across a desk or floor.												
23.1.6.	Observation, interviews, or review of site-specific procedure confirm that the staff person's immediate supervisor is notified when keys are lost or broken keys.												
23.1.7.	Observation supports that incarcerated individuals were not in unauthorized areas.												
23.1.8.	Observation supports that incarcerated individual workers are directly supervised.												
23.2.		All health care staff maintain control of hazardous material and supplies and maintain a perpetual inventory of sharps and tools in accordance with IDOC policy.											
23.2.1.		Observation or inspection supports that surgical instruments, suture removal kits and other sharps are in locked drawers, cabinets or closets when not in use (score all or nothing).											
23.2.2.		Observation, inspection, or interviews support that all reserve/stock items are stored in a secure area accessible only to staff (score all or nothing).											
23.2.3.		Observation or inspection supports that the items needed for daily use are checked out or securely maintained in the operational area(s) of the health services and inpatient units (use % of total number of days or the # of times an item was checked out).											
23.2.4.		All logs or other documentation support that sharps and tools which are identified as daily use supply are counted on each shift in facilities with 24/7 nursing staff and daily in facility with a single shift nursing coverage. (use a month – and score based on the % of the total number of counts e.g. 3 shifts for 30 days would be 90 total number of counts).											

[illegible]

[illegible]

[illegible]

25.9.8.	Documentation supports that when RhOGAM was prescribed, it was administered as ordered.								
25.9.9.	Documentation supports that a urine culture was obtained at the first prenatal visit.								
25.9.10.	Documentation supports that serology for syphilis, HIV, Hepatitis B and C were obtained.								
25.9.11.	Documentation supports that a pap smear and cultures for gonorrhea and chlamydia were obtained.								
25.9.12.	Documentation supports that STDs (gonorrhea, chlamydia, syphilis) were treated.								
25.9.13.	Documentation supports that bacterial vaginosis was treated or health record documentation explains the reasons treatment was contraindicated.								
25.9.14.	Documentation supports that influenza vaccine was offered during the influenza season (October through December).								
25.9.15.	Documentation supports that a blood pressure was obtained at each prenatal visit.						Y		
25.9.16.	Documentation supports that a weight was obtained at each prenatal visit.								
25.9.17.	Documentation supports that fetal heart tones were assessed at the 10-12-week prenatal visit and every visit after thereafter.								
25.9.18.	Documentation supports that Fetal anomaly/biochemical screening was done between 10 and 18 weeks.								
25.9.19.	Documentation supports that fundal height was measured at each prenatal visit during the second and third trimester.								
25.9.20.	Documentation supports that screening for gestational diabetes was done between 24 and 28 weeks of gestation.								
25.9.21.	Documentation supports that a culture for Group B Streptococcus was obtained between the 35 and 37 weeks of gestation.								
25.9.22.	Documentation supports that postnatal care was provided as scheduled.								

Contractor will maintain statistics on the number of off-site referrals requested, the number approved and the number of Alternative Treatment Plans.

25.10.	Documentation (logs, meeting notes) show monthly number of requested referrals that are approved and deferred.								
25.10.1.	All prior authorization requests for off-site referrals are processed within three working days and the health record contains documentation of the outcome or decision regarding the request.								
25.11.	26. Staffing and Employee Competency								
26.1.	All staff members are appropriately licensed, certified, and credentialed in each staff member's discipline of practice as required by law. All staff members receive in-service training in accordance with IDOC procedures and Health Care Services Directive (HCSD) 1.24.		Y		Y		Y		
26.2.	All job descriptions are consistent with HCSD 1.23.								
26.3.	All health care staff are properly oriented including receiving training on the health care services directives, security measures, appropriate standards, code of conduct and all Performance Measures.								
26.4.	All health care staff received training in accordance with the IDOC requirements as described by SD&T.								
26.5.	Statistics are maintained which reflect the number of filled positions, the number of vacant positions and the turnover of staff and given to the CMO and Executive Directors of Healthcare Services monthly.								
26.6.	All deviations from the established staffing plan are communicated to the contract monitoring staff and facility administrator or designee, CMO and Executive Directors of Healthcare Services.								
26.7.	Each facility's staffing plan provided enough staff to prevent delays in access to care or the development of backlogs.								
26.8.	Facility administrative staff and the facility's quality assurance manager is notified when key administrative and clinical staffing plan a leave of absence. Notification must include the identity of the staff member covering for employee on leave.								

PERFORMANCE MEASURES		Penalty	Meggs	Riley	Keris/Mays	Moore
31. Dental Services	quarter					
Oral hygiene education will be provided in accordance with Health Care Services Directive (HCSD) 2.03 (Adult and Juvenile). Education is to include information on brushing and flossing and the relationship between tobacco products, alcohol, and other drugs to oral diseases.	4					
Documentation supports that all incarcerated individuals at intake or reception facilities were provided with oral hygiene instruction within 14 days of arrival.	4	y	y	y		y
All incarcerated individuals referred for dental services are seen within the timeframes established in HCSD 2.04A and the Dental Services Manual.	4					
Documentation supports that, for routine services, the incarcerated individual was seen by the dentist within 6 weeks of the date the HCRF was received.	4	y	y	y		y
Dental waiting list including lists for prophylaxis/teeth cleaning do not exceed the timeframes established in the RFP, HCSD 2.33A and the Dental Services Manual.	4	y	y			
Documentation supports that dental staff are maintain a waiting list of incarcerated individuals not seen within 6 weeks for a routine evaluation.	4					y
Documentation supports that when the facility has a dental waiting list, this has been communicated to the facility's contract monitor and appropriate IDOC central office staff.	4					
The dental record reflects that all incarcerated individuals with recall or return appointments are seen within the prescribed timeframe.	4					
Documentation shows that all incarcerated individuals with recall or return appointments have been seen within 6 weeks or unless otherwise ordered by the dentist.	4		y			
Necessary dental care will be provided to all incarcerated individuals consistent with professional standards of practice and the provisions in the RFP, applicable HCSD and the Dental Services Manual.	4					
Documentation supports that an examination by a dentist was done within 30 days of the incarcerated individual's arrival.	4					
Emergency dental care is of the highest priority and will be provided during dental triage. This includes but is not limited to treatment for relief of severe dental pain, traumatic injuries, and acute infections.	4	y				y
Documentation supports that an incarcerated individual who presented with severe dental pain not responsive to simple oral analgesic medication, tooth abscess or other infection such as severe bleeding, dry socket, or severe traumatic disruption of tissue was seen immediately.	4					
Dental screening and triage are conducted in accordance with time frames established in the dental services manual.	4					
Documentation supports that an incarcerated individual's health care request form was screened within 24 hours.	4					
The co-pay process is applicable to dental services. Dental staff will assess co-pay in accordance with state statute, administrative rules, and executive directives. Co-pay is to be applied to incarcerated individual-initiated visits and first prescriptions.	4					y
For all adult facilities, documentation reflects that co-pay is charged for all incarcerated individuals who initiated contact with a covered Health Care Professional.	4					
For all adult facilities, documentation reflects that co-pay is charged for all initiation prescriptions of medications, or medications provided at a single visit (expectations are psychotropic and neuroleptic medications)	4					

31.9.	Dental staff will triage and prioritize incarcerated individual health care request forms for services and schedule appointments based on need. Routine services must be provided within 6 weeks of the incarcerated individual's request.	4					
31.9.1.	Documentation supports that appointments were scheduled for all healthcare requests and that the incarcerated individual was seen by dental staff.	4					
31.10.	When a health care request form has been triaged by a nurse, a dental services staff member must review, face to face, when necessary, routine dental service requests within 14 days of submission.	4					
31.10.1.	Documentation supports that when an HCRF was screen by a nurse, the incarcerated individual was seen by a dental services staff member within 14 days of the HCRF submission.	4					
31.11.	Reception screening is completed within the time frames established in HCSD 2.03A, American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCCHC) standards.	4					
31.11.1.	Documentation supports that all incarcerated individuals in intake/reception facilities were screen by dental staff within 7 days of arrival.	4					
	32. Dental - Administrative Requirements						
32.1.	The Dental Director will visit each site with onsite dentistry at least once each year.						
32.2.	The facility's dentist will attend each scheduled MAC meeting CQJ meeting, and any meeting deemed appropriate.						
32.3.	All infection control practices including the sterilization of instruments are consistent with the American Dental Association guidelines or the Centers for Disease Control and Prevention (CDC) recommendations for dental health care settings.						
	33. Dental - Provision of Prosthesis						
33.1.	All decisions regarding prior authorization for prosthesis are noted in the electronic dental record.	4					
33.1.1.	Documentation shows that authorization regarding prosthesis is in the electronic dental record.	4					
33.2.	All prior authorization requests for dental prosthesis are processed within 5 working days.	4					
33.2.1.	Documentation supports that a prior authorization request for dental prosthesis was processed within 5 working days.	4					
33.3.	The provision of dental prosthesis is consistent with the guidelines in the Dental Services Manual.	4					
33.3.1.	Documentation supports that when a prior authorization request has been approved, documentation supports that initial visit to fabricate the prosthetic, occurred within 6 weeks of the receipt of the prior authorization request.	4					
33.3.2.	Documentation supports that after an initial visit for prosthesis, there are no delays throughout the fabrication process. There should not be long gaps of time (e.g. > 14 days) between the time impressions were received at the facility and the time when the incarcerated individual was seen.	4					
	34. Dental - Staffing						
34.1.	All staff licenses and certification and staff training documents are maintained in one location readily accessible to the facility's quality assurance manager.						
34.2.	All staff shall have current training in CPR and Infection control including but not limited to blood borne pathogens, cleaning and sterilizing instruments, and maintenance of waterlines.						
34.3.	All staff adhere to IDOC safety and security procedures including tool control and maintenance of perpetual inventories.						
34.4.	Staffing levels are maintained for all facilities.						

	Dental staff members shall be available at all times to direct facility staff in the management of emergencies.								
34.5.	All dental staff members who operate radiological devices have proper certification.								y
34.6.	35. Dental - Tool Control and Workplace Hazards								
	X-ray units will be inspected and calibrated as required by the Indiana State Department of Health, Department of Radiological Health, recommendation of the manufacturer or in accordance with IDOC policy and procedures.								
35.1.	All dental personnel potentially exposed to x-ray irradiation must be provided with dosimeter badges and instruments.								
35.2.	All incarcerated individuals are provided dental services in accordance with the dental services manual, Health care services directives (HCSO), IDOC procedures, ACA and NCHC standards, and American Dental Association recommendations.								
35.3.	Informed refusal is obtained in accordance with the guidelines of HCSD 1.30A.								
35.4.	A dental screening exam will be completed once each year on all incarcerated individuals with diabetes, HIV, and seizure disorders on Dilantin, unless the incarcerated individual is edentulous.								
35.5.	Documentation supports that for all diabetics a dental screening was done annually.								
35.5.1.	Documentation supports that for all HIV infected incarcerated individuals a dental screening was done annually.								
35.5.2.	Documentation supports that for all incarcerated individuals receiving phenytoin (Dilantin) they received a dental screening annually.								
35.5.3.	Dental health care services shall be provided in accordance with the priority levels established in the Dental Services Manual.								
35.6.	Informed consent is obtained for all patients undergoing dental extraction, oral surgery, or any other procedures in which consent is obtained as one aspect of contemporary standards of care consistent with the guidelines established in HCSHCSD 1.30								y
35.7.	36. Addiction Recovery Services								
36.1.	Access to Treatment:								
	Once the incarcerated individual arrives at their assigned facility and is referred for a treatment assessment, the CSUA will be completed level of care determined , a progress note justifying admission or specifying clinical cause for non-admission to an addiction recovery treatment will be completed.								
36.1.1	From the time a referral to Addiction Recovery was received, documentation supports that the incarcerated individual was contacted within 20 days by an Addictions Recovery staff member.								
36.1.2.	Incarcerated individuals will go through an orientation within 30 days of the CSUA where the program will be explained, and questions will be answered. A signed copy of the informed consent for treatment will be filed in the incarcerated individual's chart and this will be document in EMR (or current electronic reporting system).								
36.1.3.	Time Cut Submission:								
36.5.	All time cuts must be submitted within 5 working days of an incarcerated individual's successful completion of OP .								
36.5.1.	37. Transitional Healthcare Services								

37.1.	If incarcerated individual is not released with medication and/or script, the Medical Vendor shall overnight medication and/or script by close of business the day of notification, as required in Healthcare Service Directive (HCSD) 2.17. Medication must deliver within 24 hours of notification.	3						
37.2.	Medical Vendor shall ensure that the release parole planning template is documented in EMR and updated for release planning purposes. Vendor shall ensure all required documentation is current including but not limited to diagnoses match the problem list, detailed H&P if required, detailed description of assistance needed, and any durable medical equipment required for release. EMR information will be updated and accurate at time of incarcerated individual's discharge. Vendor shall adhere to HCSD 2.20 and 2.27.	3				y		
37.3.	All disability, behavioral health and physical health classification code changes shall be reported to the Classification department on the same business day of occurrence.	3						
37.4.	Release procedures set by IDOC Medical Division during public health crisis or pandemic shall be followed.	3						
37.5.	Vendor shall provide Transitional Healthcare Vendor staff necessary technology, IDOC email address, and request for systems access submitted within (ten) business days of start date. Any circumstance interfering with this timeline must be communicated with IDOC Executive Director of Transitional Healthcare.	3						
37.6.	THL will have documented contact (or document attempted contact in OCMS) with referred parolees within one week of receiving a referral or upon the parolee's initial reporting appointment to the parole district after his/her release. More than three occurrences of lack of documentation within a 180-day period will result in a failure to do so will result in a failed performance measure.	3				y	y	
37.7.	THL will connect with incarcerated individuals classified as a C, D, E/F mental health code, physical health code B/C/ F, and disability code B/C, face to face or via phone weekly for the first 30 days post release. If incarcerated individual continues to struggle with his/her transition into the community through noncompliance of referrals or stipulations, the THL will continue weekly contact until stabilization has been made.	3					y	
37.8.	THL and THF will enter notes into OCMS under note type Transitional Healthcare within (3) business days of contact with offender, parolee or a community partner regarding the offender or parolee, adhering to HIPAA Standards. More than 3 (three) HIPAA violation occurrences from same staff member within a 365-day period will result in failed performance measure.	3						
37.9.	THL will maintain files on all referred parolees in a HIPAA compliant space. The files will consist of a minimum of a referral form, an intake assessment sheet, Recovery Works referral, and releases of information for the community partners with which the THL and parolee are collaborating. All refusals are to be documented and included in the parolee's file. More than 3 (three) HIPAA violation occurrences from same staff member within a 365-day period will result in failed performance measure.	3						
37.10.	THL will collect and maintain data regarding the number of Parolee contacts, county of residence, community referrals made for mental health, substance abuse, medical, education, employment, benefits, housing, and other relevant referrals each month. Data will be provided to IDOC Medical by Vendor. More than two failed attempts to provide data within a 180-day period will result in a failed performance measure.	3						

37.11.	THL will collect and maintain data regarding the outcome of each parolee who was referred to the program. Outcome options for each referral include, does not want services, incarcerated individual completed parole, incarcerated individual is declared delinquent from Parole, incarcerated individual returned to DOC (for a violation or new charge-specify WHY), and incarcerated individual reached his/her goals. Data will be provided to IDOC Medical by Vendor. More than two failed attempts to provide data within a 180-day period will result in a failed performance measure.	3						
37.12.	THL will collect and maintain data regarding the number of referrals received for failed UDS' (Urine Drug Screens) from Parole Agents. Data will be provided to IDOC Medical by Vendor. More than two failed attempts to provide data within a 180-day period will result in a failed performance measure.	3						
37.13.	THF will collect and maintain data regarding the number and type of referrals completed monthly. Data will be provided to IDOC Medical by vendor. More than two failed attempts to provide data within a 180 day period will result in a failed performance measure.	3						
37.14.	THF will document in EMR a minimum of 1 face to face meeting with those on the special needs dashboard prior to release. More than two occurrences of lack of documentation in a 180-day period will result in a failed performance measure	3						
37.15.	THF will provide educational material to releasing incarcerated individuals as needed and indicate if material was given in EMR. More than two occurrences of lack of documentation in a 180- day period will result in a failed performance measure.	3						
37.16.	THL will facilitate a Transitional Healthcare meeting monthly at their assigned IDOC sites and maintain routine communication with their assigned IDOC site(s). Communication with site HSA and /or site DQN should be at a minimum of once weekly.	3						
37.17	THL will collect and maintain data regarding the number and type of referrals received from Parole Agents. Data will be provided to IDOC Medical by Vendor. More than two failed attempts to provide data within a 180 day period will result in a failed performance measure.	3						

CQI Program

Process Study Report Template and Example

A **Process Study** examines the effectiveness of the health care delivery process (triage levels in the sick call process, renewing medications during chronic care process)

I. State the Problem or Indicator

Describe the problem or issue to be studied

Example: Patients are not being seen by provider within 7 days of nurse referral from sick call.

II. Methods Used to Study Current Problem

Describe the study to be used to identify the current problem or indicator

Example: Audit tool was completed for the sick call process

III. Results of Study

Describe the results of the study. These are the results of the assessment of how things are currently working, *prior to implementing an intervention or improvement plan*. Attach audit tool, time study or log review results.

Example: The sick call audit results indicated only 72% of patients referred from nurse sick call were seen by a provider within 7 days

IV. Analysis of the Problem

Discuss the analysis you completed, showing what parts of the process need to be improved. Attach the process assessment, and 5 WHYs analysis.

Example: Based on the audit results, a process assessment and 5 Whys analysis were conducted. It was discovered that there is no current tracking of timeliness of nurse to provider referrals. Based on these findings, a Corrective Action Plan was implemented.

V. Plan

Describe the desired changes, using the SMART goal format when implementing the Corrective Action Plan. Discuss steps needed to effect the desired change. Attach copy of the Corrective Action Plan.

Specific
Measurable
Achievable
Results-focused
Time-bound

Example: **GOAL** (Specific) - **Within 120 days** (*time-bound*), **90%** (achievable, measurable, results focused) **of patients referred by nurse sick call will be seen by a provider within 7 days.**

VI. Follow-up Activities

Describe follow-up activities that were performed. Attach documentation of education completed, new forms implemented, list of new process steps, and re-audit tools.

Example: XXXX was implemented. Training in XXXX was provided to XXXX. Process step XXXXX was changed.

VI. Results

Describe results of follow-up activities and how the results related to the goal. Include any future plans for study, if appropriate. Attach final CQI re-audit tools, final updated time study results, or final log review used..

Example: After 30 days, XXXX was achieved. After 90 days, XXXX was achieved. After 120 days, XXXX was achieved.

Report Completed by:

Date: _____

CQI Program

OUTCOME STUDY REPORT TEMPLATE AND EXAMPLE

An **Outcome Study** examines if expected outcomes of patient care were achieved (number of patients with normal HbA1c results; number of patients with BP >140/90; number of patients that are re-admitted for same diagnosis within 30 days; number of patients on multiple medications)

I. State the Problem

Describe the problem or issue to be studied.

Example: Determine the effectiveness of Chronic Care Clinics in controlling diabetes by assessing the number of patients with HbA1c >8)

II. Methods Used to Conduct the Study

Describe process for assessing current status of the problem/issue.

Example: HbA1c levels for Chronic Care Clinic diabetic patients during the 3rd QTR of 2016 were inputted into a spreadsheet for analysis.

III. Results of the Study

Describe the results of the outlined study. Attach audit tool, time study, medical record review, or log review results.

Example: The HbA1c spreadsheet compiled of patients in the Chronic Care Clinic for diabetes indicated that 40% of the patients in the clinic had an HbA1c level > 8.

IV. Analysis of the Study and Plan

Discuss the steps needed to achieve desired change. Attach the Corrective Action Plan.

Example: Based on the results of the study, the medical records of patients with HbA1c >8 were analyzed. The analysis indicated that healthcare staff did not consistently document the provision of education on diet and that medication compliance was not reviewed with the patient at each Chronic Care Clinic visit. A Corrective Action Plan was implemented to address the findings.

V. Follow-Up Activities

Describe follow-up activities that were performed. Attach documentation of education completed, new forms implemented, list of new process steps, and re-audit tools.

Example: Commissary log was reviewed every Monday for diabetic patients with HbA1c > 8. Patients were provided education on diet and exercise program. Patients with HbA1c > 8 were scheduled for an accucheck every Friday afternoon. Education was provided at all Chronic Care Clinic visits. Medication compliance was reviewed during each Chronic Care Clinic visit.

VI. Results

Describe the results of the follow-up activities, and how the results related to the goal. Include any future plans for study, if appropriate. Attach final CQI re-audit tools, final updated time study results, or medical record/log reviews used.

Example: 80% of diabetic patients with an original HbA1c > 8 achieved an HbA1c \leq 7.9. For the remaining 20% of diabetic patients who still had an HbA1c > 8, Chronic Care Clinic visits will be scheduled for every 60 days. These patients will continue to have weekly commissary reviews and weekly accuchecks. Provider will also consider medication changes.

Completed by:

Date: _____

SCORECARD

[illegible]

Centurion CQI Annual Report Example

NAME OF SITE/CONTRACT (YEAR)

INTRODUCTION	<p>This annual review presents an overview of Centurion's CQI program activity for (site/contract name) for the _____ reporting year. The purpose of this report is to highlight CQI activities, summarize trending results, discuss improvement efforts, as well as demonstrate the positive impacts on healthcare services as a result of corrective action plans.</p> <p>Centurion utilizes a comprehensive CQI program to ensure compliance with not only contract requirements, but to ensure NCCHC and/or ACA standards are being met. Additionally, Centurion continues to work in collaboration with (client's name), other healthcare vendors (if we do not have both Medical and MH parts of contract), and other auditing bodies to ensure CQI activities remain an interdisciplinary team approach.</p> <p>The Continuous Quality Improvement (CQI) Program works to proactively identify process and outcome challenges, note trends, analyze audit/study results and then develop corrective action plans to meet/exceed best practice guidelines, accreditations standards and promotes quality outcomes. The goal of CQI is to assure appropriateness of patient care and to improve the well-being of the patient population. The Centurion CQI program strives to create innovative improvement methodologies, share best practices, and inspire all health care professionals to put the interests of the patient above all else.</p> <p>The CQI process generally involves the following:</p> <ul style="list-style-type: none">• Understanding the needs of the people who are served by the process• Formation of a team that conducts assessments to identify areas of improvement• Embraces the process assessment and analysis needed to make improvement decisions• And works together to improve not only threshold scores, but benchmark for quality patient care.
SUMMARY	<p>(Provide a summary of any changes in facilities' mission, significant changes in ADP or scope of services, additional or reduction in number of facilities). Note any NCCHC/ACA, etc surveys that were conducted during the year and the outcome of those surveys.</p>

Centurion CQI Annual Report Example

CQI STUDIES AND CORRECTIVE ACTION PLANS	<p>The CQI studies are created and implemented to review specific areas of care that encompass the standard of care with the delivery of health care. To ensure each major process is reviewed at least once a year, Centurion's CQI develops an annual calendar to align with (client's name) contract/monitoring criteria and policies, as well as NCCHC/ACA standards.</p> <p>The annual calendar is subject to change with directives from the Centurion corporate office, recommendations from the Regional CQI committee, needs of the (client name) or as identified needs by individual facilities (if a multi-facility contract).</p> <p>The CQI studies completed for (year)_____ are noted below. Additionally, 1 process study and 1 outcome study are completed per year.</p> <p>Centurion has a standard minimum threshold of 90% for each criteria studied unless (client's name) monitoring criteria requires a higher threshold. If an indicator is below the threshold, a Corrective Action Plan (CAP) is developed, implemented and monitored. The CAP will remain active/open until it's verified as having sustained compliance with the criteria's threshold.</p> <p>CQI meetings occur (monthly/quarterly). Included in the agenda is a review of audit/study results, statistical review and analyses of trending data, discussion of new and ongoing CAP activities. and results of re-audits.</p> <p style="text-align: center;">ANNUAL REVIEW OF STUDIES COMPLETED DURING THE YEAR AND RESULTANT SCORES</p> <p>(Attach a copy of your SCORECARD Graphs, Telehealth graphs, etc. SUMMARIZE CAPS that were opened during the year and how many are "closed" vs how many remain open. Also include CAPS that were initiated related to M & M reviews here as well)</p>
REPORTED BY SITE (IF THIS REPORT IS A ROLL UP OF ALL FACILITIES IN A CONTRACT, BREAK OUT INFO BY SITE)	
MORBIDITY & MORTALITY/ SENTINEL EVENTS	<p>(facility name/contract name) had (#) deaths in (year). The M&M Committee reviewed all charts and discussed opportunities for improvement when appropriate. There are (X) pending review (if any).</p> <p>(You can also attach a YTD copy of your oSEL report here) – DO NOT TIE YOUR CAPS RELATED TO M & M findings here. They go in the above section</p>
ADVERSE PATIENT OUTCOMES	<p>(NOTE ANY ADVERSE OUTCOMES AND WHAT WE DID TO PREVENT IT FROM HAPPENING AGAIN) – again you can use your oSEL report to show these events.</p>
GRIEVANCES	<p>(site name/contract name) grievances are reported via the monthly grievance report. Centurion completes an additional monthly grievance roll up report. Grievance trends are discussed, as applicable, during the monthly site CQI meeting as well as during the Regional Quarterly CQI meeting.</p>

Centurion CQI Annual Report Example

	<p>(Attach your monthly Grievance Roll up Report here and/or YTD graphs)</p> <p>Analyzing the month to month grievance trend, (make note of any high # of category types and explain why and what you are doing to reduce that number).</p>																				
SAFETY AND ENVIRONMENT REPORTS	(note any safety or environmental concerns you have had over the past year and what was done to correct it)																				
CHRONIC CARE CLINICS	<p>(Describe how you use/update your chronic clinic database, average time between follow ups, etc (for medical and/or MH and if you have any back logs. If there is a backlog, explain why and what you are doing to catch up)</p> <p>Current Chronic Clinics include:</p> <table border="1"> <thead> <tr> <th>CLINIC NAME</th></tr> </thead> <tbody> <tr><td>Cardiac</td></tr> <tr><td>HTN</td></tr> <tr><td>Endocrine</td></tr> <tr><td>Diabetes</td></tr> <tr><td>Gastrointestinal</td></tr> <tr><td>Hep C</td></tr> <tr><td>HIV</td></tr> <tr><td>Infectious Disease</td></tr> <tr><td>INH</td></tr> <tr><td>Neuro</td></tr> <tr><td>Seizure</td></tr> <tr><td>Ortho</td></tr> <tr><td>Psychiatry – may be done tele-med</td></tr> <tr><td>Respiratory (Pulmonary, Asthma, COPD)</td></tr> <tr><td>OB/GYN</td></tr> <tr><td>Special Needs</td></tr> <tr><td>Pain Management</td></tr> <tr><td>Anticoagulant</td></tr> <tr><td>Dialysis</td></tr> </tbody> </table>	CLINIC NAME	Cardiac	HTN	Endocrine	Diabetes	Gastrointestinal	Hep C	HIV	Infectious Disease	INH	Neuro	Seizure	Ortho	Psychiatry – may be done tele-med	Respiratory (Pulmonary, Asthma, COPD)	OB/GYN	Special Needs	Pain Management	Anticoagulant	Dialysis
CLINIC NAME																					
Cardiac																					
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Diabetes																					
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Hep C																					
HIV																					
Infectious Disease																					
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Respiratory (Pulmonary, Asthma, COPD)																					
OB/GYN																					
Special Needs																					
Pain Management																					
Anticoagulant																					
Dialysis																					
PHARMACY & THERAPEUTICS	(Discuss issues, studies completed and achievements about medication – med errors, poly-pharmacy, etc. state how often you have a P & T committee meeting and when your pharmacy consultant comes)																				
INFECTION CONTROL	(Discuss how often you have an infection control meeting – or if you include it in your monthly CQI meeting. List what you discuss: HIV, MRSA, INH and Hep C. etc. Note any trends you have with Hep C patients and how many were on meds during the year. Also list any "epidemics" you may have had during the year and how you controlled it).																				
MAN DOWN AND DISASTER DRILLS	(List the # of man down drills completed and the dates of the 2 required disaster drills you completed. Describe the scenario – or if you had a real disaster – how medical did during the drill and what, if anything you needed to improve)																				
UTILIZATION OF SERVICES	Use the chart below or utilize your own information/graphs to show ER, off-site and admissions information.																				

Centurion CQI Annual Report Example

	Total # off-site appts	Total # ER Visits	Total # of Admissions
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

Discuss what your top 5-10 off site appointment types were. Discuss if you have a backlog of appointments and why. Explain what you have done to reduce the backlog or late appointments.

Utilize your telehealth stats/graphs to show how Telehealth has helped reduce off site appointments and/or if it's helped reduce your backlogs.

	Total # TeleMed appts	Total # TelePsych appts	Total # My Wound Dr appts
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

PHYSICIAN PEER REVIEW	Note here how many Peer Reviews were completed for each employee category (i.e. nurse, LPN, NP, MD, dentist etc)
NEXT STEPS	After reviewing our year of CQI studies, audits and surveys results and reviewing the status of our open CAPS, we will be concentrating on: (list 2-3 processes you are focusing on) in 2021.
SUMMARY ACHIEVEMENTS CONCLUSION	<p>Provide bullet statements of things you are most proud of, achievements and successes. Try to include activities that showed collaboration with security and/or the client.</p> <p>End with a paragraph about your continued commitment to providing quality patient care and improving outcomes.</p>

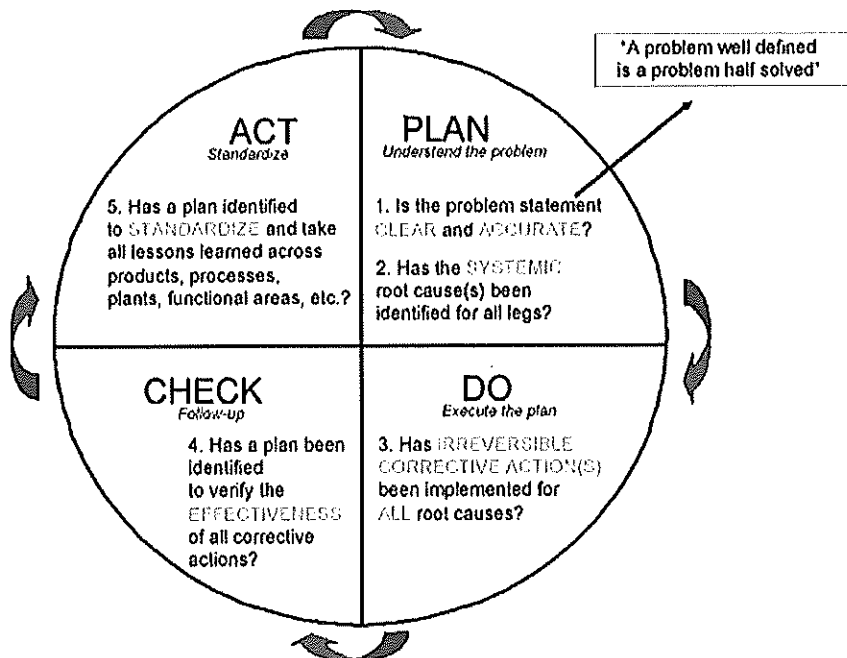
PLAN, DO, CHECK, ACT (PDCA) SUMMARY

Although different contracts/clients may have a minimum "threshold" (minimal % of compliance), Centurion sets a threshold of 90% for each criteria (question) within a process.

When an audit (CQI audit, Process and/or Outcome Study, Client or ACA/NCCHC results) shows any indicator with a score of less than 90%, a Corrective Action Plan (CAP) needs to be completed for those criteria. (i.e. sick call overall audit score is $\geq 90\%$ but question/indicator #3 and #5 are $< 90\%$ then those 2 indicators need to be put on a CAP).

EACH processes should have its own CAP (i.e. sick call has 2 indicators on a single CAP, but if there is also 2 indicators with scores of $< 90\%$ on an infirmary audit, those would go on a separate/different CAP)

Centurion uses the PDCA model in our CQI program:



PLAN

The plan part of the PDCA cycle includes:

1. Reviewing the steps in the current process; Identifying what the problem steps are
 - a. Complete the **Process Assessment**, writing down each step of the Current process
 - b. Ensure every staff member who touches the process gives their input
2. Analyzing what is causing the problem(s)
 - a. Complete the **5 WHYS analysis** to assist in identifying the root cause of the problem. This is an extremely important step – sometimes our perception of why a problem exists is NOT really the cause – don't jump to conclusions

3. Identifying what the process NEEDS to look like
 - a. Once the Process Assessment and 5 WHYS analysis are completed, begin brainstorming on what needs to be fixed, changed, or added to the current process
 - b. Review current policies and procedures and audit results to determine what needs to be done to become compliant
4. Put together your success guide/plan (aka your CAP)
 - a. The CAP should be considered your Success Guide. Use the CAP to guide you in putting together implementation steps to make improvements.
 - b. Review the Centurion policy CT. COMP.05, **Corrective Actions planning and Follow-up** and corresponding Guideline to assist with prioritizing your CAPS. The policy includes the tools to use for developing, tracking and monitoring the CAPS.
 - i. Corrective Action Plan Template
 - ii. Re-Audit tool Template
 - iii. Master CAP Roster
 - c. Use SMART GOAL Worksheet to ensure you construct your CAP clearly

SMART Goal Worksheet

S.M.A.R.T.	Questions...
Specific	Does your goal clearly and specifically state what you are trying to achieve? <i>If your goal is particularly large or lofty, try breaking it down into smaller, specific SMART goals.</i>
Measurable	How will you (and others) know if progress is being made on achieving your goal? Can you quantify or put numbers to your outcome?
Attainable	Is achieving your goal dependent on anyone else? Is it possible to reframe your goal so it only depends on you and not others? What factors may prevent you from accomplishing your goal?
Relevant	Why is achieving this goal important to you? What values in your life does this goal reflect? What effect will achieving your goal have on your life or on others?
Time-bound	When will you reach your goal? <i>Again, if your goal is particularly large, try breaking it down into smaller goals with appropriate incremental deadlines.</i>

DO

The "DO" phase is where changes that were planned on our CAP are implemented. For example:

1. Set up training dates
2. Revise a form or policy
3. Develop a new process flow

Ensure staff involved in the process are included in the development and implementation of the CAP.

All CAPs should be included in the monthly/quarterly CQI meeting minutes. This is the time to review its progress and what still needs to be completed.

CHECK

After changes have been implemented and/or training has occurred, verify that the process has actually improved.

1. Depending on CAP goal date, ensure enough time for change to occur and reflect in the process before you re-audit.
2. Complete a re-audit on those criteria that were originally not compliant.
 - a. Continue to re-audit those criteria until the compliance is 90% or greater for at least two separate re-audits.

ACT

Once your "check" phase is completed, finalize your changes

1. Revise policies/procedures
2. Update training materials
3. Update Process Flowcharts

PROCESS ASSESSMENT TOOL

PROCESS BEING REVIEWED: _____

SITE: _____

DATE PROCESS INITIALLY ASSESSED: _____

[illegible]

5 WHYs ANALYSIS

PROBLEM STATEMENT:

↓

WHY #1:

WHY #2:

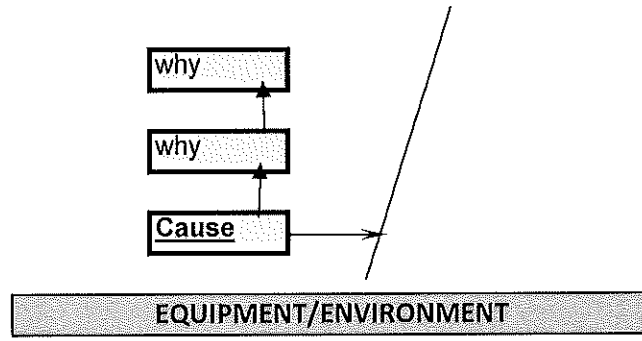
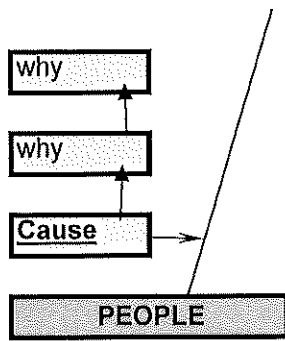
WHY #3:

WHY #4:

WHY #5:

ROOT CAUSE?

ROOT CAUSE:



Centurion Continuous Quality Improvement: Corrective Action Plan (CAP) Guideline

Guideline for an Acceptable Corrective Action Plan

(From policy CT.COMP.05, Corrective Action Planning and Follow-Up)

If during the completion of a specific audit or study by the client, ACA, Centurion, or the site, any line item that falls below compliance rate of the specific audit/study (usually between 90% and 98%) requires a CAP. Process for developing CAPs is outlined in CQI-003, *CAP Templates for Initiating and Tracking*. Process for monitoring progress in improvement for specific CAP is also outlined in CQI-003, *CAP Templates for Initiating and Tracking*.

CQI-005, CAP Templates for Initiating and Tracking:

- **“CAP” Tab:** Incorporate all noncompliant items for a particular process into a single CAP (all audited indicators from Sick Call process should be under one CAP, listing each indicator on a separate line of the CAP). There is sample information on the template about how to complete. The sample can be deleted after the process for initiating a CAP is understood.
***REMEMBER:** If several indicators for Sick Call are non-compliant (by more than one auditing body), use one CAP for all indicators for that process. Each “process” should have a separate CAP template.*
- **“Running Re-Audit Scores” Tab:** Each time a re-audit for the CAP is completed, note the scores to identify improvements and/or room for improvement.

CQI-006, Re-Audit Tool Template: Lists indicators/performance measures that are to be re-audited. This form is used to conduct re-audits. The template is already set up to calculate the scores.

- **“CAP Re-Audit Tool Sample” Tab:** There is sample information on the tab about how to complete a re-audit tool. The sample can be deleted after the process for using the re-audit tool is understood.
Make sure that each re-audit completed is saved and/or printed for the CAPs binder/book, so another re-audit is not documented over the top of the last re-audit.
- **“Blank CAP Re-Audit Tool” Tab:** Tool for completing re-audits.
Make sure that each re-audit completed is saved and/or printed for the CAPs binder/book, so another re-audit is not documented over the top of the last re-audit.

CQI-007, Master CAP Roster Template: Template for tracking status of all CAPs. All information related to a CAP is entered on this template to facilitate the identification of the CAPs that have been started, are in process, and are closed throughout the year. This roster allows identification of more than one auditing body noting the same noncompliance. This facilitates work on the indicator(s) for ALL of the auditing bodies using the same CAP and re-auditing tools.

- **“Master CAP Roster Sample” Tab:** Sample information provided to outline how Master Cap Roster is to be completed.
- **“Blank Master CAP Roster” Tab:** Tool for developing the Master CAP Roster.

Centurion Continuous Quality Improvement: Corrective Action Plan (CAP) Guideline

PRIORITIZING CAPS

Since it is impossible to complete 10 to 50 separate CAPS simultaneously, ensure that the **Master CAP Roster** consolidates ALL related noncompliant indicators. By using this on-going roster, CAPs for each process and the indicators for each process already being worked on can be identified. In this way, LESS separate CAPs will be initiated and efforts will not be duplicated for the same issues.

Auditing bodies monitor our ability to **set a CAP completion date** and have the CAP actually completed and resolved by the date **WE** set. It is important to be realistic on how long an issue will take to "fix."

Fix it right the first time by taking the time to identify the issue(s), address the issue(s) and implement sustaining process changes to prevent noncompliance in a later audit (and thus having to do another CAP for the same thing).

When adding a CAP, the efforts to address need to be prioritized. Use the following levels as a guide when setting priorities:

QUICK FIX - Complete within 30 days

- Typically, there is a need to fix/change/add one process, and the issue can be resolved within 30 days
- After process change has been implemented and staff education has been completed, re-audit in 2 weeks and again before the end of 30 days to ensure compliance and completion of CAP

INTERMEDIATE FIX - Complete within 60 days

- Typically, there is a need to fix/change/add one to two changes to resolve the issue within 60 days
- After process change has been implemented and staff education has been completed, re-audit in 2 weeks and every 2 weeks thereafter, until compliance has been noted within the 60 days

IN-DEPTH PROCESS REVIEW AND FIX – Complete within 90 to 120 days

- Typically, in-depth review of multiple process steps to determine where issue(s) lie
- There may be more than two processes that need to be fixed/changed/added or client/site security collaboration may be needed to effect change
- Between days 1 and 30, CQI team should review process, identify the issues preventing compliance, and brainstorm ideas to resolve noncompliance
- Between days 31 to 60, changes should be planned, implemented, and staff education completed. Re-audits should be completed every 2 weeks to monitor compliance to new process steps
- At the end of 60 days and re-audits, review/tweak if still not fully compliant. With complex, multiple changes, staff will need AT LEAST 30 days to become used to the new process before the new process can be assumed not to be successful
- Continue with re-audits every 2 weeks to ensure compliance before end of 90 to 120 day CAP completion date

Centurion Continuous Quality Improvement: Corrective Action Plan (CAP) Guideline

COMPLETION OF CAPs

- Ensure that CAPs are updated and reviewed during monthly Staff Meetings and Monthly CQI Meetings.
- If there is any delay in implementing changes that are beyond medical's control, CAP needs to note the reason for the delay and the change in CAP completion date.
- Maintain organized CQI notebook/binder to ensure it is possible to readily determine the status of progress on each CAP.
- Once a CAP is determined to be compliant, the completed CAP is to be submitted to the auditing body. Once the auditing body concurs the CAP has achieved the goal(s) and the process item is compliant, the **Master CAP Roster** should be updated to note that the CAP has been closed.

[illegible]

[illegible]

***Date problem was resolved.
Include any follow up
monitoring you will perform
to ensure ongoing
compliance in updates.***

DATE COMPLIANCE GOAL ACHIEVED

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MASTER CAP ROSTER

[illegible]

Site: _____

[illegible]

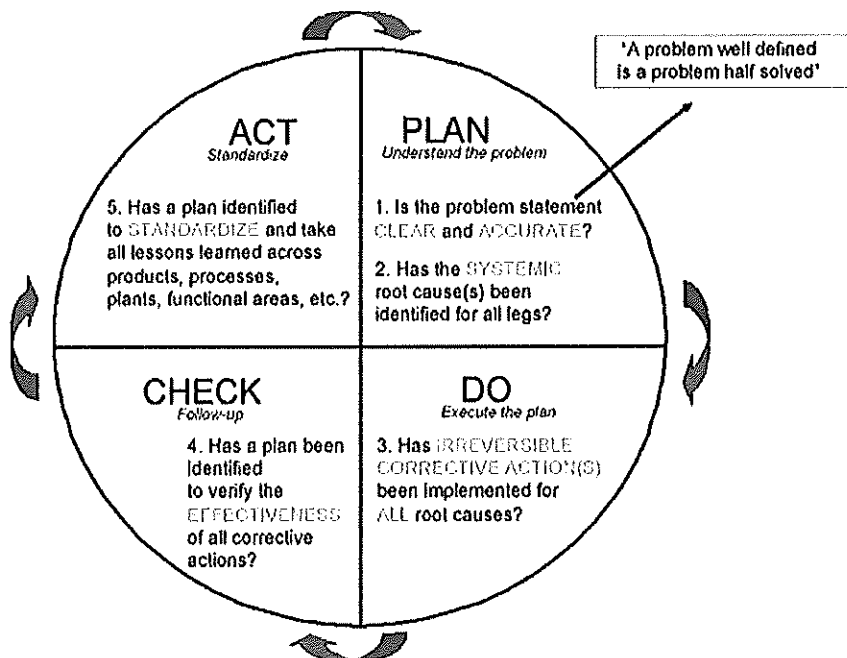
PLAN, DO, CHECK, ACT (PDCA) SUMMARY

Although different contracts/clients may have a minimum "threshold" (minimal % of compliance), Centurion sets a threshold of 90% for each criteria (question) within a process.

When an audit (CQI audit, Process and/or Outcome Study, Client or ACA/NCCHC results) shows any indicator with a score of less than 90%, a Corrective Action Plan (CAP) needs to be completed for those criteria. (i.e. sick call overall audit score is $\geq 90\%$ but question/indicator #3 and #5 are $< 90\%$ then those 2 indicators need to be put on a CAP).

EACH processes should have its own CAP (i.e. sick call has 2 indicators on a single CAP, but if there is also 2 indicators with scores of $< 90\%$ on an infirmity audit, those would go on a separate/different CAP)

Centurion uses the PDCA model in our CQI program:



PLAN

The plan part of the PDCA cycle includes:

1. Reviewing the steps in the current process; Identifying what the problem steps are
 - a. Complete the **Process Assessment**, writing down each step of the Current process
 - b. Ensure every staff member who touches the process gives their input
2. Analyzing what is causing the problem(s)
 - a. Complete the **5 WHYS analysis** to assist in identifying the root cause of the problem. This is an extremely important step – sometimes our perception of why a problem exists is NOT really the cause – don't jump to conclusions

3. Identifying what the process NEEDS to look like
 - a. Once the Process Assessment and 5 WHYS analysis are completed, begin brainstorming on what needs to be fixed, changed, or added to the current process
 - b. Review current policies and procedures and audit results to determine what needs to be done to become compliant
4. Put together your success guide/plan (aka your CAP)
 - a. The CAP should be considered your Success Guide. Use the CAP to guide you in putting together implementation steps to make improvements.
 - b. Review the Centurion policy CT. COMP.05, **Corrective Actions planning and Follow-up** and corresponding Guideline to assist with prioritizing your CAPS. The policy includes the tools to use for developing, tracking and monitoring the CAPS.
 - i. Corrective Action Plan Template
 - ii. Re-Audit tool Template
 - iii. Master CAP Roster
 - c. Use SMART GOAL Worksheet to ensure you construct your CAP clearly

SMART Goal Worksheet

S.M.A.R.T.	Questions...
Specific	Does your goal clearly and specifically state what you are trying to achieve? <i>If your goal is particularly large or lofty, try breaking it down into smaller, specific SMART goals.</i>
Measurable	How will you (and others) know if progress is being made on achieving your goal? Can you quantify or put numbers to your outcome?
Attainable	Is achieving your goal dependent on anyone else? Is it possible to reframe your goal so it only depends on you and not others? What factors may prevent you from accomplishing your goal?
Relevant	Why is achieving this goal important to you? What values in your life does this goal reflect? What effect will achieving your goal have on your life or on others?
Time-bound	When will you reach your goal? <i>Again, if your goal is particularly large, try breaking it down into smaller goals with appropriate incremental deadlines.</i>

DO

The "DO" phase is where changes that were planned on our CAP are implemented. For example:

1. Set up training dates
2. Revise a form or policy
3. Develop a new process flow

Ensure staff involved in the process are included in the development and implementation of the CAP.

All CAPs should be included in the monthly/quarterly CQI meeting minutes. This is the time to review its progress and what still needs to be completed.

CHECK

After changes have been implemented and/or training has occurred, verify that the process has actually improved.

1. Depending on CAP goal date, ensure enough time for change to occur and reflect in the process before you re-audit.
2. Complete a re-audit on those criteria that were originally not compliant.
 - a. Continue to re-audit those criteria until the compliance is 90% or greater for at least two separate re-audits.

ACT

Once your "check" phase is completed, finalize your changes

1. Revise policies/procedures
2. Update training materials
3. Update Process Flowcharts

CQI COMMITTEE GUIDELINES, MEETING AGENDA AND MEETING MINUTES TEMPLATES

CQI Committee

Centurion's goal is to develop and implement a continuous quality improvement (CQI) program in accordance with our mission and strategic goals, federal and state laws and regulations, accreditation standards, and specific contractual requirements. To ensure continuous review of processes and outcomes, review of trending and monitor progress with Corrective Action Plans, Centurion will form a CQI committee at each site and collaborate with the Indiana Department of Corrections (IDOC) in conducting a quarterly Regional Level CQI committee meeting.

Member of the CQI committee are expected to:

- Actively participate in site and client CQI meetings
- Participate in Centurion and client CQI initiatives
- Maintain on-going monitoring of high risk indicators (emergency hospitalizations; suicide attempts; use of restraints; use of emergency medication)

Site CQI committee meeting members will include:

- Site Medical Director
- Health Service Administrator (or designee)
- Behavioral Health representative
- CQI Coordinator
- Dental Health representative
- Warden/designee
- representatives from nursing to include infection control
- Substance use treatment representative
- health record management
- food services
- fire and safety
- Other Ad-hoc members as CQI issues indicate

CQI Committee Meetings

The site level CQI Committee will meet (monthly) to review and discuss CQI reports/audit results, data collection and analysis, CAP status, improvement initiatives and clinical process reviews.

During this meeting, any identified areas for improvements that are outside the control of clinical authority will be discussed with the Warden/designee to discuss recommendations and action plans. The CQI Committee will utilize the **CQI meeting agenda**.

Responsibilities of CQI committee members:

- Develop a client-approved **annual CQI calendar**. Calendar should include identification of staff responsible for the data collection
- Assess/review monthly reports, logs, systems, policies, and procedures for the identification, collection, and analysis of performance measurement data that ensures information collected is based on objective unbiased methodology
- Develop and conduct contract-specific performance monitoring as well as approving process and patient outcome studies
- Collect, analyze summarize performance data, identify opportunities for improvement, and review findings for development of corrective actions
- Disseminate CQI information in a clear, understandable language that accurately reflects study findings
- Disseminate CQI recommendations to all staff; this is essential if CQI activities are to be “agents of change.” Suggestions for disseminating the CQI information include through monthly client conference calls, monthly MAC meetings, and monthly staff meetings.
- Review Grievance and Sentinel Event trends
- Review completed Morbidity and Mortality reports
- Coordinate Peer Review process
- Review the **annual report** and approve the following year’s plans/goals
- Provide training to staff on the CQI process and their respective responsibilities in carrying out the quality improvement program to facilitate staff participation in CQI activities and to promote staff acceptance of findings and recommendations
- Monitor status of Corrective Action Plans related to client or internal audits

Regional Level CQI committee

Centurion Regional Leadership in collaboration with the Indiana Department of Corrections (IDOC) will meet quarterly to review CQI activities, audit results, monthly statistical reports and other items as requested by (IDOC).

Centurion CQI Meeting Agenda/ Minutes

Date/Time: _____
Site/Location: _____

Attendees: _____

I. CALL TO ORDER

A. Acknowledgment of guests

B. Approval of previous meeting minutes

II. OLD BUSINESS

A. Review of open CAPs

CAPs Updates (attach copies of CAPS)

CAPs Recently Closed	New CAPs Opened	Other CAP Updates

B. Other old business (open items from last meeting)

III. STANDARD REPORTING

A. Risk Management Updates

Sentinel/Adverse Events (attach oSEL report)

Injury Events

Review of Credentialing Log

Medication Issues/Errors

B. Infection Control Report

Statistics

Education completed: (attach training materials and sign in sheets)

Review/case findings:

Centurion CQI Meeting Agenda/ Minutes

C. Summary/Trends in Grievances

Stats: (attach a copy of Grievance roll up log)

Trending noted:

D. Peer Reviews

Completed last month (either total # completed or type of staff completed):

E. Pharmacy & Therapeutics (review of reports, audits, results)

F. Safety and Environmental

Date of last safety inspection

G. Physician Feedback

UM issues/trending:

Medical records review trending:

H. Review of Policies, procedures and forms

Site specific policies:

New Centurion/Contract policies and/or forms:

NCCHC/ACA standards prep:

I. Medical specific related CQI updates

J. Mental Health specific related CQI updates

K. Substance Abuse specific related CQI updates

Centurion CQI Meeting Agenda/ Minutes

L. Dental specific related CQI updates

--

M. Annual report/review date completed: _____

IV. NEW BUSINESS

A. Review of Past Quarter's CQI audit results (attach completed audits to meeting minutes)

Audit (name) completed	Date audit completed	Compliance score	CAP required?

B. Review of upcoming audits (per CQI audit Calendar – attached to meeting minutes)

Audit to be completed	Month to be conducted

V. ADJOURN

Regional and Indiana Department of Corrections Quarterly CQI Meeting Agenda/Minutes

Date/Time:

Site/Location:

Attendees:

I. CALL TO ORDER

A. Acknowledgment of guests

--

B. Approval of previous meeting minutes

--

II. OLD BUSINESS

(open items from last meeting)

III. STANDARD REPORTING

A. Risk Management Updates

Sentinel/Adverse Events (attach oSEL report)
M & M reviews (pending/completed)
Discussion: templates to use for Mortality reviews (Centurion's or Client specific)?
Updates on Credentialing during 2020
Medication Issues/Errors (summary by facility)

B. Infection Control Report

Statistics (update on COVID stats)
Specific case findings/reviews:

C. Summary/Trends in Grievances

Stats: (attach a copy of Master Grievance roll up log)
Trending noted:

Regional and Indiana Department of Corrections Quarterly CQI Meeting Agenda/Minutes

D. Pharmacy & Therapeutics (review of reports, audits, results)

Trends noted

E. Peer Reviews

Status of 2020 Peer Reviews completed for 2020 by site (copy of log from each site)

F. Accreditation

Review of site specific policies/procedures: (list policies that have been reviewed/updated since last meeting)

New Centurion/Contract policies and/or forms:

ACA standards prep status:

G. Review of open CAPs

CAPs Updates (attach copies of Master CAPS Roster)

CAPs Recently Closed	New CAPs Opened	Other CAP Updates

IV. NEW BUSINESS

A. Review of Past Quarter's CQI audit results (attach completed Master Roll-up audit Reports and Scorecard to meeting minutes)

Audit (name) completed	Date audit completed	Compliance score	CAP required.

Regional and Indiana Department of Corrections Quarterly CQI Meeting Agenda/Minutes

1. Medical specific related CQI updates

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2. Mental Health specific related CQI updates

--

3. Substance Abuse specific related CQI updates

--

4. Dental specific related CQI updates

--

5. Telehealth specific related CQI updates: (attach copy of telemed and telepsych reports)

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B. Review of upcoming audits (attach CQI audit Calendar)

Audit to be completed	Month to be conducted

C. Miscellaneous

Discussion: audit tool needed for LPN chart review on LPN's who perform sick call?
Discussion: templates for NP supervisory review process

**Regional and Indiana Department of Corrections
Quarterly CQI Meeting Agenda/Minutes**

V. ADJOURN

GRIEVANCE PROCEDURE SUMMARY

Centurion follows the Indiana Department of Corrections (IDOC) Grievance policy. Each site utilizes the approved **Daily Grievance Tracker Log** to track all received grievances. Grievances are tracked by discipline types, category types and outcome of grievance. At the end of each month, the Daily Grievance Tracker Log is incorporated into the monthly **Grievance Roll-up Report**.

The monthly roll-up report is also uploaded to the (Centurion Indiana) Centurion's *CQI reporting section* of the Centurion Portal. The report provides a means to track month over month trending and compliance with turnaround times from receipt of grievance to response of grievance (per policy this is within 14 business days). This information is shared with meetings with the Client, during monthly site meetings, CQI meetings and Staff meetings. If a trend in a particular grievance category is noted, Centurion will further research the reasons for the trend and may conduct further studies and/or implement a Corrective action plan.

Corporate Centurion also maintains a Company-wide Roll Up report which monitors all contracts' monthly grievance roll up reports to review for possible company-wide trends. This Corporate report is reviewed during the Quarterly Compliance Committee meeting.

Attachment B is a model policy for Grievances (include this in your CQI manual if used. If using the client specific policy instead, make that Attachment B instead)

Program/Facility

Model Prison Policies and Procedures

Policy Number:
P-A-10

Subject:

Grievance Process for Health Complaints

Related Standards:

NCCHC: P-A-10 (2018)

ACA: 5-6A-4344, 5-6C-4394, 5-6D-4410 (2018)

Other:

I. Purpose

A grievance mechanism for healthcare complaints is designed to ensure that patients have the right to disagree with or question the healthcare system. This policy is designed to support healthcare staff in a coordinated informal grievance review process.

II. Policy

1. A grievance process is in place in the facility.
2. The grievance policy includes:
 - a. A time frame for response
 - b. The process for appeal
3. Responses to patient grievances are:
 - a. Timely
 - b. based on principles of adequate medical care
 - c. Include documentation of response
4. The CQI process includes monitoring of a systematic process for investigation of complaints and grievances

III. Procedures

1. Healthcare staff will inform patients of their right to express concern, to question the healthcare services provided, and to make a complaint about the healthcare they receive upon admission to the jail and when receiving services.
2. Health staff are involved with investigating and responding to complaints about health care. If someone other than a member of the health staff responds to health care grievances, health staff input is solicited before responding to the patient's complaint.
3. Healthcare complaints may be included in the formal grievance process or in a separate process.
4. Receipt, responses to and resolution of informal patient complaints will be monitored and tracked by the Health Services Administrator (HSA) or designee using the *Site Daily Grievance Log* (ADM-007). Responses to informal complaints will be maintained in the Healthcare Unit together with the patient's complaint in the grievance or patient complaint file.
5. Informal complaints will be logged upon receipt, assigned to a healthcare staff member to review, investigate and formulate a response.
6. A face to face interview by the HSA, responsible physician, or nursing supervisor should be conducted where possible, in order to resolve problems and demonstrate concern.
7. Formal grievances related to healthcare services may not be received directly by healthcare staff but may be sent to the designated institutional department. Upon receipt of a grievance related to healthcare, staff will forward to the HSA or designee.
8. The HSA or designee will log the receipt on the *Site Daily Grievance Log* (ADM-007) and assign a staff member to complete a face-to-face interview with the patient and respond to the grievance in writing within the client's established time frame.

Program/Facility

Model Prison Policies and Procedures

Policy Number:
P-A-10

9. If the HSA or designee determines that the grievance is of a serious nature, involves multiple programs or staff members, or indicates a risk to the program, the HSA or designee will meet with the patient following the investigation.
10. Disposition of the grievance will be noted on the Site Daily Grievance Log.
11. Patient grievances and responses will not be filed in the patient's health record but will be filed in a grievance file in the healthcare unit.
12. Response to a formal grievance will be completed promptly, within the time frame set by the client and stated in policy.
13. The Grievance Log will include the following:
 - Patient name
 - Patient ID#
 - Date grievance received
 - Type of grievance
 - Category of grievance
 - Staff assigned to investigate/respond
 - Date patient received response
 - Resolution
 - Date resolution submitted to administration
14. The grievance mechanism is an important component of the facility's continuous quality improvement program and will be routinely reviewed as part of the CQI program. Well-founded grievances provide valuable feedback regarding opportunities for improving health services.
15. Grievances that pertain to key health care functions should be tracked through the CQI program. Grievances are reviewed to identify any recurrent issues. If identified, these issues are evaluated, and corrective action implemented if indicated.
16. Grievances should be reviewed at least quarterly, in order to identify trends.
17. Each facility will complete the *Site Monthly Grievance Roll-up Report (CQI-012)* and forward to their site/contract CQI leader by the 8th of every month.
18. The *Site Daily Grievance Log* will be maintained for a minimum of three years.

Referenced Forms:

Grievance and Informal Complain Log (ADM-007)
Site Monthly Grievance Roll-Up Report (CQI-012)

References:

Clinical Operations Revision Dates:

August 2018
August 2019

Reviewed/ Approved By	Facility	Effective Date	Review Date
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>

[illegible]

2010

x in these columns) Categorize the total number of grievances received into the appropriate category column (if more than 1 compliant on grievance

[illegible]

TELEHEALTH AND SPECIALTY CONSULTS SUMMARY

Part of the CQI program includes tracking telehealth (medical and mental health appointments) to ensure timeliness of appointments and to trend usage. Centurion has developed 2 tracking tools to capture this information:

- **Daily site TeleMedical and specialty consult log**
- **Daily site TelePsych log**

Each site completes these logs throughout the month. At the end of the month, the logs are sent to the Regional Telehealth Coordinator, who then collates the site information into the TeleMedical and Telepsych Master Roll Up reports.

Sites use this information to monitor:

- Number of patients seen for telehealth or specialty consults
- Timeliness of appointments
- Tracking reasons why appointments are not being seen as scheduled

[illegible]



CENTURION PEER REVIEW PROTOCOL

Centurion supports a peer review process to provide the opportunity for confidential clinical practice review between licensed clinicians of the same discipline who are not in a supervisor/supervisee role. Peer review, referred to by NCCHC as Clinical Performance Enhancement, is the process of peers assessing the quality of healthcare services. The peer review process includes medical record review, discussion of clinical practices and peer-to-peer feedback with the goal of enhancing individual competence and identifying potential areas for improvement.

A peer review is not a performance review. Individual-specific peer review findings are not used in the system-wide Continuous Quality Improvement (CQI) program; however, the peer review process is an annual component of the CQI program. Peer reviews do not replace the need for the physician supervisory reviews of nurse practitioners and physician assistants required by collaborative agreements. Peer reviews are conducted for all licensed healthcare staff to include licensed nursing staff and mental health professionals unless union agreements prohibit.

Peer reviews are completed by licensed staff of the same discipline who are not the immediate supervisor of the staff member being reviewed. Staff who regularly work at least 20 hours a week (FT/ PT/PRN) are included in the annual peer review process. A site Medical Director reviews another site Medical Director; a physician reviews another physician; a nurse practitioner reviews another nurse practitioner; and a physician assistant reviews another physician assistant. Peer review of a supervisor of a specific clinical discipline is completed by a supervisor of the same discipline with similar responsibilities. When no supervisor peers are available within the contract, peer review of the supervisor is completed by a supervisor of the same discipline with similar responsibilities in another contract. For licensed nursing staff, Centurion permits nursing supervisors to complete peer reviews for nursing staff. NCCHC approves this approach for nursing staff.

Peer review medical record reviews are completed using Centurion Model Peer Review Tools. The Model Peer Review Tools are offered to provide guidance in developing conducting peer reviews specific for a contract. Each Peer Review Tool includes the audit form and second page for noting comments for specific items as well as guidelines for conducting the process with the specific tool. The model tools are to be modified by a contract to meet contract-specific requirements and to reflect compliance with current standards of care. The Statewide Medical Director and/or Medical Director - Mental Health Director (Chief Psychiatrist) are responsible to ensure annual review and updating of discipline-specific peer review tools in collaboration with supervisors of the specific discipline.

The contract's Vice President of Operations establishes the timeframe for completion of the annual peer review process. The contract's CQI Manager/Director/Coordinator or designee is responsible for coordinating the peer review process. The assignment of specific peer reviews is determined by the supervisor of the clinical discipline. The Vice President of Operations has final approval for peer review assignments and can make reassignments as needed.

The peer review process includes:

1. Review of a minimum of ten medical records by the peer reviewer using the applicable Peer Review Tool. If the majority of indicators on the Peer Review Tool are non-applicable for a particular medical record, another record is selected in place of the non-applicable record.
2. For Centurion staff who have administrative/supervisory responsibilities as well as direct care clinical duties, the Peer Review Tool provides a template for asking relevant questions about these duties. The peer review includes discussion of these duties as well as observation of responsibility-related duties.
3. Reviewer and reviewed peer discuss Peer Review Tool findings to facilitate a productive exchange of ideas between peers. Face-to-face discussion of findings is preferable. The reviewer and the reviewed peer sign the Peer Review Verification form confirming the discussion. When a face-to-face discussion of findings is not possible, the reviewer signs the Peer Review Verification form and indicates the date and time of the telephone, teleconference or videoconference discussion with the reviewed peer.
4. If the peer reviewer identifies minor deficits, reasonable solutions and corrective actions will be discussed by the reviewer and reviewed peer. It is recognized that institutional factors beyond the reviewed peer's control will sometimes preclude full compliance with standards.
5. If the peer reviewer identifies what he/she determines serious problems/deficiencies, the peer reviewer notifies his/her supervisor for follow-up.
6. Upon completion of the peer review process, the reviewer forwards the original Peer Review Tool and original Peer Review Verification form to the Site Health Services Administrator or designee. The Peer Review Tools and Verification forms are to be kept in a locked cabinet. Copies of the Peer Review Tools and Peer Review Verification forms are sent to the contract's CQI Manager/Director/ Coordinator or designee. These copies are maintained in a locked cabinet in the Regional Office.
7. Coordination of the peer review process by the CQI Manager/Director/Coordinator or designee includes:
 - a. Preparation of peer review packets for each peer reviewer that includes: cover sheet providing information on his/her peer review assignment as well as the designated completion date (sample attached); discipline-specific Peer Review Tool; the Centurion Peer Review Protocol which includes a copy of the Peer Review Verification form.
 - b. Distribution of the peer review packets and follow-up to ensure that peer reviewers understand the expectations of the process.
 - c. Maintenance of an assignment and completion log to ensure the completion of the peer review occurs within the designated timeframe. The log indicates the peer reviewer's name; his/her discipline; his/her assigned peer to be reviewed; when the

peer review packet was sent; date when copies of the completed Peer Review Tool and Peer Review Verification form were returned; and an indication of when the specific peer review process was completed.

- d. Submission of completed Peer Review Verification forms to the discipline-specific supervisor to ensure identification of peer reviews that indicate serious performance deficiencies requiring an independent performance review.
 - e. Submission of completed Peer Review Tools with the identification of the peer reviewer and the peer reviewed redacted to the discipline-specific supervisor to permit the supervisor to analyze for system-wide areas for improvement.
 - f. When the peer review process has been completed, a letter is sent to the client verifying the completion of annual peer review (sample attached).
8. Supervisor follow-up of peer review findings:
- a. If problems of serious nature are identified by a peer review, the supervisor of the specific clinical discipline conducts an immediate focused independent performance review.
 - b. Focused independent performance reviews may be conducted by the supervisor of the specific discipline or designee in the following circumstances:
 - Peer reviewer identifies significant or multiple deficiencies of serious nature
 - Peer reviewer identifies a probable breach of ethics
 - Client requests a review of a licensed healthcare staff
 - The client and Centurion corporate leadership are informed of peer reviews identifying serious concerns with clinical practices.
9. Maintenance of peer review documentation:
- a. It is Centurion's position that peer reviews and related materials are privileged and legally protected from disclosure; however, we acknowledge that this confidentiality may be challenged.
 - b. Completed Peer Review Tools are maintained in a locked confidential file in accordance with NCCHC peer review standards. Information regarding the identities of the patients are redacted.
 - c. When serious problems/deficiencies identified by the peer reviewer are independently reviewed by the supervisor of the specific clinical discipline, a statement indicating the findings of the independent review and actions will be included in the peer review documentation file.
 - d. Copies of Peer Review Verification forms are maintained in Continuous Quality Improvement files to confirm completion of the peer review process.



- e. The Vice President of Operations is responsible for maintaining the confidentiality of the peer review process.

Forms: Staff Notification of Peer Review Expectation
 Peer Review Verification – ADM-005
 Model Letter for Client after Peer Review – ADM-006

Resources: Centurion Model Peer Review Tools
 Centurion Model Policy CEN-C02: Clinical Performance Enhancement



To: Centurion Licensed Healthcare Staff
From: Centurion Vice President of Operations
Date:
Re: Peer Review Process

Centurion has a professional and contractual obligation to conduct peer reviews of licensed healthcare staff each year. Your participation in this process as both a peer reviewer and reviewed peer is appreciated and expected. The Centurion Peer Review Protocol is attached for your information.

As the reviewer, you are expected to complete the Peer Review Tool and Peer Review Verification form. The Peer Review Tool has been developed to be as effective and efficient as possible and requires the audit of no less than ten randomly selected patient medical records. We have tried to focus the formal peer review questions on areas determined to be the most helpful and realistic to evaluate. In addition to the standard questions listed, you are encouraged to include other information regarding professionalism, practice patterns, or other comments that you think are appropriate.

As the reviewing peer, you are expected to discuss the findings of the peer review with the staff member reviewed and to consider the recommendations provided. As the peer being reviewed, if you disagree with the peer review findings or recommendations, please contact your clinical supervisor.

Peer review documentation is maintained in a locked, confidential file in accordance with NCCHC standards and will not be included in personnel or credential files. The discipline-specific supervisor will address peer review findings of a serious nature.

Peer review is a mandatory assignment since the process is required by NCCHC standards and Centurion contractual agreements. It is essential that the assigned peer reviews are completed and submitted by the date indicated below. If travel is required to complete the assigned peer review, you will be reimbursed for the travel.

Prior to completing the peer review, please call the peer to be reviewed and arrange for applicable medical records to be available for reviews. You will want to request that a representative sample of records that will address as many topics of the Peer Review Tool as possible are available.

If you have questions about the peer review assignment, please contact the Centurion Vice President of Operations immediately. Peer review is a very important part of an overall plan to improve the quality of professional services for your correctional program. Your participation is appreciated.

Centurion staff member to be reviewed: _____ Facility: _____
Staff member to complete the peer review: _____
Date Peer Review Tool and Peer Review Verification form to be submitted: _____

Attachments: Centurion Peer Review Protocol
Applicable Peer Review Tool with guidance in completing the review

PEER REVIEW VERIFICATION

Peer review of _____ was completed on _____.
(Licensed Healthcare Staff) (Date)

Position of staff member reviewed: _____

Patient ID numbers of medical records reviewed:

- ☐ Peer review found no deficiencies
- ☐ Peer review found only minor deficiencies and reasonable solutions/corrective actions were identified and agreed upon
- ☐ Peer review found only minor deficiencies; however, reviewer and peer reviewed are in disagreement about findings and corrective actions (Refer to supervisor of specific discipline for independent review)
- ☐ Peer review found potentially serious deficiencies. Refer to supervisor of specific discipline for independent review

Signature/Date of Peer Reviewer

Credentials of Reviewer

Signature/Date of Peer Reviewed

- ☐ Face-to-face discussion of peer review between peer reviewer and peer reviewed not practical. Discussion was conducted by telephone/teleconference/videoconference

Date/Time of Contact _____

*Form to be submitted with completed Peer Review Tool.
Peer review process is protected under applicable federal and state peer review statutes*



CLIENT NAME
PEER REVIEW 20XX
Date Submitted

The 20XX Peer Review Tools for each discipline were reviewed for possible revision. No revisions were made. *(If revision(s) were made, please indicate and submit copy(s) of blank tools to the letter.)*

The Peer Review Tools were designed to emphasize peer evaluation of clinical services provided and to facilitate a productive exchange between peers regarding pertinent clinical practices.

If a peer review revealed minor deficits, the peers were instructed to develop reasonable solutions and corrective action plans at the peer level. Based on standards of peer review procedures, the results of the process are kept confidential at this level.


If more serious deficits were found, the reviewer was instructed to indicate this on the Peer Review Verification form and submit to the supervisor of the specific clinical discipline for an independent review. If problems of very serious nature involving possible malpractice or breaches of ethics were identified, the supervisor of the specific clinical discipline conducted an independent review and reported findings to Centurion corporate management. The matter was handled at the management level and appropriate staff of the client informed of the outcome.

Peer Review Tools and review assignments were distributed to Centurion licensed healthcare staff in (month/year) with a completion deadline of (Month/Day/Year).

The majority of Centurion staff reported completion of the peer review assignment by (Month/Day/Year). The few assignments yet to be completed are scheduled and will be completed by (Month/Day/Year). Copies of the Peer Review Verification forms are attached.

Issues raised during the peer review process were resolved at the initial peer level for XX Centurion staff. XXX Centurion staff were referred to the supervisor of the specific clinical discipline for deficiencies of a serious issue. XXX Centurion staff were reviewed for problems of a very serious issue.

If there are questions, please contact XXXXXXXX at XXXXXXXX.


 Centurion™ Prison - Model Policies and Procedures	Policy Number: CEN-C02	Page 1 of 5
Subject: Clinical Performance Enhancement	Related Standards: NCCHC: P-C-02 (2014) ACA: 4-4411	
Approved: _____ Date: _____	Effective Date: Review Date:	
Revised: _____ Date: _____		

I. Purpose

To provide the opportunity for confidential clinical practice review between licensed clinicians of the same discipline. Clinical performance enhancement is the process of assessing healthcare delivery for individual staff members in a collaborative way among peers. The review includes dialogue and conversation between peers working in the same or similar roles to enhance competence and to focus resources on areas needing improvement. The clinical performance enhancement process is neither a performance review nor a clinical case conference.

II. Policy

1. The clinical performance enhancement process evaluates the appropriateness of services delivered by all direct patient care providers, mental health professionals, registered nurses, and licensed practical nurses.
2. *Clinical performance enhancement* reviews are kept confidential and incorporate at least the following elements:
 - a. The name of the individual being reviewed
 - b. The date of the review
 - c. The name and credentials of the reviewer
 - d. A summary of the findings and corrective action, if any
 - e. Confirmation that the review was shared with the individual being reviewed.
3. A log or other written record listing the names of the individuals reviewed and the dates of their most recent reviews is available.
4. The Responsible Health Authority implements an independent review when there is serious concern about any individual's competence.
5. The Responsible Health Authority implements procedures to improve an individual's competence when such action is necessary.


 Centurion™ Prison - Model Policies and Procedures	Policy Number: CEN-C02	Page 2 of 5
Subject: Clinical Performance Enhancement		

III. Definitions


1. *Clinical performance enhancement:* The process of having a health professional's work reviewed by another professional of at least equal training in the same general discipline, such as the review of the facility's physicians by the responsible physician.
2. *Direct patient care clinicians:* All licensed practitioners providing the facility's medical, dental, and mental health care including physicians, dentists, nurse practitioners, physician assistants, mental health professionals, and licensed nursing staff.
3. *Independent review:* The assessment of a healthcare professional's compliance with discipline-specific and community standards. The review includes an analysis of trends in a practitioner's clinical practice. This review may be conducted by someone who may or may not be directly employed by the institution, as long as the reviewing practitioner has not been previously involved in the care of the patient(s) involved.

IV. Procedures


1. Peer review process is an annual component of the Continuous Quality Improvement (CQI) Program.
2. Peer reviews are completed using relevant peer review tools or tools that reflect compliance with clinical standards of care.
 - a. When record reviews are completed as part of the peer review process, a minimum of ten health records are reviewed.
 - b. If clinical procedures or practices are observed or reviewed as a part of the peer review process, a minimum of three instances of the same procedure are recommended.
 - c. If the majority of indicators on the peer review tool are non-applicable for a particular health record or procedural observation, another record or observation is selected in its place.
3. Peer reviews are conducted for all licensed healthcare staff to include nursing and mental health professionals unless union agreements prohibit.

 Centurion™ Prison - Model Policies and Procedures	Policy Number: CEN-C02	Page 3 of 5
Subject: Clinical Performance Enhancement		

4. Peer reviews are completed by licensed staff of the same discipline who are not the staff member's immediate supervisor.
5. When staffing plans do not allow for clinical peer review among licensed nursing staff, nursing supervisors may complete peer reviews of nursing staff that they supervise. When it is necessary for a supervisor to complete a peer review of subordinates, this clinical review will be separate from the annual performance review.
6. Clinical practice peer review of a supervisor of a specific clinical discipline is completed by a supervisor of the same discipline with similar clinical responsibilities. When no supervisor peers are available within the program, peer review of the supervisor is completed by a supervisor of the same discipline with similar responsibilities from another contract.
7. Supervisory reviews completed in accordance with collaborative practice agreements between a nurse practitioner/physician assistant and supervising physician/psychiatrist DO NOT constitute peer reviews and are not to be substituted for peer reviews.
8. The assignment of specific peer reviews is developed by the supervisor of the clinical discipline. The Vice President of Operations will establish a timeframe for completion of the peer reviews. The Vice President of Operations has final approval for all peer review assignments and can make reassignments as needed.
9. The contract's CQI Manager/Director/Coordinator or designee is responsible for coordinating the peer review process. This coordination includes:
 - a. Annual review and updating of discipline-specific Peer Review Tools in collaboration with representatives from the specific disciplines. The Clinical Operations Department provides model peer review tools for each discipline.
 - b. Preparation of peer review packets for each peer reviewer that include: cover sheet providing information on the peer review assignment as well as the designated completion date; discipline-specific Peer Review Tool; copy of the Centurion Peer Review Protocol which includes a copy of the Peer Review Verification form.
 - c. Distribution of the peer review packets and follow-up to ensure that peer reviewers understand the expectations of the process.

 Centurion™ Prison - Model Policies and Procedures	Policy Number: CEN-C02	Page 4 of 5
Subject: Clinical Performance Enhancement		

- d. Maintenance of the assignment and completion log to ensure that the completion of the peer review occurs within the designated timeframe. The log will indicate the peer reviewer's name; his/her discipline; his/her assigned reviewed staff member; when the peer review packet was sent; date when copy of the completed Peer Review Tool and Peer Review Verification form are returned to the CQI Manager/Director/Coordinator or designee; and an indication of when the specific peer review process was completed.
 - e. When the peer review process has been completed, a letter or CQI report is shared with the client verifying the completion of annual peer review.
 - f. Prior to filing the Peer Review Tools, it is recommended that copies of the tools with the identification of the peer reviewers and the reviewed staff member redacted are submitted to the discipline supervisor to permit the supervisor to analyze for system-wide areas for improvement.
10. Once the reviewer has completed the Peer Review Tool, the reviewer and the reviewed staff member discuss peer review findings to facilitate a productive exchange of ideas between peers. Face-to-face discussion of findings is preferable. The reviewer and the reviewed staff member will sign the Peer Review Verification form. When a telephone discussion or a teleconference is necessary, the reviewer will sign the Peer Review Verification form and indicate the date and time of the discussion with the reviewed staff member.
11. Upon completion of the peer review process, the reviewer will:
- a. Forward the original Peer Review Tool and original Peer Review Verification form to the Site Health Services Administrator or designee. Peer Review Tools and Peer Review Verification forms will be placed in a locked confidential file in accordance with NCCHC peer review standards and applicable state peer review statutes. Information regarding the identities of the patients may be redacted. The Vice President of Operations is responsible for maintaining the confidentiality of the peer review documents.
 - b. Send a *copy* of the Peer Review Tool and Peer Review Verification form to the contract's CQI Manager/Director/Coordinator or designee.
12. The CQI Manager/Director/Coordinator provides copies of Peer Review Verification forms to the supervisor of the specific clinical discipline to ensure identification of peer reviews that indicate serious performance deficiencies for independent follow-up.

 Centurion™ Prison - Model Policies and Procedures	Policy Number: CEN-C02	Page 5 of 5
Subject: Clinical Performance Enhancement		

13. If problems of serious nature involving possible malpractice or breach of ethics are identified, the supervisor of the specific clinical discipline will consult with Corporate leadership for assistance in conducting an immediate review.
14. Focused independent performance reviews may be conducted by the supervisor of the specific discipline or designee in the following circumstances:
 - a. Peer reviewer identifies significant or multiple deficiencies of serious nature
 - b. Peer reviewer identifies a probable breach of ethics during the review
 - c. Serious peer review findings are reported to the supervisor of the specific clinical discipline
 - d. The client requests a review of a clinician
15. Peer reviews and related materials are considered privileged and legally protected from disclosure. Management of documents and information associated with the process will be in accordance with other information deemed privileged and legally protected.

Forms: Peer Review Verification (ADM-005)
 Model Letter for Client after Peer Review (ADM-006)

Comments/feedback regarding strengths/limitations, site-specific program concerns and corrective action plans (if applicable) to be documented on this page.

Title of Position: Peer Review Tool Comments

Title of Position Reviewed: _____ Date: _____

Aspect of Care	Comments/Corrective Action Plans
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	

Guidelines for Each Aspect of Care of the Peer Review Tool Should be Provided

Comments/feedback regarding strengths/limitations, site-specific program concerns and corrective action plans (if applicable) to be documented on this page.

Physician – Medical: Peer Review Tool Comments

Clinician Reviewed: _____

Date: _____

Aspect of Care	Comments/Corrective Action Plans
Legible clinical notes are documented using SOAP format	
Objective documentation is complete and includes vital signs	
Plan of Care is consistent with Assessment (Diagnosis)	
Orders written in Plan of Care are documented on appropriate order form	
Clinical notes indicate patient education is provided	
Rationale for specialty consultations and off-site care is documented	
Results of ordered testing and off-site care reports are in the medical record and are reviewed	
Treatment changes and follow up, as indicated from results of ordered testing and off-site care, is appropriate and timely	
Chronic Care Clinic visits and treatment follow disease-specific Disease Management Guidelines	
Chronic Care Clinic documentation includes as applicable medication compliance, education and notation regarding review of testing and reports with patient	
Chronic Care Clinic follow-up and treatment is completed as ordered	
Infirmity rounds are documented per contract and patient condition	
Telephone orders are reviewed and signed off according to timeframes	
New and renewal medication orders are written and completed as ordered	

Guidelines for Physician – Medical: Peer Review Tool

Legible clinical notes are documented using SOAP format:

Patient encounters are documented in the progress notes using the Subjective Objective Assessment Plan format unless a specific visit form is required such as Chronic Care Clinic documentation forms. Documentation in the health record must be legible and include the provider's signature, date and time of encounter.

Objective documentation is complete and includes vital signs:

Physical assessment and review of pertinent data adequately addresses patient complaint. Vital signs, including weight when clinically relevant, are documented.

Plan of Care is consistent with Assessment (Diagnosis):

Medications, testing, treatment and follow-up orders are appropriate for diagnosis.

Orders written in Plan of Care are documented on appropriate order form:

When orders for treatments, testing, medications, etc. are required on a separate order document, complete orders are reflected on order form.

Clinical encounter documentation indicates patient education is provided:

Notation of education for indicated self care, treatments and follow-up are discussed with patient.

Rationale for specialty consultations and off-site care is documented:

Documentation includes reason for the consultation, specialty group or individual providing consultation and specific service(s) requested. When prior approval for consults is required, this documentation is available. Emergency Room care rationale is documented. If documentation is made by nursing staff, there is evidence that the provider was notified and approved. Inpatient hospitalizations have, at a minimum, rationale for hospitalization and a discharge summary.

Results of ordered testing and off-site care reports are in the health record and are reviewed:

Evidence that testing results, off-site care reports, including emergency room reports and inpatient hospitalization discharge summaries, are reviewed in a timely manner after service is completed. The review may be indicated by the provider's initials and date on the actual report; however, when treatment changes are made based upon these reports, there is a note and orders in the health record.

Treatment changes and follow-up, as indicated from results of ordered testing and off-site care, is appropriate and timely:

When testing results are abnormal, there is a documented treatment change such as medication adjustment, patient counseling and/or follow-up for retesting. Specialty and off-site care recommendations are ordered or rationale for not accepting and an acceptable alternative plan is documented. Timeliness would be immediate or within an acceptable timeframe.

Chronic Care Clinic visits and treatment follow disease-related Disease Management Guidelines:

Follow-up of Chronic Care Clinic visit frequency is ordered and conducted at intervals based upon the disease stability identified in the Disease Management Guidelines

and/or contractual requirements. Baseline testing, procedures, and vaccines are completed at the frequency outlined in Disease Management Guidelines. Depending upon Chronic Care Clinic, examples may include, but not limited, to laboratory testing, electrocardiograms, annual eye examinations, flu vaccine etc.

Chronic Care Clinic documentation includes as applicable medication compliance, education and notation regarding review of testing and reports with patient:

The patient's compliance with medications is reviewed at each visit. Education is provided at each visit and may include reinforcement of treatment, disease-specific topics and related self-care instructions.

Chronic Care Clinic follow-up and treatment is completed as ordered:

The health record should indicate that follow-up visits occurred as ordered or appropriate notation of why a visit was missed and rescheduled or patient's refusal noted.

Infirmity rounds are documented per contract and/or patient condition:

Documentation of provider rounds on infirmity patients includes current status and treatment changes. Provider rounds are made at a frequency based upon patient condition and requirements of contract.

Telephone orders are reviewed and signed off according to timeframes:

Documentation includes the co-signature of the ordering provider and a notation in the progress notes that pertinent information relating to the order was reviewed.

New and renewal medication orders are written and completed as ordered:

There is a clinical encounter or other note written by the provider in the health record that indicates the need for medication orders and reorders.



CLIENT NAME
PEER REVIEW 20XX
Date Submitted

The 20XX Peer Review Tools for each discipline were reviewed for possible revision. No revisions were made. *(If revision(s) were made, please indicate and submit copy(s) of blank tools to the letter.)*

The Peer Review Tools were designed to emphasize peer evaluation of clinical services provided and to facilitate a productive exchange between peers regarding pertinent clinical practices.

If a peer review revealed minor deficits, the peers were instructed to develop reasonable solutions and corrective action plans at the peer level. Based on standards of peer review procedures, the results of the process are kept confidential at this level.

If more serious deficits were found, the reviewer was instructed to indicate this on the Peer Review Verification form and submit to the supervisor of the specific clinical discipline for an independent review. If problems of very serious nature involving possible malpractice or breaches of ethics were identified, the supervisor of the specific clinical discipline conducted an independent review and reported findings to Centurion corporate management. The matter was handled at the management level and appropriate staff of the client informed of the outcome.

Peer Review Tools and review assignments were distributed to Centurion licensed healthcare staff in (month/year) with a completion deadline of (Month/Day/Year).

The majority of Centurion staff reported completion of the peer review assignment by (Month/Day/Year). The few assignments yet to be completed are scheduled and will be completed by (Month/Day/Year). Copies of the Peer Review Verification forms are attached.

Issues raised during the peer review process were resolved at the initial peer level for XX Centurion staff. XXX Centurion staff were referred to the supervisor of the specific clinical discipline for deficiencies of a serious issue. XXX Centurion staff were reviewed for problems of a very serious issue.

If there are questions, please contact XXXXXXXX at XXXXXXXX.

SENTINEL EVENTS AND MORBIDITY AND MORTALITY REVIEWS

Sentinel Events

Centurion monitors significant adverse clinical outcomes by utilizing the **On-line Sentinel Event Log (oSEL)** program. This allows for timely review and follow-up with the appropriate site provider to gather more information if needed. Based on the events listed in the **Centurion Sentinel Event Reporting and Investigation policy, P-A06a**, each site enters the required information. Entered events can be sent directly to the Centurion State Medical Director, the County and Centurion's Chief Medical Officer via an email notification. Any deaths (anticipated/unanticipated/completed suicides) are also automatically sent to Corporate Risk Management Department via oSEL notification.

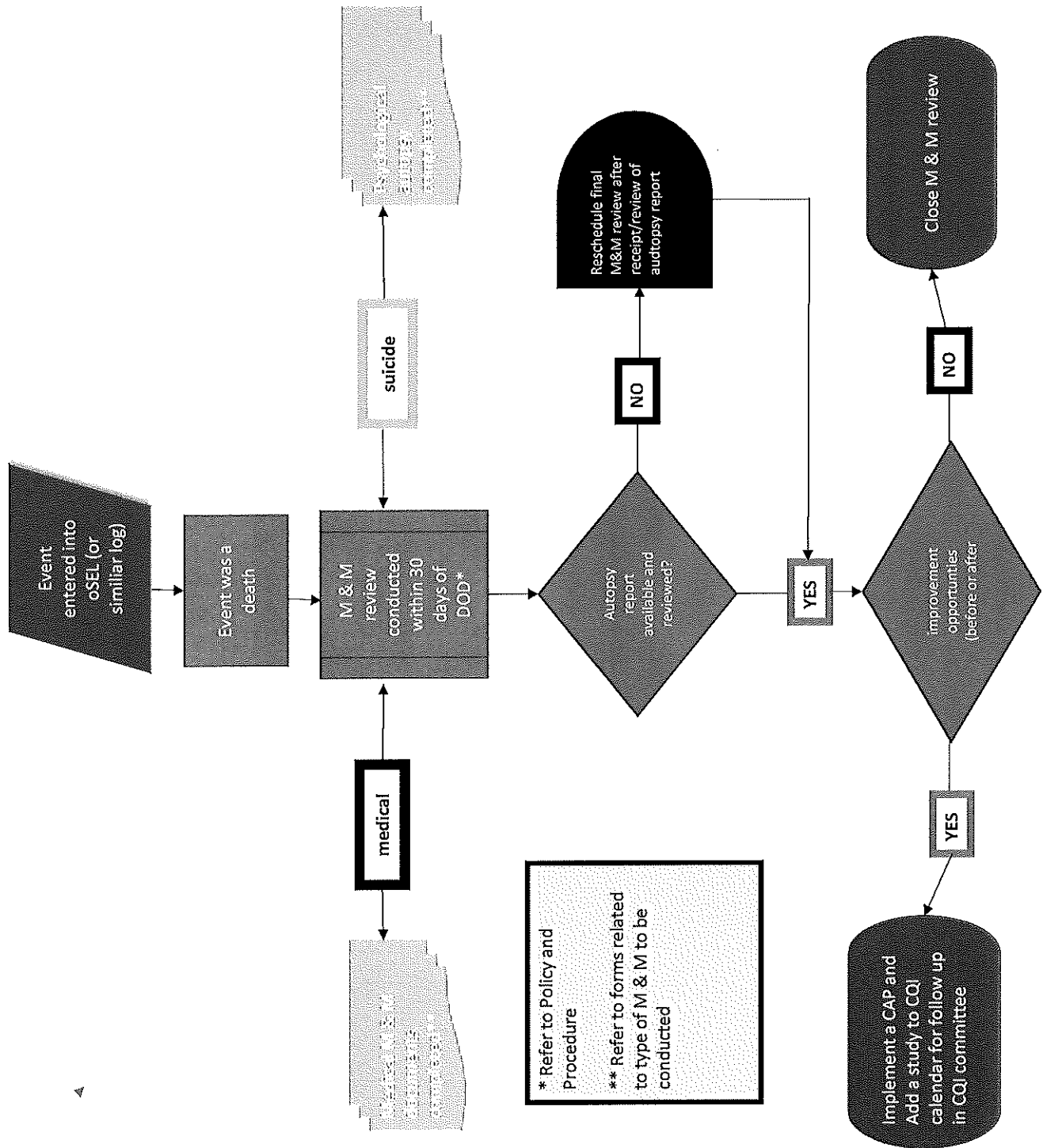
Each month, the data from the oSEL program can be exported via OSEL on the Pima County portal page to allow for a monthly report. This report can then be used by Pima County site, the County, Centurion Medical Director and CQI to review trends and to ensure timely follow-up of events as necessary. Events that show opportunities for improvement will be reviewed by the CQI Committee and may result in further study or CAP.

Morbidity and Mortality review

Centurion has a comprehensive **Morbidity and Mortality policy (P-A-09)** and associated forms and tools. The Centurion Medical Director will oversee the mortality review process with the assistance of Centurion's CQI Coordinator. Centurion's Morbidity and Mortality processes and reviews are compliant with NCCHC and ACA standards.

oSEL – Sentinel Event categories

Category 1 Sentinel Events		
Category Header	Event Type	Event Type Code
Unanticipated Death	Completed Suicide	CS
	Unanticipated Death	UD
Permanent Harm, this includes dismemberment, significant disfigurement, permanent loss or significant loss of the use of an organ or function	Permanent Harm	PH
Category 2 Sentinel Events		
Category Header	Event Type	Event Type Code
Severe Temporary Harm/Illness	Diabetic Ketoacidosis	DK
	Emergency Surgery (unexpected surgery done within 24 hours of transport to the emergency department)	ESURG
	Intensive Care Unit Admissions	ICUADM
	Severe Temporary Harm	STH
	Status asthmatics requiring admission to the hospital	SAADM
	Status epilepticus requiring admission to the hospital	SEADM
	Suicide Attempt/self-injury requiring off-site medical care	SASI
Category 3 Sentinel Events		
Category Header	Event Type	Event Type Code
Anticipated Deaths	Anticipated Deaths	AD
Active Tuberculosis	Active Tuberculosis	AT
Extraordinary Event	Extraordinary Event	EXEV
	Potential Communicable Disease Outbreak	PCDO
Fetal Demise or Stillborn	Fetal Demise or Stillborn	Fetdem
Hunger strikes requiring medical monitoring or intervention	Hunger strikes requiring medical intervention	HS
On-site Obstetric Delivery	On-site Obstetric Delivery	OOD
Potentially life threatening medication occurrence/adverse reactions	Potentially life threatening medication occurrence/adverse reactions-this event includes adverse drug events as well as medication errors that caused life threatening condition	PLTM
Sexual Assault	Sexual Assault/PREA	SEXAS
Trauma with injury enough to require off-site care		TR
Violent Act	Violent Act	VA



Program/Facility

Model Prison Policies and Procedures

Policy Number:
P-A-06a

Subject:

Sentinel Even Reporting and Investigation

Related Standards:

NCCHC: P-A-06, P-A-09 (2018)

ACA: 5-ACI-6D002, 5-ACI-6D-08, 5-ACI-6D-09

Other: The Joint Commission, Patient Safety Systems Chapter, Sentinel Event Policy

I. Purpose

The Centurion Sentinel Event Policy is written to facilitate reporting and investigation of serious adverse medical events.

II. Policy

1. Sentinel events are unexpected medical or behavioral health events serious enough to require immediate investigation and response.
2. Careful tracking of these events and conducting an investigation into their root causes is needed to identify safety issues or overall medical/behavioral health care. Tracking and investigating these events will help protect patients and improve healthcare processes to prevent further harm.
3. The health services administrator is responsible to ensure that sentinel event tracking is consistently updated each day.
4. The CQI program, under the direction of the medical director, is responsible for ensuring that sentinel events are investigated and that identified corrective actions are developed, implemented and monitored when indicated.

III. Definitions

Sentinel Medical or Behavioral Health Event: is any unexpected circumstance that results in one of the following categories:

Category 1 Sentinel Events

- Unanticipated Death
 - a. Completed Suicide
 - b. Unanticipated death
- Permanent Harm: This includes dismemberment, significant disfigurement, permanent loss or significant limitation of the use of an organ or function

Category 2 Sentinel Events

- Severe Temporary Harm Requiring Intervention to Sustain Life
 - Intensive Care Unit admissions
 - Diabetic ketoacidosis
 - Status asthmaticus requiring admission to the hospital
 - Status epilepticus requiring admission to the hospital
 - Emergency surgery (unexpected surgery done within 24 hours of transport to the emergency department)
 - Severe temporary harm – illness/injury that is acute and likely to be resolved
 - Suicide attempt/self-injury requiring off-site medical care

Category 3 Sentinel Events: Other medical events important enough to be tracked and investigated.

- Anticipated deaths
- Active TB
- Extraordinary event – to be used if no other event type category type is appropriate, or to enter an event that happened due to extreme weather, riot or other extraordinary event
- Potential communicable disease outbreak
- Fetal demise or stillborn
- Hunger strikes requiring medical intervention
- Behavioral health emergency
- On-site obstetric delivery
- Potentially life-threatening medication occurrence/adverse reactions – this event includes adverse drug events, suspected overdose, as well as medication errors that caused life threatening condition
- Sexual assault/PREA
- Suicidal ideation
- Trauma with injury enough to require off-site care
- Violent Act

IV. Procedures

Reporting of Sentinel Events:

1. The health services administrator and/or CQI lead is responsible for ensuring that designated healthcare staff are trained in accurately inputting information into oSEL.
2. Sentinel events are reported immediately (or as soon as is practicable) using the Centurion Online Sentinel Event Log (oSEL). If the contract does not utilize the oSEL program, the health services administrator will be responsible for notifying the risk/legal paralegal for all Category I and Category II events.
3. If utilizing oSEL, the health services administrator or designee is responsible for ensuring that oSEL events are accurately completed and updated daily.
4. Inputting sentinel events into oSEL does not replace the requirement to report other types of events to Risk Management/Legal as outlined in the *Centurion Incident Reporting Policy (MHM Legal Policy # CNT.COMP.150)*.
5. Each contract should review sentinel events at least quarterly during the CQI committee meeting.
 - a. Category One sentinel events are presented individually
 - b. Category Two and Category Three sentinel events can be presented statistically or individually, per the medical director's discretion

Investigation of Sentinel Events:

1. Investigation into the root cause of sentinel events is coordinated by the CQI program under the direction of the medical director, assisted by the director of nursing and/or the facility's health services administrator
 - a. Category 1 sentinel events require formal Mortality and Morbidity Committee review within 30 days

- b. Category 2 and Category 3 sentinel events may require a morbidity review at the discretion of the site/regional medical director
- c. The health services administrator has the responsibility for appropriately scheduling, recording and reporting all investigations into the root cause of sentinel events.

Referenced Forms:

References:

Clinical Operations Revision Dates:

August 2019
September 2019

Reviewed/ Approved By	Facility	Effective Date	Review Date

Program/Facility

Model Prison Policies and Procedures

Policy Number:
P-A-09

Subject:

Procedure in the Event of an Inmate Death

Related Standards:

NCCHC: P-A-09 (2018)

ACA: 5-2A-4425, 5-6A-4373-1, 5-6C-4395,
5-6D-4410

Other:

I. Purpose

The responsible health authority conducts a thorough review of all deaths in custody in an effort to improve care and prevent patient deaths and to define the procedure for a comprehensive review of inmate deaths in the verbal or written format as required by the client.

II. Policy

1. If oSEL is used, an entry will be made into oSEL for the following events:
 - a. Anticipated death
 - b. Unanticipated death
 - c. Completed Suicide
2. A preliminary clinical review will be completed within 10 business days of death.
3. A *clinical mortality review* is conducted within 30 calendar days.
4. An *administrative review* is conducted in collaboration with custody staff within 45 calendar days.
5. A *psychological autopsy* is conducted within 30 calendar days for all deaths by suicide.
6. When/If individual performance deficiencies are identified during the course of the mortality review, treating staff will be informed of pertinent findings via the peer review process.
7. The CQI Committee or suicide prevention sub-committee will include a summary of any recommendations for areas that may need improvement on the monthly/quarterly CQI Committee agenda.
8. The CQI committee will maintain a log to track timely completion of mortality reviews. The log will include:
 - a. Patient name or identification number
 - b. Age at time of death
 - c. Date of death
 - d. Date of clinical mortality review
 - e. Date of administrative review
 - f. Cause of death (e.g., hanging, respiratory failure)
 - g. Manner of death (e.g., natural, suicide, homicide, accident)
 - h. Date pertinent findings of review shared with staff
 - i. Date of psychological autopsy, if applicable.

III. Definitions

1. *Preliminary Clinical Review* is a multidisciplinary, comprehensive medical record review, chronicling medical and mental health care and pertinent treatment leading up to the mortality.
2. *Clinical Mortality Review* utilizes information gathered from the Multidisciplinary Mortality Preliminary Review Report to assess the clinical care provided and the circumstances leading up to the death as well as provide recommendations for improvements, if any.

3. *Administrative Review* is completed in collaboration with security and assesses the correctional and emergency response actions and other non-direct patient care issues surrounding the inmate's death as well as provide recommendations for improvement, if any.
4. *Psychological autopsy* (sometimes referred to as a psychological reconstruction or postmortem) is a written reconstruction of an individual's life with an emphasis on factors that led up to or may have contributed to the death. A psychologist or other designated qualified mental health professional usually drafts it.

IV. Procedures when Notified of a Death

1. Upon notification of an inmate death, the highest-ranking healthcare staff member will notify the medical director/chief psychiatrist and health services administrator and security. Additionally, if using oSEL, the event will be entered into oSEL (automatic notifications of events can be set up for site, security, and client leadership).
2. The institution's administration will notify the medical examiner and request an autopsy as dictated by administrative directives as set forth in the client's policies and procedures.
3. Designated institutional administrative staff will notify the inmate's family (or designated person) as set forth in the client's policies and procedures.
4. One copy of the inmate's health record is made immediately after healthcare staff have completed documentation or after the off-site hospital has notified the healthcare staff of an inmate death. The copy is secured in the healthcare unit with access limited to the medical director, health services administrator, or designee. The original health record is maintained according to the client's policies and procedures. For clients that utilize an electronic health record, the record is locked with limited access, and no further entries can be made.
5. When requested by the client or on-site security administrative staff, mental health staff will provide support to the correctional officers, healthcare staff and inmates who may have observed or been directly affected by the death. Debriefings will be coordinated through mental health leadership and the client's medical director and director of mental health.
 - a. Guidance in offering support for correctional officers and medical staff is provided in *Mental Health Clinical Guidelines: Critical Incident Education for Staff*.
 - b. Guidance for debriefing inmates is provided in *Mental Health Clinical Guidelines: Psychological Debriefing Following a Discrete Traumatic Event*.

V. Procedure for Participation in Mortality Review

1. An *administrative review (Multidisciplinary Administrative Review Report – ADM-003c)* is conducted in conjunction with custody staff. The administrative review includes a review of the incident and facility procedures used; training received by involved staff; emergency response; and recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures.
2. A *preliminary clinical review* should be completed within 10 business days of death (*Multidisciplinary Mortality Preliminary Review Report, ADM-003a*). This preliminary review allows for an in-depth review of medical record to provide a timeline of all relevant medical and mental health services
3. As soon as possible, but in no more than 30 calendar days after an inmate death, the Mortality Committee will conduct a *clinical review*. At a minimum, the committee should include:
 - a. Site medical director/chief psychiatrist
 - b. Unit physician/psychiatrist not involved in the patient's treatment
 - c. Health services administrator or designee

Program/Facility

Model Prison Policies and Procedures

Policy Number:
P-A-09

- d. Site director of nursing or designee
- e. CQI staff member

There may be times when the client, an outside medical group or other entity will conduct their own review. The medical director/chief psychiatrist or designee will participate as requested. In case of a suicide, or if a psychological autopsy was completed, the person who conducted the psychological autopsy will also participate in any other-entity review as requested.

4. For inmate medical deaths, the presiding physician will conduct the clinical review. (*Multidisciplinary Clinical Mortality Review Report, ADM-003b*). The requirement for a clinical mortality review also applies to those deaths, whether natural or otherwise, that occur off-site while the facility is responsible for the inmate.
5. For inmate suicides, the presiding chief psychiatrist or designee will conduct the review using the *Mortality Review Outline-Inmate Suicide (ADM-002)*.
 - a. The mortality review will include a psychological reconstruction (autopsy) with special attention to reviewing the inmate's biopsychosocial history, including previous suicide attempts, if any, during prior and/or current incarceration.
Guidance in completing the reconstruction is provided by *Mental Health Clinical Guidelines: Psychological Reconstruction of an Inmate's Suicide*.
 - b. When a serious suicide attempt results in the need for off-site medical care, the mental health medical director, at his/her discretion, may conduct or assign a designee to conduct a review similar to those completed for deaths.
6. When/If systemic or individual performance deficiencies are identified during the course of the mortality review, the deficiencies are referred/reviewed separately with the treating staff via the peer review process. The peer review process will be conducted through the Centurion Regional Administration in collaboration with legal counsel and the client. Unless required by the client's policies, systemic and individual performance deficiencies are not included in a written mortality review.
7. Results of the verbal or written mortality review, including the psychological reconstruction in the event of a suicide, are shared with the Centurion Internal CQI program.
8. Medical and mental health staff are informed of relevant findings from the mortality review and/or psychological reconstruction during regularly scheduled staff meetings.
9. Any corrective action plans addressing systemic deficiencies are developed and implemented through the CQI program. Corrective action plans will be tracked for progress/completion through the CQI program.
10. The CQI committee will maintain a log to show that mortality reviews are completed promptly. The log will contain the following:
 - a. Patient name or identification number
 - b. Age at date of death
 - c. Date of death
 - d. Date of preliminary clinical review
 - e. Date of administrative review
 - f. Date of clinical mortality review
 - g. Date of psychological reconstruction, if applicable
 - h. Date autopsy received
 - i. Date information shared with CQI Committee
 - j. Date information shared with site staff

11. Reviews and forms are confidential and are not distributed except on a need to know basis and after consultation with Centurion's General Counsel. All details regarding this review, including but not limited to the identity of those participating, the topics discussed and documents generated in preparation for and as a result of the review, are privileged under state law and disclosure of this information to anyone could potentially nullify the peer review protections afforded by state law.

Referenced Forms:

Multidisciplinary Mortality Preliminary Review (ADM-003a)
Multidisciplinary Clinical Mortality Review (ADM-003b)
Multidisciplinary Clinical Mortality Review Guidelines
Multidisciplinary Administrative Review (ADM-003c)
Mortality Review Tracking Log (ADM-003d)
Mortality Review Outline-Inmate Suicide (ADM-002)
BH Clinical Guidelines - Psychological Reconstruction
BH Clinical Guideline - Psychological Debriefing following A Discrete Traumatic Event
BH Clinical Guideline - Critical Incident Education for Staff

References:**Clinical Operations Revision Dates:**

August 2018
July 2019

Reviewed/ Approved By	Facility	Effective Date	Review Date

Mortality Review Outline For Inmate Death By Suicide

I. SOURCES OF INFORMATION

- A. List the categories of documents reviewed if report is written
- B. Must review at least the following, if available
 - 1. Inmate's medical records
 - 2. Inmate's mental health records
 - 3. Inmate's institutional files
 - 4. Incident reports regarding emergency response
 - 5. Review of physical scene to determine if there is a hazardous environment (e.g., lack of rails on stairways, etc.)
 - 6. Review of mental health staff reports of significant details identified during inmate debriefings, if relevant
 - 7. The psychological reconstruction: a written reconstruction of an individual's life with an emphasis on factors that may have contributed to the individual's death; sometimes referred to as a psychological autopsy and usually conducted by a psychologist or other qualified independently licensed mental health professional
 - 8. Autopsy report or preliminary autopsy findings, if available
- C. Insert language providing context for the review if report is written

This review is intended to serve as an assessment of clinical care provided and the circumstances leading up to a death, identifying areas of patient care or system policies and procedures that can be improved. The author of this review has used reasonable efforts to ensure that relevant sources of information were considered in drafting this review, and has noted sources of such information relied upon by the author, such as medical records, mental health records, incident reports, and similar sources of information. Information which was unavailable or unknown to the author of this review at the time of issuance may impact conclusions or recommendations contained in this review.

II. INFORMATION ON DECEDENT

Focus of this section should be on information known to staff at the time of death and background information that may be relevant to evaluation of the incident.

- A. Identifying Information
 - 1. Age
 - 2. Sex
 - 3. Race
 - 4. Height/Weight, if available
- B. Relevant Background Information
 - 1. Education, family, significant historical events
 - 2. History of prior crimes and incarcerations

Mortality Review Outline For Inmate Death By Suicide

3. Relevant medical history, if applicable
4. Mental health history prior to most recent incarceration
5. Chronology of psychological history, if applicable
6. Events prior to most current incarceration

III. SUMMARY OF MOST RECENT INCARCERATION

Depending on the length of incarceration, the focus should be on information that is relevant to the incident

A. Incarceration at current facility

1. Reason for transfer to current facility
2. Length of stay at facility prior to incident
3. Pertinent housing changes at current facility

B. Relevant medical treatment

1. Diagnoses
2. Medication
3. Treatment compliance

C. Mental health treatment

1. Mental health classification, if applicable
2. Diagnoses and relevant changes to diagnoses during incarceration
3. Medications and relevant changes to medications
4. Treatment adherence
5. History of past suicide risk screenings and assessments, if applicable
6. History of past suicidal ideation, communications, and/or behaviors, to the extent history is known
7. Recent encounters with mental health clinicians

IV. ANALYSIS OF KNOWN RISK FACTORS

Focus should be risk factors known to providers at the time of inmate's treatment, not information learned after-the-fact. The purpose of this section is simply to list rather than analyze the known risk factors. Risk factors first identified after the inmate's death are not included in this section.

- A. Medical factors
- B. Psychological factors
- C. Environmental factors
- D. Other factors, if any

Mortality Review Outline For Inmate Death By Suicide

V. SUMMARY OF INCIDENT

This section is not designed to analyze the causes for the incident but to give an overview of what occurred and attempts to provide medical/mental health intervention, if applicable. The incident summary outlines the sequence of events leading up to and including the inmate's death in sufficient detail to enable readers to understand what happened. It does not attempt to explain why the death occurred.

VI. CONCLUSION/FINDINGS

This section should only be included in the written report if this section is specifically required by the client. If you are unsure, check with your program manager/VPO. The purpose of the conclusion section is not to assign blame or responsibility for the inmate's death but rather to develop an understanding of factors in the inmate's life that led up to and may have contributed to the death. When systematic or individual performance issues are identified during the course of completing a mortality review, these will be referred separately through regional administration in collaboration with legal counsel and the client. Any system or process issues identified through the mortality review process as in need of improvement will be pursued through the Continuous Quality Improvement program.

Multidisciplinary Mortality Preliminary Review Report

Date of Review: _____	Institution: _____
Patient Name: _____	Patient #: _____
DOB: _____ Age: _____	Gender: _____ Race: _____
Date of Death: _____	Place of Death: _____

This Multidisciplinary Mortality Preliminary Review Report used to complete a comprehensive medical record review, chronicling medical and behavioral health care, interventions and treatment leading up to the mortality. Use the corresponding Guideline for assistance in completing this report.

A. Incident Summary Narrative

1. Date & time incident discovered: _____
2. Name of person(s) who discovered the patient: _____
3. If on-site, details of the response: (correctional and medical/ MH response):
 - a. Code response of first responder: _____
 - b. Response time of first health care provider: _____
 - c. If pertinent, note time of activation of 911 emergency and time of EMS arrival _____
 - d. Other response details: _____
4. Medical/ Behavioral Health interventions utilized: _____
5. Circumstances of death: _____
6. Details relevant to the scene: _____
7. Place/ location of Death: _____
8. Date of Death: _____
9. Time of Death: _____
10. Date/ Time medical examiner was notified: _____

B. Medical Health History

1. Current/ Past Medical Diagnosis (if none, state N/A): _____
2. Allergies: _____
3. Vaccination history (if pertinent): _____
4. List of Medical or Behavioral Health Medications: _____
5. Sate of most recent intake: _____
6. Date of most recent Chronic Care visit: _____
7. Date of most recent periodic health assessment: _____
8. Date of most recent review of medication compliance: _____
9. Type of active medical clearances/ restrictions or if patient was in disciplinary or seclusion status at time of the event (if any): _____
10. DNR order? ☐ Yes ☐ No
11. Advance Directive/ Living Will? ☐ Yes ☐ No
12. Timeline Summary of major medical issues/ problems and relevant treatment: _____

_____	_____	_____
Patient Name	ID #	DOB

THIS DOCUMENT WAS CREATED AS PART OF CONTINUOUS QUALITY IMPROVEMENT AND MAY NOT BE DISCLOSED. THIS DOCUMENT IS PART OF A PROTECTED PEER REVIEW PROCESS AND IS NOT SUBJECT TO DISCOVERY.

Multidisciplinary Mortality Preliminary Review Report

C. Behavioral Health History

1. Current/ Past BH Diagnosis (if none, mark N/A): _____
2. Prior pertinent behavioral health treatment in the community: _____
3. History of drug/ alcohol? _____
4. Family history of mental illness/ suicide? _____
5. Date of most recent treatment plan: _____
6. Date of most recent review of medication compliance: _____
7. Date of most recent Behavioral Health encounter: _____
8. Pre-suicidal functioning: _____
9. Timeline Summary of major behavioral health issues/problems and relevant treatment: (History of any inpatient psychiatric admissions (including reasons for and disposition upon discharge, dates of any prior suicidal or self-injurious behavior, date of AIMS, date and results of any diagnostic labs)

D. Major Life Stressors:

Names and titles of staff who participated in preliminary review:	
Staff Name	Title
Staff Name	Title
Staff Name	Title
Staff Name	Title
Staff Name	Title
Staff Name	Title

Date Preliminary Review Completed: _____

_____	_____	_____
Patient Name	ID #	DOB

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Multidisciplinary Mortality Preliminary Review Report

Guidelines for Completion

A preliminary mortality review shall be conducted within **10 days** of morbidity or mortality event (or per your client's policy). The Health Service Administrator, Director of Nursing and/or Medical and Behavioral Health provider, as appropriate, should complete this preliminary, comprehensive medical record and timeline review. Utilize the **Multidisciplinary Mortality Preliminary Review** form (ADM-003)

Document the following information on the Preliminary Review Form

INCIDENT SUMMARY NARRATIVE:

1. Date & Time when incident discovered – Note the date and time a code/Emergency was called
2. Name of person(s) who discovered the patient – name of the Centurion and/or Security staff who discovered the patient
3. If on site, details of the response: (correctional and medical/MH response):
 - a. Code response time of first responder
 - b. Response time of first health care provider.
 - c. If pertinent, note time of activation of 911 emergency and time of EMS arrival
 - d. Other response details
4. Medical or Behavioral Health interventions utilized – note any interventions that were conducted during the initial response (i.e. CPR, medication):
5. Circumstances of death - note what was seen upon response to code/Emergency, if patient was in hospice, incident was a result of violence.
6. Details relevant to the scene – note presence or absence of a suicide note, description of how/where patient's body was found
7. Place/location of Death - on-site in infirmary, in pod, cell, name of off-site hospital
8. Date of Death:
9. Time of Death:
10. Date and time Medical examiner was notified.

MEDICAL HEALTH HISTORY

1. Current/Past Medical Diagnosis (if none, state N/A) – list all current and past medical diagnosis (that should be listed on the problem list).
2. Allergies – to any medication, food, environmental
3. Vaccination history - if pertinent, list latest vaccinations received
4. List of Medical or Behavioral Health Medications – List all current medication and if pertinent any past medication

_____	_____	_____
Patient Name	ID #	DOB

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Multidisciplinary Mortality Preliminary Review Report

5. Date of most recent intake – date of last intake document.
6. Date of most recent Chronic Care visit – if patient had a chronic illness, note when the last CC visit was completed
7. Date of most recent periodic health assessment – if patient incarcerated longer than 12 months, list date of most recent periodic health assessment
8. Date of most recent review of medication compliance – note when last review concerning medication compliance was documented.
9. Type of active medical clearances/restrictions or if patient was in disciplinary or seclusion status at time of the event (if any) – note if the patient had a diet restriction, bottom bunk, or other clearances/restrictions, was in disciplinary or seclusion status.
10. DNR order? – Did the patient have an active DNR order?
11. Advance Directive/ Living Will? – Did the patient have an active Advance Directive/Living Will?
12. Timeline Summary of major medical issues/problems and relevant treatment – review medical record and put together a timeline, noting:
 - a. Dates and results of all pertinent active medical issues/problems,
 - b. Date and results of treatments from on-site appointments (nurse or provider sick call, follow ups, specialty clinic/provider)
 - c. Date and results of treatments from off-site appointments
 - d. Dates and results of admissions and discharges from infirmary or off-site hospital,
 - e. Dates and results of ordered diagnostics,
 - f. Dates and results of procedures with prognosis pre and post procedures, surgeries, peri-operative evaluations and procedures

BEHAVIORAL HEALTH HISTORY

1. Current/Past BH Diagnosis (if none, mark N/A) - list all current and past behavioral health diagnosis (that should be listed on the problem list).
2. Prior pertinent behavioral health treatment in the community – If recently incarcerated, note previous community BH treatment received, if any
3. History of drug/alcohol abuse?
4. Family history of mental illness/suicide?
5. Date of most recent treatment plan – note the date of the most recently updated treatment plan.
6. Date of most recent review of medication compliance - note when last review concerning medication compliance was documented.
7. Date of most recent Behavioral Health encounter – note date of last encounter with any BH staff
8. Pre-suicidal functioning – Note dates of any documentation that addresses (if any)

_____	_____	_____
Patient Name	ID #	DOB

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Multidisciplinary Mortality Preliminary Review Report

- a. Recent major changes in mental status (i.e. acute deterioration in mental functioning, onset of major mental illness, agitated psychosis with command hallucinations, psychosis with depression and severe depression)
 - b. Any sudden changes in behavior (i.e. social withdrawal, agitation, provocativeness, increased or decreased appetite, disturbed sleep, etc.).
 - c. Recent changes in mood (i.e. depression, hopelessness, helplessness, fearfulness, unfounded happiness, lability, anger, hostility, and impulsivity);
 - d. Recent changes in attitude (i.e. unrealistic sense of the future, apathy, overly optimistic and overly pessimistic).
 - e. Previous specific behaviors suggestive of suicide planning (i.e. giving away possessions, saying good-bye to friends, telephoning or writing to family and/or friends to say good bye, talking about death and/or suicide, rehearsing suicidal act, asking about ways to die and accumulating the means to kill oneself, asking about the frequency and timing of security rounds, threatening suicide)
9. Timeline Summary of major medical issues/problems and relevant treatment – review Behavioral Health record and put together a timeline, noting:
- a. Dates and results of all pertinent active medical issues/problems
 - b. Dates and results of MHP/Psychiatry appointments (i.e. sick call, suicide watches, segregation rounds)
 - c. Dates of any inpatient psychiatric admissions (including reasons for and disposition upon discharge)
 - d. Dates of any prior suicidal or self-injurious behavior
 - e. Date of most recent AIMS testing and results
 - f. Date and results of any diagnostic labs

MAJOR LIFE STRESSORS

To be completed by medical or MH staff based on review of medical record. Note any pertinent information related to:

- a. Physical/sexual assault, threats against life
- b. Dissolution of significant relationship
- c. Crisis in family such as death of a loved one
- d. Added time to sentence, convicted of additional crime, loss of appeal
- e. Diagnosis of a serious medical condition
- f. Anniversary dates (i.e. crime, conviction, commencement of prison term, birthday(s) of significant people, death of loved one, wedding)
- g. Acute onset of mental illness or exacerbation of mental disorder (i.e. Agitated psychosis with depression and command hallucinations to kill oneself) or longstanding mental illness (e.g. chronic depression with suicidal ideation);
- h. Breakdown of support system (i.e. break up with significant other or abandonment of family).

_____	_____	_____
Patient Name	ID #	DOB

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GUIDELINES FOR COMPLETING MULTIDISCIPLINARY MORTALITY PRELIMINARY REVIEW (ADM-003a)

A preliminary mortality review shall be conducted within 10 business days of morbidity or mortality event (or per your client's policy). The Health Service Administrator, Director of Nursing and/or Medical and Mental Health provider, as appropriate, should complete this preliminary, comprehensive medical record and timeline review. Utilize the **Multidisciplinary Mortality Preliminary Review** form (ADM-003a)

Document the following information on the Preliminary Review Form

INCIDENT SUMMARY NARRATIVE:

1. Date & Time when incident discovered – Note the date and time a code/Emergency was called
2. Name of person(s) who discovered the patient – name of the Centurion and/or Security staff who discovered the patient
3. If on site, details of the response: (correctional and medical/MH response):
 - a. Code response time of first responder
 - b. Response time of first health care provider.
 - c. If pertinent, note time of activation of 911 emergency and time of EMS arrival
 - d. Other response details
4. Medical or Mental Health interventions utilized – note any interventions that were conducted during the initial response (i.e. CPR, medication):
5. Circumstances of death - note what was seen upon response to code/Emergency, if patient was in hospice, incident was a result of violence.
6. Details relevant to the scene – note presence or absence of a suicide note, description of how/where patient's body was found
7. Place/location of Death - on-site in infirmary, in pod, cell, name of off-site hospital
8. Date of Death:
9. Time of Death:
10. Date and time Medical examiner was notified

Patient Name:	Patient #:	DOB:
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GUIDELINES FOR COMPLETING MULTIDISCIPLINARY MORTALITY PRELIMINARY REVIEW (ADM-003a)

MEDICAL HEALTH HISTORY

1. Current/Past Medical Diagnosis (if none, state N/A) – list all current and past medical diagnosis (that should be listed on the problem list).
2. Allergies – to any medication, food, environmental
3. Vaccination history - if pertinent, list latest vaccinations received
4. List of Medical or Mental Health Medications – List all current medication and if pertinent any past medication
5. Date of most recent intake – date of last intake document.
6. Date of most recent Chronic Care visit – if patient had a CC illness, note when the last CC visit was completed
7. Date of most recent periodic health assessment – if patient incarcerated longer than 12 months, list date of most recent periodic health assessment
8. Date of most recent review of medication compliance – note when last review concerning medication compliance was documented.
9. Type of active medical clearances/restrictions or if patient was in disciplinary or seclusion status at time of the event (if any) – note if the patient had a diet restriction, bottom bunk, or other clearances/restrictions, was in disciplinary or seclusion status.
10. DNR order? – Did the patient have an active DNR order
11. Advance Directive/ Living Will? – Did the patient have an active Advance Directive/Living Will?

Patient Name:	Patient #:	DOB:
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GUIDELINES FOR COMPLETING MULTIDISCIPLINARY MORTALITY PRELIMINARY REVIEW (ADM-003a)

12. Timeline Summary of major medical issues/problems and relevant treatment – review medical record and put together a timeline, noting:

- a. Dates and results of all pertinent active medical issues/problems,
- b. Date and results of treatments from on-site appointments (nurse or provider sick call, follow ups, specialty clinic/provider)
- c. Date and results of treatments from off-site appointments
- d. Dates and results of admissions and discharges from infirmary or off-site hospital,
- e. Dates and results of ordered diagnostics,
- f. Dates and results of procedures with prognosis pre and post procedures, surgeries, peri-operative evaluations and procedures

MENTAL HEALTH HISTORY

1. Current/Past MH Diagnosis (if none, mark N/A) - list all current and past mental health diagnosis (that should be listed on the problem list).
2. Prior pertinent mental health treatment in the community – If recently incarcerated, note previous community MH treatment received, if any
3. History of drug/alcohol abuse?
4. Family history of mental illness/suicide?
5. Date of most recent treatment plan – note the date of the most recently updated treatment plan.
6. Date of most recent review of medication compliance - note when last review concerning medication compliance was documented.
7. Date of most recent Mental Health encounter – note date of last encounter with any MH staff
8. Pre-suicidal functioning – Note dates of any documentation that addresses (if any)
 - a. Recent major changes in mental status (i.e. acute deterioration in mental functioning, onset of major mental illness, agitated psychosis with command hallucinations, psychosis with depression and severe depression)

Patient Name:	Patient #:	DOB:
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GUIDELINES FOR COMPLETING MULTIDISCIPLINARY MORTALITY PRELIMINARY REVIEW (ADM-003a)

- b. Any sudden changes in behavior (i.e. social withdrawal, agitation, provocativeness, increased or decreased appetite, disturbed sleep, etc.).
 - c. Recent changes in mood (i.e. depression, hopelessness, helplessness, fearfulness, unfounded happiness, lability, anger, hostility, and impulsivity);
 - d. Recent changes in attitude (i.e. unrealistic sense of the future, apathy, overly optimistic and overly pessimistic).
 - e. Previous specific behaviors suggestive of suicide planning (i.e. giving away possessions, saying good-bye to friends, telephoning or writing to family and/or friends to say good bye, talking about death and/or suicide, rehearsing suicidal act, asking about ways to die and accumulating the means to kill oneself, asking about the frequency and timing of security rounds, threatening suicide)
9. Timeline Summary of major medical issues/problems and relevant treatment – review Mental Health record and put together a timeline, noting:
- a. Dates and results of all pertinent active medical issues/problems
 - b. Dates and results of MHP/Psychiatry appointments (i.e. sick call, suicide watches, segregation rounds)
 - c. Dates of any inpatient psychiatric admissions (including reasons for and disposition upon discharge)
 - d. Dates of any prior suicidal or self-injurious behavior
 - e. Date of most recent AIMS testing and results
 - f. Date and results of any diagnostic labs

MAJOR LIFE STRESSORS

To be completed by medical and/or MH staff – based on review of medical record note any pertinent information related to:

- a. Physical/sexual assault, threats against life
- b. Dissolution of significant relationship
- c. Crisis in family such as death of a loved one
- d. Added time to sentence, convicted of additional crime, loss of appeal
- e. Diagnosis of a serious medical condition
- f. Anniversary dates (i.e. crime, conviction, commencement of prison term, birthday(s) of significant people, death of loved one, wedding)

Patient Name:	Patient #:	DOB:
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GUIDELINES FOR COMPLETING MULTIDISCIPLINARY MORTALITY PRELIMINARY REVIEW (ADM-003a)

- g. Acute onset of mental illness or exacerbation of mental disorder (i.e. Agitated psychosis with depression and command hallucinations to kill oneself) or longstanding mental illness (e.g. chronic depression with suicidal ideation);
- h. Breakdown of support system (i.e. break up with significant other or abandonment of family).

Patient Name:	Patient #:	DOB:
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Multidisciplinary Mortality Clinical Review Report

Date Review Completed: _____	Institution: _____
Patient Name: _____	Patient #: _____
DOB: _____ Age: _____	Gender: _____ Race: _____
Date of Death: _____	Place of Death: _____

This Multidisciplinary Mortality Clinical Review Report utilizes information gathered from the Multidisciplinary Mortality Preliminary Review Report to assess and evaluate incident response, clinical history, medication history, medical and mental health interventions (both on and off-site), appointments, or admissions. Below are the findings based on record review, administrative review, and the preliminary review report.

This Multidisciplinary Mortality Clinical Review Report will be reviewed by the CQI committee and any recommendations will be incorporated into the monthly CQI activities.

A. Incident Summary Narrative:

Summary of code/emergency call response and interventions:

	Yes	No - explain:	CQI Recommendations
Response time related to Code/Emergency call was timely	<input type="checkbox"/>	<input type="checkbox"/>	
Interventions related to Code/Emergency call were conducted appropriately for incident	<input type="checkbox"/>	<input type="checkbox"/>	
If EMS activated, response was timely (how long did it take from call to arrival)	<input type="checkbox"/>	<input type="checkbox"/>	
If EMS not-activated, other transportation means were appropriate	<input type="checkbox"/>	<input type="checkbox"/>	

B. Medical Health History:

Current Medical Diagnosis:

1. _____
2. _____
3. _____
4. _____
5. _____

Past/ Inactive Medical Diagnosis:

1. _____
2. _____
3. _____
4. _____
5. _____

DNR and/ or Advance Directive: ☐ Yes ☐ No

_____	_____	_____
Patient Name	ID #	DOB

Multidisciplinary Mortality Clinical Review Report

List of Current Medications (medical and psychiatric):

1. _____
2. _____
3. _____
4. _____
5. _____

Recently discontinued medications (medical and psychiatric):

1. _____
2. _____
3. _____
4. _____
5. _____

Medication non-compliance (medical and psychiatric – name of medication and duration of non-compliance):

1. _____
2. _____
3. _____
4. _____
5. _____

	Yes	No – Explain	CQI Recommendations
Patient was seen timely for sick call (nurse or provider)	<input type="checkbox"/>	<input type="checkbox"/>	
Patient was seen as ordered for Chronic Care	<input type="checkbox"/>	<input type="checkbox"/>	
Patient's control of disease status was documented	<input type="checkbox"/>	<input type="checkbox"/>	
Patient was appropriately and timely referred to off-site specialty care for new or acute complaints	<input type="checkbox"/>	<input type="checkbox"/>	
Patient was seen timely for off-site appointments procedures, surgeries	<input type="checkbox"/>	<input type="checkbox"/>	
Patient's off-site appointments, procedures, pre/post-surgery results/reports and/or orders were reviewed and acted upon timely	<input type="checkbox"/>	<input type="checkbox"/>	
Patient was informed of results/reports and/or plan of care after return from off-site appointment	<input type="checkbox"/>	<input type="checkbox"/>	
There was no lapse in renewal medication orders	<input type="checkbox"/>	<input type="checkbox"/>	
Patient received timely diagnostic testing and was informed of results	<input type="checkbox"/>	<input type="checkbox"/>	

Patient Name	ID #	DOB
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Multidisciplinary Mortality Clinical Review Report

If diagnostic testing was conducted and abnormal, it was reviewed and acted upon timely	<input type="checkbox"/>	<input type="checkbox"/>	
Procedures and/or Pre/peri/post-operative surgeries were without complications	<input type="checkbox"/>	<input type="checkbox"/>	
Required documentation was available in the medical record during review	<input type="checkbox"/>	<input type="checkbox"/>	
Other criteria – add as appropriate	<input type="checkbox"/>	<input type="checkbox"/>	

C. Behavioral Health History:

Current Behavioral health diagnosis:

1. _____
2. _____
3. _____

Past/ inactive behavioral health diagnosis:

1. _____
2. _____
3. _____

History of drug and/or substance abuse: _____

History of previous suicide attempts: _____

History of previous self-injurious behaviors: _____

	Yes	No – Explain	CQI Recommendations
Patient was on the active BH caseload	<input type="checkbox"/>	<input type="checkbox"/>	
Patient was appropriately designated as SMI or non-SMI	<input type="checkbox"/>	<input type="checkbox"/>	
Patient was seen timely for sick call (nurse or provider)	<input type="checkbox"/>	<input type="checkbox"/>	
Patient was seen/followed up with appropriate frequency per orders	<input type="checkbox"/>	<input type="checkbox"/>	
Treatment plan was current and specific to patient	<input type="checkbox"/>	<input type="checkbox"/>	
Patient received timely diagnostic testing and was informed of results	<input type="checkbox"/>	<input type="checkbox"/>	
If diagnostic testing was conducted and abnormal, it was reviewed and acted upon timely	<input type="checkbox"/>	<input type="checkbox"/>	
Appropriately assigned to seclusion or suicide watch if applicable	<input type="checkbox"/>	<input type="checkbox"/>	
If on watch or observation, level of supervision was appropriate	<input type="checkbox"/>	<input type="checkbox"/>	

_____	_____	_____
Patient Name	ID #	DOB

Multidisciplinary Mortality Clinical Review Report

If on watch or observation rounding was conducted as required	<input type="checkbox"/>	<input type="checkbox"/>	
If patient not on watch or observation, should (s)he have been?	<input type="checkbox"/>	<input type="checkbox"/>	
Patient participated in group or individual therapy as appropriate/ordered	<input type="checkbox"/>	<input type="checkbox"/>	
Required documentation was available in the medical record during review	<input type="checkbox"/>	<input type="checkbox"/>	
D. Life Stressors			
Recent major life stressors that may have contributed to incident were documented in the record	<input type="checkbox"/>	<input type="checkbox"/>	
E. Cause of Death **			
1. Date death certificate available _____			
2. Date autopsy report received _____			
3. Date toxicology results received _____			
4. Toxicology results _____			
<p>** If autopsy report is not available, the M & M review will remain open until the autopsy is received. The final M & M summary review (section below) may be appended with applicable information from the autopsy report.</p> <p>F. Summary Review (summary of incident, medical and behavioral health (as either/both applicable) care received autopsy, toxicology findings and any further comments related to recommendations above).</p>			

Meeting Date: _____

Mortality Review Committee

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____	_____	_____
Patient Name	ID #	DOB

Multidisciplinary Mortality Administrative Review Report

Date of Review: _____	Institution: _____
Patient Name: _____	Patient #: _____
DOB: _____ Age: _____	Gender: _____ Race: _____
Date of Death: _____	Place of Death: _____

This Multidisciplinary Mortality Administrative Review Report should take place between staff/leadership from Centurion and Security. This report reviews and assesses the non-direct clinical issues related to the mortality and provides recommendations for improvement.

Recommendations from this administrative review will be forwarded to the CQI committee for follow up.

A. Incident Response Review

Summary of any issues not already addressed on the Multidisciplinary Mortality Clinical Review Report related to response to the incident.

Recommendations for improvement:

B. Criminal History Review

Summary of any relevant criminal history that contributed to the incident:

C. Staffing Review

Summary of medical, mental health and security staffing on the day of the incident:

Recommendations for improvement

D. Training/ Credentialing/ Certification Needs Review

Summary of medical, mental health and security staff who were not adequately trained for incident or do not have appropriate credentials or certifications (BLS/CPR/First Responder)

Recommendations for improvement

_____	_____	_____
Patient Name	ID #	DOB

Multidisciplinary Mortality Administrative Review Report

Date of last man down drill and/or mass casualty drill: _____

E. Equipment Issues Review

List any equipment that was not available or not in working order that hindered the response or intervention of the incident

List staff training needs in regards to use of equipment

Recommendations for improvement

F. Physical Barriers to Care Review

List any physical barriers (locked doors, lost keys, etc.) that hindered the response or intervention of the incident

Recommendation for improvement

G. Communication Review

List any issues that hindered response or intervention of the incident due to lack of communication between medical, mental health security, EMS, or outside hospital

Recommendations for improvement

H. Housing Review of Relevant Facility Placements (overall adjustment to environment)

List relevant housing placements/movement or any recent placement in segregation – list any issues related to pre-screening process before placement in segregation or post UOF. Describe any issues related to physical design of the patient's cell that contributed to or hindered the incident and intervention

Patient Name

ID #

DOB

Multidisciplinary Mortality Administrative Review Report

Recommendations for improvement
I. History of Relevant Disciplinary Status Summary of any relevant disciplinary status that may have contributed to incident
Recommendations for improvement

Meeting Date: _____

Mortality Review Committee

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____	_____	_____
Patient Name	ID #	DOB

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Multidisciplinary Morbidity Review Report: Multi-Patient Report

Date of Review:	_____	Institution:	_____
Patient Name:	_____	ID #:	_____
Patient Name:	_____	ID #:	_____
Patient Name:	_____	ID #:	_____
Patient Name:	_____	ID #:	_____
Patient Name:	_____	ID #:	_____
Date(s) of Event:	_____		
Place(s) of Event:	_____		

This multi-patient Multidisciplinary Morbidity Review Report reviews information gathered from trending events that resulted in an unexpected outcome or could have resulted in an unexpected outcome (near-miss or unsafe practices) involving multiple patients. Use this form to assess and evaluate event timelines, circumstances that led to the events and any relevant clinical history, administrative issues, medication history, medical and mental health interventions or equipment issues. The information below is a summary of the events based on record reviews, timeline reviews, and administrative reviews.

The CQI committee reviews this Multidisciplinary Morbidity Review Report. Any recommendations are incorporated into the monthly Centurion internal CQI program.

A. Code/Emergency Summary Narrative: (if applicable)

Summary of code/emergency call response and interventions (if reviewing a trend of an outcome such as overdoses, summarize the code response):

Date/Time/Patient ID:

Date/Time/Patient ID:

Date/Time/Patient ID:

Date/Time/Patient ID:

Date/Time/Patient ID:

Multidisciplinary Morbidity Review Report: Multi-Patient Report

	YES	NO – explain for each pt where answer was NO	N/A	CQI Recommendations
Response time related to Code/Emergency call was timely	<input type="checkbox"/>			
Interventions related to Code/Emergency call were conducted appropriately for event	<input type="checkbox"/>			
If EMS activated, response was timely	<input type="checkbox"/>			
If EMS not-activated, other transportation means were appropriate	<input type="checkbox"/>			
All necessary equipment was available and in working order	<input type="checkbox"/>			
Staff who attended the code were trained to handle the necessary equipment	<input type="checkbox"/>			
The patient was in/had been in restraints at the time the code was called	NO <input type="checkbox"/>	YES- explain		

B. Morbidity Type:

Type	Definition	(Note YES in this column for those event types that apply to this review)
Severe Temporary Harm/Illness - Suicide attempts and/or serious self-injurious behavior	Trending of a single patient's events or trending of multiple patients' attempts of suicide and/or serious self-injurious behaviors, requiring intervention beyond first aid level of care or could have resulted in death or serious bodily injury. For example, injuries requiring sutures, surgeries, CPR, X-ray, CT scans, MRI's, IV's, etc. that are not performed as a perfunctory assessment or intervention	
Extraordinary Event – Potential Communicable Disease outbreak	Trending of multiple patients with new diagnosis of Hepatitis A, B, or C	
Potentially Life-Threatening Medication Occurrence/Adverse Reactions	Trending data of widespread illicit drug overdoses within the facility, necessitating intervention to revive patients. OR	

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Multidisciplinary Morbidity Review Report: Multi-Patient Report

	Trending of multi-patient adverse reactions to the same medication.	
Equipment, device, or product failure	Trending of missing or malfunctioning of the same piece of equipment	
Equipment, device or product misuse	Trending of end user's lack of competency/training in the use of equipment/product	
Other:	Explain here:	

C. Relevant Background Information (statuses that are relevant to the trending event):

	Any medical or mental health clearances	Yes	No	N/A	Any medical or mental health restrictions or holds	Yes	No	N/A
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	In disciplinary status at time of event	Yes	No	N/A	On suicide watch or on observation at time of event	Yes	No	N/A
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	History of drug and/or substance abuse	Yes	No	N/A	History of previous suicide attempts/self-injurious behaviors	Yes	No	N/A
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Currently on the active MH caseload	Yes	No	N/A	Type of equipment, device or product failure	Yes	No	N/A
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PT ID:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Multidisciplinary Morbidity Review Report: Multi-Patient Report

D. Summary Timelines

- a. If reviewing trending of suicides/serious injurious behavior, note patient(s) dates and times and locations when event occurred
- b. If reviewing trending of overdoses, note dates, times and location of each patient when event occurred
- c. If reviewing trending of infectious disease outbreak, note dates, times and location of each patient for the event
- d. If reviewing trending of equipment, device or product failure or misuse, note dates, location and issues with competencies noted

E. Summary of Findings (after review of all the above, note any common causes, locations, circumstances):

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Multidisciplinary Morbidity Review Report: Multi-Patient Report

F. Summary of CQI Recommendations (next steps such as conducting a Root Cause Analysis and/or Corrective Action Plan)		
CQI Recommendation	Conduct Root Cause Analysis?	Develop a Corrective Action Plan?

Notice: Reviews and forms are confidential and are not distributed except on a need to know basis and after consultation with Centurion's General Counsel. All details regarding this review, including but not limited to the identity of those participating, the topics discussed, and documents generated in preparation for and as a result of the review, are privileged under State law and disclosure of this information to anyone could potentially nullify the peer review protections afforded by State law.

Meeting Date: _____

Morbidity Review Committee Attendees

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Centurion Clinical Guidelines: Conducting a Morbidity Review

This clinical guideline may not be applicable to all types of patient events noted and there may be additional events where conducting a morbidity review would provide clinical insight.

Use your clinical judgment. Centurion's Clinical Guidelines for Morbidity Reviews are intended to supplement rather than supplant any client-specific protocols and processes. These Guidelines do not establish policy requirements.

A Morbidity Review is a structured, multidisciplinary clinical case review that addresses a non-fatal but clinically significant adverse outcome that is unexpected, appears to involve multiple service delivery systems, or is otherwise identified as in need of clinical review.

Conducting a Morbidity Review allows for an in-depth review of an event that resulted in an unexpected adverse outcome or could have resulted in an unexpected adverse outcome (e.g., near miss or unsafe practices). Conducting a Morbidity Review can have a positive impact in improving patient care, treatment and services, as well as preventing future sentinel events.

Morbidity Reviews assist with identifying contributing factors that led to the event as well as areas of service delivery in need of improvement. The review may lead to changes in the program's systems and disease-specific clinical and/or prescribing guidelines.

Definition of events that would trigger a Morbidity Review:

- **Permanent Harm:** dismemberment, significant disfigurement, permanent loss or significant loss of the use or function of an organ or limb
- **Severe Temporary Harm/Illness – Emergency surgery:** unexpected surgery done within 24 hours of transport to the emergency department
- **Severe Temporary Harm/Illness – Intensive Care Admission:** unexpected admission to the ICU as a result of transport to the emergency department
- **Severe Temporary Harm/Illness - Suicide attempts and/or serious self-injurious behavior:** Unexpected and/or serious suicide attempts and/or self-injurious behavior requiring intervention beyond first aid level of care or could have resulted in death or serious bodily injury. This may include injuries requiring sutures, surgeries, CPR, X-ray, CT scans, MRI's, IV's, etc., that are not performed as a perfunctory assessment or intervention. Due to the frequency of self-injury in correctional settings, use clinical judgment to select those cases in which a Morbidity Review is likely to yield actionable changes in care or service delivery processes.
- **Severe Temporary Harm/Illness - Injury related to restraint use:** Current or previous use of restraints that resulted in an injury
- **Extraordinary Event – Potential Communicable Disease outbreak:** e.g., Hepatitis A, B, or C outbreak
- **Potentially Life Threatening Medication Occurrence/Adverse Reactions:** A medication administration occurrence or adverse reactions that resulted in a life-threatening or clinically significant adverse outcome. This event type would also include trending data of widespread illicit drug overdoses within the facility, necessitating intervention (e.g., application of Narcan) to revive patients.

Centurion Clinical Guidelines: Conducting a Morbidity Review

- Clinically significant delay in access to care (e.g., delay in on-site appointment, specialty consult, or diagnostic testing), that contributed to a delay in or missed clinical diagnosis and/or treatment plan
- Equipment, device, or product failure - Missing or malfunctioning equipment
- Equipment, device or product misuse - end user lacked competency/training in use of equipment/product

Members of the Morbidity Committee should include:

- Chairperson of the committee (a provider that was not involved in direct care of the patient being reviewed)
- Site Administrator or designee
- Director of Nursing or designee
- Site Medical Director or designee
- Site Mental Health Director or designee as appropriate to event
- Site Psychiatrist or Psychologist or designee as appropriate to event
- CQI Coordinator
- Security member as appropriate to event

Agenda for Morbidity Review includes: (see "Morbidity Meeting Agenda/Minutes template CQI-013)

OLD BUSINESS - Updates of previous and/or open Morbidity Review Action Items from CQI Committee

NEW BUSINESS –

- A. Review of New Morbidity Event(s) –** Review of Multidisciplinary Morbidity Review Reports
- 1) Single Patient(s) Review reports
 - 2) Multi-Patient Review Reports
- B. Discussion of relevant finding**
- 1) Single Patient(s) Review reports
 - 2) Multi-Patient Review Reports
- C. Discussion of Action Items –**
- 1) No current action items required
 - 2) Revision of current treatment plan
 - 3) Send to Peer Review Committee
 - 4) Revision of process or systemic changes needed - send to the CQI committee to complete a Root Cause Analysis and/or develop, implement and monitor a Corrective Action Plan as needed

Centurion Clinical Guidelines: Conducting a Morbidity Review

Conducting a Morbidity Review:

If reviewing a single patient event

- Utilize the *Multidisciplinary Morbidity Review Report – Individual Patient event (ADM – 003e)*

If reviewing a trending event (e.g., disease outbreak, multiple drug overdose events, equipment failure)

- Utilize the *Multidisciplinary Morbidity Review Report – Multi-Patient event (ADM – 003f)*

CQI Department is an integral part of the review process:

- Results of the verbal or written morbidity review are shared with the Centurion internal CQI program
- Relevant systemic findings are discussed during CQI and staff meetings.
- When/if individual performance deficiencies are identified during the course of the morbidity review, the deficiencies are referred/reviewed separately with the treating staff via the peer review process. The peer review process is conducted through the Centurion Regional administration in collaboration with legal counsel and the client. Unless required by the Client's policies, individual performance deficiencies are not included in a written morbidity review.
- Relevant systemic findings are further studied and a Root Cause Analysis conducted.
- Any Corrective Action Plans addressing relevant findings are developed and implemented through the CQI program
- Corrective Actions Plans to be tracked for progress/completion at the CQI meetings

References:

- *Most Commonly Reviewed Sentinel Event Types* – The Joint Commission
- *10 Most Common Sentinel events* – Nursing 2019 Nov 2004, Volume 34 – issue 11

Forms:

- Morbidity Meeting Agenda/Minutes template CQI-013
- Multidisciplinary Morbidity Review Report – Individual Patient event ADM – 003e
- Multidisciplinary Morbidity Review Report – Multi-Patient event ADM – 003f

Centurion
Morbidity Meeting Agenda/Minutes



Date/Time:
Site/Location:
Attendees:

--

I. CALL TO ORDER

A. Acknowledgment of guests

--

B. Approval of previous meeting minutes

--

II. OLD BUSINESS

A. Updates of previous and/or open Morbidity Review Action Items from CQI Committee

Name of Morbidity event reviewed	Root Cause Analysis Status	Corrective Action Status

B. Other old business (open items from last meeting)

Centurion
Morbidity Meeting Agenda/Minutes



III. NEW BUSINESS

A. Review of New Morbidity Event(s) – Review of Multidisciplinary Morbidity Review Reports

- 1) Single Patient(s) Review reports
- 2) Multi-Patient Review Reports

B. Discussion of relevant finding

- 1) Single Patient(s) Review reports
- 2) Multi-Patient Review Reports

C. Discussion of Action Items –

- 1) No current action items required
- 2) Revision of current treatment plan
- 3) Send to Peer Review Committee
- 4) Revision of process or systemic changes needed, send to the CQI committee to complete a Root Cause Analysis and/or develop, implement and monitor a Corrective Action Plan as needed

IV. ADJOURN

CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



Critical Incident Education for Staff

The following Guidelines are intended to assist Centurion mental health staff in responding to requests for interventions with facility staff following a traumatic event, such as an inmate's death or a natural disaster.

NCCHC requires debriefings to be available and offered to affected inmates and personnel following an inmate suicide. In most correctional systems where Centurion provides services, debriefing for staff is completed by the client and is the responsibility of the client. If Centurion staff are requested to provide these services to co-workers, it is essential that the services provided do not compromise ethical and practice standards.

These Guidelines are intended to assist Centurion staff in providing affected personnel with education and information regarding how to access services following a critical or traumatic event, such as an inmate death or a natural disaster. These Guidelines facilitate Centurion staff in providing affected personnel educational support, in the form of the attached handout. They are not intended to facilitate Centurion staff in engaging in direct debriefing or treatment of staff members. Unless Centurion staff are specifically identified as members of a debriefing response team by the client and/or facility, such direct debriefing and/or treatment of staff should not be undertaken. When Centurion staff are identified as members of a debriefing response team, they must have all the necessary training required to participate on such teams. Inclusion of Centurion staff in the debriefing response team should be explicitly indicated in the contract with the client or within local policy.

DEFINITION

Critical Incident Education for staff involves reviewing written information regarding stress reactions and possible methods of decreasing stress reactions of affected staff members.

LIMITS OF SCOPE AND INTENT

Critical Incident Education is not Critical Incident Stress Debriefing. It does not include the provision of psychotherapy of any kind, and does not imply a professional relationship between mental health staff and any affected staff member. Any staff requesting information should be made aware of these limitations at initiation of contact with and/or request for assistance from mental health staff.

ETHICAL CONSIDERATIONS

Mental health staff need to avoid entering into dual/multiple relationships, including providing clinical services to co-workers. Provision of Critical Incident Stress Debriefing to colleagues is permissible only when staff have received training and are members of a formal debriefing response team authorized by the client.

PROCEDURE

- I. **Response to Request.** If a Centurion staff member is approached and asked to provide support services to another staff member affected by a critical incident, and if the Centurion staff member is not part of a formal debriefing response team, the response should include a statement that, as a mental health staff member within the correctional facility, providing clinical services to co-workers is prohibited. What can be provided is the review and discussion of an educational handout that may assist the staff member in seeking appropriate services and support. If the Centurion staff member is part of a formal debriefing team, the response to a request for assistance should follow the facility's protocol.
- II. **Provision of Educational Materials.** Once the above limitations have been explained, the attached Critical Incident Education Sheet should be reviewed with the staff member(s). Affected staff should be encouraged to read the document and to share it with healthy supports, such as friends and family members. Affected

CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



personnel can also be reminded of the Employee Assistance Program and debriefing response team contact information, where these resources are available.

- III. **Reporting.** Unless otherwise indicated in local policy, there is no expectation for formal documentation of interactions with staff members requesting support or information. Verbal notification of all such interactions should be made to one's direct supervisor.



CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES

CRITICAL INCIDENT EDUCATION SHEET

(based on information from the International Critical Stress Foundation, Inc. ©)

GENERAL INFORMATION REGARDING EXPOSURE TO A CRITICAL INCIDENT

You have been through or witnessed a traumatic event or an incident that has caused strong emotional reactions. Such incidents and your reactions to these incidents may get in the way of your ability to function the way you usually do. Even though the event is in the past, you may be experiencing (or could experience in the future) difficult emotional or physical reactions because of the event. It is very common, and in fact quite normal, for people who have been through what you have been through to experience significant emotional, behavioral and physical changes. Sometimes, these changes or stress reactions occur immediately after the event. Other times, these reactions take hours or days to surface. For some people, weeks or months may go by before they experience these changes and reactions.

The important thing for you to know is that stress reactions to events like the one you experienced are common. These reactions may be unpleasant for you and may make you question your ability to handle things. These reactions are a normal response to an abnormal event. Trauma and other critical incidents are *not* normal. They are not expected or predictable. When they happen, your mind and body have to respond in ways that may feel abnormal, because you are responding to abnormal events. In fact, your reactions may be quite normal. Think about a sneeze. When you sneeze, the muscles in your body contract in order to expel abnormal material from your lungs and nose. When you think about it, a sneeze is not common behavior. It is not something that we do all the time. Yet, a sneeze is quite normal in the sense that it is a normal reaction for your body when something abnormal gets in your nose.

Stress reactions are similar. In fact, many reactions are predictable and are the reactions that people naturally experience following a traumatic or critical incident. Examples are included below along with examples of strategies that can help you get through the experience. Not all strategies work for all people, so keep trying until you find what works for you.

COMMON STRESS REACTIONS

<u>Physical*</u>	<u>Emotional</u>	<u>Behavioral</u>	<u>Cognitive</u>
Nausea/Vomiting	Fear	Problems with Sleep (too much or too little)	Confusion
Sweating	Guilt	Withdrawing from Others	Hypervigilance
Difficulty Breathing	Grief	Inability to Rest or Calm	Intrusive Thoughts/Images
Fainting	Panic	Down	Poor Attention
Twitching	Denial	Emotional Outbursts	Poor Problem Solving
Muscle Tremors	Feeling Numb	Pacing	Nightmare
Headaches	Anxiety	Jerky Movements	Poor Concentration
Dizziness	Agitation	Easily Startled	Poor memory
Weakness	Irritability	Change in Social Activity	Disorientation
Chest Pain	Depression	Loss or Increase in Appetite	Loss of Time
Chills	Intense Anger	Being Hyperalert	Suspiciousness
Thirst	Uneasiness	Increased Substance Use	Unsure of Perceptions
Fatigue	Emotional Shock	Change in Speech Patterns	Loss of Trust for Others/Self
Increased Blood Pressure	Feeling Overwhelmed	Antisocial Acts	Poor Self-Image
Increased Heart Rate	Loss of Emotional Control	Being Violent or Destroying	
Problems with Vision	Unfitting Emotional	Property	
Grinding of Teeth	Responses	Reckless Behavior	
Symptoms of Shock			

(*persistent or serious physical symptoms may require medical attention)

POSSIBLE COPING/STRESS MANAGEMENT TECHNIQUES

CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



<p>Balance appropriate physical exercise with relaxation</p> <p>Get plenty of rest</p> <p>Structure your time, keep busy</p> <p>Maintain a normal schedule</p> <p>Eat healthy foods; don't overeat or avoid eating</p> <p>Remind yourself that you are having natural and predictable reactions; don't label yourself as "crazy"</p> <p>Talk to friends/family</p> <p>Avoid overuse of alcohol and drugs; these will not help numb the feelings and will only complicate things</p> <p>Don't make any big life changes or major decisions</p>	<p>Spend time with others</p> <p>Give yourself permission to feel bad and share your feelings with others</p> <p>Provide support to other co-workers who may feel similarly</p> <p>Keep a journal</p> <p>Do things that feel good to you</p> <p>Don't avoid making decisions; maintain control over your life</p> <p>Let your family and friends know when you need private time, but don't overuse it or isolate yourself</p> <p>Remind yourself that intrusive thoughts and images are natural reactions and will decrease over time</p>
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CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



Psychological Debriefing Following a Discrete Traumatic Event

The issue of providing psychological debriefing to individuals following a discrete traumatic event has been the subject of controversy. In recent years, there has been a push to provide immediate, single session group intervention to individuals who have experienced a traumatic event in order to mitigate the risk of developing a psychological disorder. Advocates of this position were initially successful in making the provision of such services standard in the field. Recent research may indicate that immediate, prophylactic psychological debriefing is at best ineffective in preventing symptoms and at worst detrimental to the mental health of affected individuals. Mandatory debriefings are not supported by the research. It appears that it may be more effective to provide early intervention to individuals who request assistance or who demonstrate clinically significant signs or symptoms.

The following Guidelines are intended to assist Centurion mental health staff who are responsible for completing psychological debriefings following a discrete traumatic event, such as an inmate's death or a natural disaster. These guidelines can also be utilized to intervene following rape or sexual assault. When this is the case, special considerations regarding Federal Prison Rape Elimination Act (PREA) standards must be taken into account. These standards include specific provisions regarding the limits of confidentiality and may include recommendations regarding housing or other safety interventions. Centurion offers two training modules related to PREA, one which addresses the federal standards for basic training and the other which addresses sensitivity in responding to sexual assault crises. Staff are encouraged to participate in both trainings prior to engaging in debriefing/acute trauma intervention with sexual assault survivors.

NCCHC requires psychological debriefings to be available and offered to affected inmates and personnel following an inmate suicide. There are other incidents for which the availability of psychological debriefings may be required or considered, such as natural disasters, inmate deaths by causes other than suicide, and incidents of sexual victimization. Inmate participation in psychological debriefings is voluntary, and inmates have the right to refuse these services. Refusal of a psychological debriefing will not prevent the inmate from seeking other mental health services. If psychological debriefing is offered to an inmate following sexual assault, the inmate must be informed that the limits of confidentiality include a requirement to report the alleged or confirmed assault, even if the inmate refuses intervention.

A psychological debriefing does not involve determination of the causes of the incident or any exploration of prior traumas or other historical material. The purpose of a psychological debriefing is not to assign blame or responsibility for the traumatic incident or to investigate the circumstances surrounding the event. Rather, the purpose is to restore a sense of safety and supportive community, educate the inmate regarding stress responses to traumatic events, validate the inmate's reactions, and assist in planning for the near-term future.

When symptoms of mental illness are detected during the course of a psychological debriefing in an inmate who is not on the mental health caseload, the inmate should be referred for further evaluation. Inmates do not need to be on the mental health caseload to access psychological debriefings, and provision of psychological debriefings does not result in automatic placement on the caseload. Provision of regular mental health services to affected caseload patients does not eliminate the obligation to offer separate psychological debriefings, and provision of psychological debriefings does not take the place of ongoing mental health services for caseload patients.

When a psychological debriefing may be indicated for a patient on the mental health caseload, the treatment team should be notified that the patient has been exposed to a potentially traumatic event. A collaborative team decision should be made regarding whether or not the debriefing

CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



process is best provided by the mental health professional currently assigned to the patient as a "primary" mental health treatment provider or by another mental health professional.

Centurion staff completing psychological debriefings should be independently licensed, masters or doctoral level mental health staff. These staff should have training in trauma-informed treatment and experience providing mental health services in correctional environments. If the incident involves an inmate death, staff providing the debriefing should not have been involved in the direct care of the deceased inmate.

Psychological debriefings are time-limited interventions with the goal of restoring or maintaining pre-incident levels of functioning. They are not intended to foster dependency on mental health staff or to imply that normal trauma reactions are pathological in nature. Because of the frequency of sessions, staff should be prepared to set aside sufficient time to complete four sessions with affected inmates.

Debriefings should be documented in the health record of the inmates who receive these services.

SPECIAL CONSIDERATION: When an inmate has been sexually assaulted (alleged or founded), mandated reporting requirements must be followed.

CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



Psychological Debriefing Following a Discrete Traumatic Event Clinical Guidelines for Mental Health Services

This document was created to serve as a guideline for completion of psychological debriefing following a critical or traumatic event, such as an inmate death, sexual assault or a natural disaster. Centurion staff offer psychological debriefings to meet NCCHC and/or PREA standards when this task falls within the scope of Centurion's contract. If these guidelines conflict with local policy or expectations, staff should take steps to resolve conflicts.

DEFINITION

A psychological debriefing is an intervention technique following discrete incidents of trauma designed to alleviate common stress reactions triggered by such events. The primary goals of the intervention are to: 1) restore a sense of safety; 2) educate the inmate about trauma reactions and normalize; and 3) re-establish a sense of self-efficacy.

LIMITS OF SCOPE AND INTENT

Psychological debriefings are time-limited and intended to assist the affected inmate in managing reactions to a traumatic event and planning for the near-term future. Inmate participation in psychological debriefings cannot be mandated. Psychological debriefings do not involve determination of responsibility for the traumatic event or any exploration of past trauma or other historical material. Inmates need not be on the mental health caseload or have a mental illness to be able to access or benefit from a psychological debriefing. Should symptoms of mental illness be identified in a non-caseload inmate during the course of psychological debriefing, referral to mental health is warranted. These guidelines are not intended to be used for debriefings with institutional staff.

PROCEDURE

Recommendations: Psychological debriefing should be completed by an independently licensed, masters or doctoral level mental health staff member who is trained and experienced in providing time-limited trauma-informed treatment and mental health services in correctional environments. A psychological debriefing should be initiated as soon as requested by an inmate or as soon as the potential for development of symptoms is identified. It is essential that participation in the debriefing is voluntary and not mandated. Psychological debriefing is designed to be provided during individual contacts with a patient over four sessions. With caution, group interventions may be considered when the traumatic event affects a larger group. However, most research indicates greater efficacy and reduced risk for harm when psychological debriefing is provided through individual contacts. Individual debriefing is preferred.

- I. **Introduction and Expectations.** During the initial contact, instilling a sense of safety is critical. This contact should include an introduction of the clinician, role of clinician, reason for the contact, voluntary nature of participation in debriefing, and discussion of the limits of confidentiality. In some instances, this initial contact will also serve as the first "session" of the debriefing and may include some of the elements discussed below. In other instances, this initial contact will be very brief. Regardless of the length of the contact, the session should be as private as possible. The inmate should be told that individuals have a number of reactions to these events and that the clinician is available to provide short-term services to assist with coping. Allow the inmate to express thoughts, feelings and concerns about such services. If the inmate is already on the mental health caseload, the patient should be informed that his/her treatment team will be notified that the psychological debriefing is taking place. Invite the inmate to a follow-up session within the next day or two.

During the first session, the clinician should consider administering an assessment instrument to determine the severity of the current reaction and to assist in the assessment of change following the intervention. The *DSM-5 Severity of Acute Stress Symptoms – Adult* is recommended and is attached to these Guidelines for ease of access.

There are special considerations regarding the limits of confidentiality when the inmate is a victim or alleged victim of sexual assault within a correctional facility or under correctional supervision. Under the PREA standards, all such incidents must be reported to the facility administration, regardless of whether or not the victim agrees to the reporting or identifies a perpetrator. This fact must be made known to the inmate. The inmate should know that this information will only be shared with individuals who need to know about the potential abuse and will not be shared more broadly. The inmate should also be made aware that regulations specifically and directly prohibit any retaliation toward the inmate for reporting such incidents, and that the

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facility has a legal responsibility to protect the inmate from any retaliation. Additionally, the inmate should be made aware of the fact that the facility is obligated to investigate the assault, with or without the consent of the inmate.

- II. Scheduling.** Psychological debriefing is designed to be completed in four sessions, no more than one week apart. Contacts should be scheduled and completed within 30 days of the event whenever possible. Some inmates will need sessions to occur close together, so having sessions every few days may be indicated. Clinical judgment is required to assess the intensity of support necessary, and staff must be able to set aside sufficient time to complete all four sessions with affected inmates. Psychological debriefing sessions with individual inmates may last between 30 and 45 minutes, but should not go longer. In all instances, the goal of the psychological debriefing is to provide support for self-efficacy and a return to or maintain pre-incident levels of functioning. Debriefing sessions should not create undue reliance on the clinician for support and coping. Instead, they should move the inmate toward termination of the contacts.
- III. Goals and Interventions.** The primary goals of Psychological Debriefings are to: 1) restore a sense of safety; 2) educate about trauma reactions and normalize; and 3) re-establish a sense of self-efficacy. These sessions should mitigate acute distress without interfering with the natural recovery process. While there is flexibility in the content of each session, the general outline for interventions is described below. Mental status examinations (including assessment of suicidal ideation and other signs of possible suicide risk) and assessment for the development of symptoms of a mental disorder should be a routine part of each session.

Session I – Introduction, limits & expectations

Introduce voluntary nature of sessions, explain limits to confidentiality, including PREA limits if applicable
Explain expectations for the sessions and timeframe
Assess safety/security concerns; follow through on identified concerns
Allow expression of thoughts, feelings, experiences (don't press for them); validate and normalize
Educate on reactions (predict)
Brief mental status exam
Complete initial assessment measure (e.g., *Severity of Acute Stress Symptoms – Adult*)
Develop immediate-term safety/coping plan and provide emergency access information

Session II – Expression, validation, prediction

Review goals and limits
Assess safety/security concerns; follow through on identified concerns
Allow expression of thoughts, feelings, experiences (don't press for them); validate
Normalize inmate's stress reactions (predict, prepare, plan with coping strategies)
Brief mental status exam
Develop/reinforce immediate-term safety/coping plan and remind inmate of access procedures

Session III – Evaluation, normalization, preparation

Briefly review goals and limits
Assess safety/security concerns; follow through on identified concerns
Evaluate coping skills and ability to utilize; evaluate efficacy of safety/coping plans discussed in previous session
Brief mental status exam
Anticipate termination, reinforce coping, and remind inmate of access procedures

Session IV – Termination and referral (as needed)

Briefly review goals and limits
Assess safety/security concerns; follow through on identified concerns
Assess inmate's ability to self-assess
Identify supports in "community" (housing unit where inmate is living and programming in which inmate is already participating) and plan for "re-entry" (return to daily routines; linkages to community supports if inmate is to be released from facility in near future)
Brief mental status exam
Complete post-intervention assessment measure (e.g., *Severity of Acute Stress Symptoms – Adult*)
Reinforce/summarize inmate's strengths, coping skills and "re-entry" plan
Leave door open, and remind inmate of access procedures

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Severity of Acute Stress Symptoms – Adult*

*National Stressful Events Survey Acute Stress Disorder Short Scale (NSESSS)

Patient Name:	Inmate Number:	Date
Please describe what happened to you:		
Date the event occurred:		

Instructions: People sometimes have problems after extremely stressful events or experiences. How much have you been bothered during the PAST SEVEN (7) DAYS by each of the following problems that occurred or became worse after an extremely stressful event/experience? **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
		Not at all	A little bit	Moderately	Quite a bit	Extremely	Item Score
1.	Having "flashbacks," that is, you suddenly acted or felt as if a stressful experience from the past was happening all over again (for example, you re-experienced parts of a stressful experience by seeing, hearing, smelling, or physically feeling parts of the experience)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
2.	Feeling very emotionally upset when something reminded you of a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
3.	Feelings detached or distant from yourself, your body, your surroundings, or your memories?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
4.	Trying to avoid thoughts, feelings, or physical sensations that reminded you of a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
5.	Being "super alert," on guard, or constantly on the lookout for danger?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
6.	Feelings jumpy or easily startled when you hear an unexpected noise?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
7.	Being extremely irritable or angry to the point where you yelled at other people, got into fights, or destroyed things?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
Total/Partial Raw Score:							
Prorated Total Raw Score: (if 1 item left unanswered):							
Average Total Score:							

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CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES

Severity of Acute Stress Symptoms – Adult*

*National Stressful Events Survey Acute Stress Disorder Short Scale (NSESSS)

Instructions to Clinicians

The National Stressful Events Survey Acute Stress Disorder Short Scale (NSESSS) is a 7-item measure that assesses the severity symptoms of acute stress disorder in individuals age 18 and older following an extremely stressful event or experience. The measure was designed to be completed by an individual upon receiving a diagnosis of acute stress disorder (or clinically significant acute stress disorder symptoms) and thereafter, prior to follow-up visits with the clinician. Each item asks the individual receiving care to rate the severity of his or her acute stress disorder **during the past 7 days**.

Scoring and Interpretation

Each item on the measure is rated on a 5-point scale (0=Not at all; 1=A little bit; 2=Moderately; 3=Quite a bit, and 4=Extremely). The total score can range from 0 to 28, with higher scores indicating greater severity of acute stress disorder. The clinician is asked to review the score of each item on the measure during the clinical interview and indicate the raw score for each item in the section provided for "Clinician Use." The raw scores on the 7 items should be summed to obtain a total raw score. In addition, the clinician is asked to calculate and use the **average total score**. The **average total score** reduces the overall score to a 5-point scale, which allows the clinician to think of the severity of the individual's acute stress disorder in terms of none (0), mild (1), moderate (2), severe (3), or extreme (4). The use of the average total score was found to be reliable, easy to use, and clinically useful to the clinicians in the *DSM-5* Field Trials. The **average total score** is calculated by dividing the raw total score by number of items in the measure (i.e., 7).

Note: If 2 or more items are left unanswered, the total score on the measure should not be calculated. Therefore, the individual receiving care should be encouraged to complete all of the items on the measure. If 1 item is left unanswered, you are asked to calculate a prorated score. The prorated score is calculated by summing the scores of items that were answered to get a partial raw score. Multiply the partial raw score by the total number of items on the NSESSS—Acute Stress Disorder (i.e., 7) and divide the value by the number of items that were actually answered (i.e., 6). The formula to prorate the partial raw score to Total Raw Score is:

$$\text{Prorated Score} = \frac{\text{Raw sum} \times 7}{\text{Number of items that were actually answered}}$$

If the result is a fraction, round to the nearest whole number.

Frequency of Use

To track changes in the severity of the individual's acute stress disorder over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the individual's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the individual that might warrant further assessment, treatment, and follow-up. Your clinical judgment should guide your decision.

CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



PSYCHOLOGICAL DEBRIEFING SESSION I CONTACT NOTE

Patient Name:	Inmate Number:	
Date of Contact:	Time:	Institution:
Nature of Event Requiring Debriefing: <i>(provide brief narrative description)</i>		

Introduction, Limits and Expectations			
1. Introduction and Limits	<p><i>Cover each of the following points and provide narrative regarding these points below if needed:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Clarification that participation in debriefing is voluntary <input type="checkbox"/> Clarification that Psychological Debriefing is not psychotherapy <input type="checkbox"/> Clarification that Psychological Debriefing is not part of an internal investigation <input type="checkbox"/> Explanation that Psychological Debriefing is support for natural reactions to abnormal or traumatic events (Emphasize that use of Psychological Debriefing services does not mean there is something "wrong" with the patient.) <input type="checkbox"/> Explanation of limits of confidentiality, including conditions under which confidentiality cannot be maintained <input type="checkbox"/> If the incident is a sexual assault/rape, PREA responsibilities and reporting requirements have been discussed <input type="checkbox"/> Description of Psychological Debriefing as comprised of four structured sessions, 30 to 45 minutes each, lasting no more than four weeks <input type="checkbox"/> Description of debriefing goals, including helping patient to get through the event through <ul style="list-style-type: none"> <input type="checkbox"/> Working on restoring sense of safety and security <input type="checkbox"/> Learning about normal reactions to traumatic events <input type="checkbox"/> Building on patient's strengths to maintain or re-establish a sense of control and effectiveness <p><i>Narrative:</i></p>		
2. Safety Assessment	<p>Assessment of patient's sense of personal safety, in light of traumatic event:</p> <p>Patient's thoughts, feelings and experiences related to traumatic event as offered by inmate (do not press for these):</p>		
3. Education	<p>Educate patient on natural stress responses and reactions to traumatic events, and document any responses the patient reports, including:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Confusion: <input type="checkbox"/> Numbing responses: <input type="checkbox"/> Intrusive experiences: <input type="checkbox"/> Activating experiences: <input type="checkbox"/> Anxiety or Fear: <input type="checkbox"/> Anger: <input type="checkbox"/> Timeframes for restoration of "feeling normal" 		
4. Mental Status	<p>Provide brief mental status, including assessment of impulse control, suicidal/self-injurious and homicidal/hostile ideation, overall distress or agitation, degree of social connectedness, and patient's strengths:</p> <p>Ask the patient to complete an initial assessment measure to determine the current level of symptoms and to help assess for changes over time. The <i>Severity of Acute Stress Symptoms – Adult</i> is recommended.</p>		
5. Plan	<ul style="list-style-type: none"> <input type="checkbox"/> Develop immediate-term coping/safety plan with patient and describe: <input type="checkbox"/> Schedule next session for _____ and <input type="checkbox"/> explain emergency contact information: 		
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Staff Signature:</td> <td style="width: 50%; border: none;">Staff Name (Printed):</td> </tr> </table>		Staff Signature:	Staff Name (Printed):
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CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



PSYCHOLOGICAL DEBRIEFING SESSION II CONTACT NOTE

Patient Name:	Inmate Number:	
Date of Contact:	Time:	Institution:
Nature of Event Requiring Debriefing: <i>(provide brief narrative description)</i>		

Expression, Validation, and Prediction			
1. Review Goals & Limits	<p><i>Cover each of the following points and provide narrative regarding these points below if needed:</i></p> <p><input type="checkbox"/> Reminder that Psychological Debriefing is support for natural reactions to abnormal or traumatic events (Emphasize that use of Psychological Debriefing services does not mean there is something "wrong" with the patient.) and that participation is voluntary and not part of any investigation.</p> <p><input type="checkbox"/> Review of limits of confidentiality, including conditions under which confidentiality cannot be maintained</p> <p><input type="checkbox"/> Description of debriefing goals, including helping patient to get through the event through</p> <p style="margin-left: 20px;"><input type="checkbox"/> Working on restoring sense of safety and security</p> <p style="margin-left: 20px;"><input type="checkbox"/> Learning about normal reactions to traumatic events</p> <p style="margin-left: 20px;"><input type="checkbox"/> Building on patient's strengths to maintain or re-establish a sense of control and effectiveness</p> <p><i>Narrative:</i></p>		
2. Assess Safety	Assessment of patient's sense of personal safety, in light of traumatic event:		
3. Expression & Validation	<p>Let the patient talk freely about his/her experiences since previous session. Document the patient's thoughts, feelings and experiences related to traumatic event as offered by patient (do not press for these). Provide validation for patient's experiences through mirroring and empathic communication.</p> <p>Indicate changes (including positive coping) between current session and previous session.</p>		
4. Normalize	<p>Remind patient that there are normal and natural stress responses and reactions to traumatic events. Indicate that returning to a previous level of functioning may include slipping back from time to time. Document patient's understanding and examples that patient provides:</p> <p>Help patient predict changes in thoughts, behaviors and feelings through education. Prepare for reactions with targeted coping strategies. Describe below:</p>		
5. Mental Status	Provide brief mental status, including assessment of impulse control, suicidal/self-injurious and homicidal/hostile ideation, overall distress or agitation, degree of social connectedness, and patient's strengths:		
6. Plan	<p><input type="checkbox"/> Develop short-term coping/safety plan with patient, including predictions and coping methods discussed during session and describe:</p> <p><input type="checkbox"/> Schedule next session for _____ and <input type="checkbox"/> review emergency contact information:</p>		
<table style="width: 100%;"> <tr> <td style="width: 50%;">Staff Signature:</td> <td style="width: 50%;">Staff Name (Printed):</td> </tr> </table>		Staff Signature:	Staff Name (Printed):
Staff Signature:	Staff Name (Printed):		

CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



PSYCHOLOGICAL DEBRIEFING SESSION III CONTACT NOTE

Patient Name:	Inmate Number:	
Date of Contact:	Time:	Institution:
Nature of Event Requiring Debriefing: <i>(provide brief narrative description)</i>		

Introduction, Limits and Expectations			
1. Review Goals & Limits	<p><i>Cover each of the following points and provide narrative regarding these points below if needed:</i></p> <p><input type="checkbox"/> Reminder that Psychological Debriefing is support for natural reactions to abnormal or traumatic events (Emphasize that use of Psychological Debriefing services does not mean there is something "wrong" with the patient.) and that participation is voluntary and not part of any investigation.</p> <p><input type="checkbox"/> Review of limits of confidentiality, including conditions under which confidentiality cannot be maintained</p> <p><input type="checkbox"/> Description of debriefing goals, including helping patient to get through the event through</p> <p style="margin-left: 20px;"><input type="checkbox"/> Working on restoring sense of safety and security</p> <p style="margin-left: 20px;"><input type="checkbox"/> Learning about normal reactions to traumatic events</p> <p style="margin-left: 20px;"><input type="checkbox"/> Building on patient's strengths to maintain or re-establish a sense of control and effectiveness</p> <p>Narrative:</p>		
2. Assess Safety	Assessment of patient's sense of personal safety, in light of traumatic event:		
3. Evaluation and Preparation	<p>Evaluate patient's coping skills and ability to utilize. Evaluate the efficacy of the "plans" discussed in previous session. Provide targeted intervention for continuing problems. Document below:</p> <p>Prepare patient for ongoing assessment of his/her own coping and functioning. Remind that next session will be the last. Document patient's concerns below:</p>		
4. Mental Status	Provide brief mental status, including assessment of impulse control, suicidal/self-injurious and homicidal/hostile ideation, overall distress or agitation, degree of social connectedness, and patient's strengths:		
5. Plan	<p><input type="checkbox"/> Describe progress and initial plans for coping after termination of sessions:</p> <p><input type="checkbox"/> Schedule next session for _____ and <input type="checkbox"/> explain emergency contact information:</p>		
<table style="width: 100%;"> <tr> <td style="width: 50%;">Staff Signature:</td> <td style="width: 50%;">Staff Name (Printed):</td> </tr> </table>		Staff Signature:	Staff Name (Printed):
Staff Signature:	Staff Name (Printed):		

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PSYCHOLOGICAL DEBRIEFING FINAL SESSION CONTACT NOTE

Patient Name:	Inmate Number:	
Date of Contact:	Time:	Institution:
Nature of Event Requiring Debriefing: <i>(provide brief narrative description)</i>		

Introduction, Limits and Expectations			
1. Review Goals & Limits	<p><i>Cover each of the following points and provide narrative regarding these points below if needed:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Reminder that Psychological Debriefing is support for natural reactions to abnormal or traumatic events (Emphasize that use of Psychological Debriefing services does not mean there is something "wrong" with the patient.) and that participation is voluntary and not part of any investigation. <input type="checkbox"/> Review of limits of confidentiality, including conditions under which confidentiality cannot be maintained <input type="checkbox"/> Description of debriefing goals, including helping patient to get through the event through <ul style="list-style-type: none"> <input type="checkbox"/> Working on restoring sense of safety and security <input type="checkbox"/> Learning about normal reactions to traumatic events <input type="checkbox"/> Building on patient's strengths to maintain or re-establish a sense of control and effectiveness <p><i>Narrative:</i></p>		
2. Assess Safety	Assessment of patient's sense of personal safety, in light of traumatic event:		
3. Re-Entry Planning	<p>Evaluate patient's ability to assess his/her own functioning and coping.</p> <p>Document patient's plans for using "community" resources (e.g., peers, family, clergy) to assist with ongoing coping. Help patient identify these resources. Validate and normalize</p>		
4. Mental Status	<p>Provide brief mental status, including assessment of impulse control, suicidal/self-injurious and homicidal/hostile ideation, overall distress or agitation, degree of social connectedness, and patient's strengths:</p> <p>Ask the patient to complete the same assessment measure that was completed during the initial session. Review changes in severity and use results to determine the need for ongoing treatment.</p>		
5. Plan	<ul style="list-style-type: none"> <input type="checkbox"/> Summarize and reflect back patient's strengths, coping skills and plan for continued coping: <input type="checkbox"/> Explain method for contacting mental health in the future, if needed: 		
<table style="width: 100%;"> <tr> <td style="width: 50%;">Staff Signature:</td> <td style="width: 50%;">Staff Name (Printed):</td> </tr> </table>		Staff Signature:	Staff Name (Printed):
Staff Signature:	Staff Name (Printed):		

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Critical Incident Education for Staff

The following Guidelines are intended to assist Centurion mental health staff in responding to requests for interventions with facility staff following a traumatic event, such as an inmate's death or a natural disaster.

NCCHC requires debriefings to be available and offered to affected inmates and personnel following an inmate suicide. In most correctional systems where Centurion provides services, debriefing for staff is completed by the client and is the responsibility of the client. If Centurion staff are requested to provide these services to co-workers, it is essential that the services provided do not compromise ethical and practice standards.

These Guidelines are intended to assist Centurion staff in providing affected personnel with education and information regarding how to access services following a critical or traumatic event, such as an inmate death or a natural disaster. These Guidelines facilitate Centurion staff in providing affected personnel educational support, in the form of the attached handout. They are not intended to facilitate Centurion staff in engaging in direct debriefing or treatment of staff members. Unless Centurion staff are specifically identified as members of a debriefing response team by the client and/or facility, such direct debriefing and/or treatment of staff should not be undertaken. When Centurion staff are identified as members of a debriefing response team, they must have all the necessary training required to participate on such teams. Inclusion of Centurion staff in the debriefing response team should be explicitly indicated in the contract with the client or within local policy.

DEFINITION

Critical Incident Education for staff involves reviewing written information regarding stress reactions and possible methods of decreasing stress reactions of affected staff members.

LIMITS OF SCOPE AND INTENT

Critical Incident Education is not Critical Incident Stress Debriefing. It does not include the provision of psychotherapy of any kind, and does not imply a professional relationship between mental health staff and any affected staff member. Any staff requesting information should be made aware of these limitations at initiation of contact with and/or request for assistance from mental health staff.

ETHICAL CONSIDERATIONS

Mental health staff need to avoid entering into dual/multiple relationships, including providing clinical services to co-workers. Provision of Critical Incident Stress Debriefing to colleagues is permissible only when staff have received training and are members of a formal debriefing response team authorized by the client.

PROCEDURE

- I. **Response to Request.** If a Centurion staff member is approached and asked to provide support services to another staff member affected by a critical incident, and if the Centurion staff member is not part of a formal debriefing response team, the response should include a statement that, as a mental health staff member within the correctional facility, providing clinical services to co-workers is prohibited. What can be provided is the review and discussion of an educational handout that may assist the staff member in seeking appropriate services and support. If the Centurion staff member is part of a formal debriefing team, the response to a request for assistance should follow the facility's protocol.
- II. **Provision of Educational Materials.** Once the above limitations have been explained, the attached Critical Incident Education Sheet should be reviewed with the staff member(s). Affected staff should be encouraged to read the document and to share it with healthy supports, such as friends and family members. Affected

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personnel can also be reminded of the Employee Assistance Program and debriefing response team contact information, where these resources are available.

- III. **Reporting.** Unless otherwise indicated in local policy, there is no expectation for formal documentation of interactions with staff members requesting support or information. Verbal notification of all such interactions should be made to one's direct supervisor.



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CRITICAL INCIDENT EDUCATION SHEET

(based on information from the International Critical Stress Foundation, Inc. ©)

GENERAL INFORMATION REGARDING EXPOSURE TO A CRITICAL INCIDENT

You have been through or witnessed a traumatic event or an incident that has caused strong emotional reactions. Such incidents and your reactions to these incidents may get in the way of your ability to function the way you usually do. Even though the event is in the past, you may be experiencing (or could experience in the future) difficult emotional or physical reactions because of the event. It is very common, and in fact quite normal, for people who have been through what you have been through to experience significant emotional, behavioral and physical changes. Sometimes, these changes or stress reactions occur immediately after the event. Other times, these reactions take hours or days to surface. For some people, weeks or months may go by before they experience these changes and reactions.

The important thing for you to know is that stress reactions to events like the one you experienced are common. These reactions may be unpleasant for you and may make you question your ability to handle things. These reactions are a normal response to an abnormal event. Trauma and other critical incidents are *not* normal. They are not expected or predictable. When they happen, your mind and body have to respond in ways that may feel abnormal, because you are responding to abnormal events. In fact, your reactions may be quite normal. Think about a sneeze. When you sneeze, the muscles in your body contract in order to expel abnormal material from your lungs and nose. When you think about it, a sneeze is not common behavior. It is not something that we do all the time. Yet, a sneeze is quite normal in the sense that it is a normal reaction for your body when something abnormal gets in your nose.

Stress reactions are similar. In fact, many reactions are predictable and are the reactions that people naturally experience following a traumatic or critical incident. Examples are included below along with examples of strategies that can help you get through the experience. Not all strategies work for all people, so keep trying until you find what works for you.

COMMON STRESS REACTIONS

<u>Physical*</u>	<u>Emotional</u>	<u>Behavioral</u>	<u>Cognitive</u>
Nausea/Vomiting Sweating Difficulty Breathing Fainting Twitching Muscle Tremors Headaches Dizziness Weakness Chest Pain Chills Thirst Fatigue Increased Blood Pressure Increased Heart Rate Problems with Vision Grinding of Teeth Symptoms of Shock	Fear Guilt Grief Panic Denial Feeling Numb Anxiety Agitation Irritability Depression Intense Anger Uneasiness Emotional Shock Feeling Overwhelmed Loss of Emotional Control Unfitting Emotional Responses	Problems with Sleep (too much or too little) Withdrawing from Others Inability to Rest or Calm Down Emotional Outbursts Pacing Jerky Movements Easily Startled Change in Social Activity Loss or Increase in Appetite Being Hyperalert Increased Substance Use Change in Speech Patterns Antisocial Acts Being Violent or Destroying Property Reckless Behavior	Confusion Hypervigilance Intrusive Thoughts/Images Poor Attention Poor Problem Solving Nightmare Poor Concentration Poor memory Disorientation Loss of Time Suspiciousness Unsure of Perceptions Loss of Trust for Others/Self Poor Self-Image

(*persistent or serious physical symptoms may require medical attention)

POSSIBLE COPING/STRESS MANAGEMENT TECHNIQUES

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<p>Balance appropriate physical exercise with relaxation</p> <p>Get plenty of rest</p> <p>Structure your time, keep busy</p> <p>Maintain a normal schedule</p> <p>Eat healthy foods; don't overeat or avoid eating</p> <p>Remind yourself that you are having natural and predictable reactions; don't label yourself as "crazy"</p> <p>Talk to friends/family</p> <p>Avoid overuse of alcohol and drugs; these will not help numb the feelings and will only complicate things</p> <p>Don't make any big life changes or major decisions</p>	<p>Spend time with others</p> <p>Give yourself permission to feel bad and share your feelings with others</p> <p>Provide support to other co-workers who may feel similarly</p> <p>Keep a journal</p> <p>Do things that feel good to you</p> <p>Don't avoid making decisions; maintain control over your life</p> <p>Let your family and friends know when you need private time, but don't overuse it or isolate yourself</p> <p>Remind yourself that intrusive thoughts and images are natural reactions and will decrease over time</p>
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CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



Psychological Reconstruction of an Inmate's Suicide

The following Clinical Guidelines are intended to assist Centurion independently licensed mental health professionals who are assigned to complete psychological reconstructions, also known as psychological autopsies, following an inmate's suicide.

In some correctional systems where Centurion provides services, psychological reconstructions are completed by the client. Since NCCHC requires psychological reconstructions to be completed following an inmate suicide, some contracts may require Centurion to complete the psychological reconstruction. Consistent with NCCHC, Centurion considers the psychological reconstruction to be an essential component of the clinical mortality review when the inmate died by suicide. Both the clinical mortality review and the psychological reconstruction are essential elements of a Continuous Quality Improvement (CQI) program. The intent of the attached Guidelines is to support that process.

A psychological reconstruction does not involve determination of whether the inmate's death was the result of suicide, homicide, natural or accidental causes. Although some correctional systems use this process to determine whether the inmate death was by suicide, homicide, or natural death, Centurion's approach is to defer that determination to the relevant investigatory authorities. Psychological reconstructions are undertaken only when an inmate's death has been determined to be a suicide. The purpose of a psychological reconstruction is not to assign blame or responsibility for the inmate's suicide but rather to develop an understanding of factors in the inmate's life that led up to and may have contributed to the inmate's death.

When systemic or individual treatment or service delivery issues are identified during the course of completing a psychological reconstruction, these should be referred to Centurion regional administration for immediate review. Findings and recommendations regarding individual performance issues should be pursued separately through Centurion regional administration in collaboration with legal counsel and the client. Recommendations regarding systemic issues may be included in the psychological reconstruction when relevant. A system to track, monitor and address any systemic issues across psychological reconstructions should be established and monitored by the CQI department.

The focus of the psychological reconstruction report is to provide an objective and factual account of the events and factors leading up to the inmate's suicide. Relevant findings from the psychological reconstruction and clinical mortality review are conveyed to the treating staff.

When systemic service delivery issues are identified through the psychological reconstruction and/or the clinical mortality review process, the issues are to be addressed through the CQI program. Psychological reconstructions are considered part of the CQI process and may be discoverable if litigation follows the inmate's suicide. Psychological reconstruction reports are to be reviewed by Centurion's legal counsel prior to finalization. The completed report and any data collected for the report should be maintained in Centurion's regional office in a locked and secure cabinet. These documents are not to be filed in the inmate's health record.

Centurion staff completing a psychological reconstruction should be independently licensed psychiatrist or psychologist or independently licensed mental health professionals. These licensed mental health professionals should have considerable experience in the provision of mental health services in correctional environments and, when possible, should not have been involved in the direct care of the deceased inmate. Licensed mental health professionals should be prepared to devote considerable time to the completion of a Psychological Reconstruction, since multiple sources of data need to be pursued and synthesized. For

CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



example, interviewing third shift staff and first responders may require the licensed mental health professional to come to the facility after hours.

CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



Psychological Reconstructions of a Patient's Suicide Clinical Guidelines for Mental Health Services

This document was created to serve as a guideline for completion of a psychological reconstruction following an inmate suicide. Centurion clinical psychologists or experienced independently licensed mental health professionals complete psychological reconstructions to meet NCCHC standards when this task falls within the scope of Centurion's contract. If these guidelines conflict with local policy or expectations, staff should take collaborative steps to resolve the differences.

DEFINITION

A psychological reconstruction is a written summary of an individual's life with an emphasis on factors that may have contributed to the death by suicide. These reconstructions are most often conducted by licensed clinical psychologists. Psychological reconstructions are designed to describe the life of the inmate who committed suicide as fully as possible and to better understand the untimely death.

LIMITS OF SCOPE AND INTENT

Psychological reconstructions are intended to provide clinical insight. Psychological reconstruction reports should not contain determinations, judgments, or conclusions with regard to responsibility and accountability. The reconstruction of an inmate's life and events leading up to death by suicide is not intended to replace administrative review, clinical mortality review or the process of a root cause analysis. If recommendations for improved service delivery at a system level are identified during the course of data gathering or synthesis, the recommendations should be included as part of the analysis and integrated into the CQI program. Any concerns regarding individual performance of clinical duties that are identified during the course of the psychological reconstruction should be referred to Centurion's regional administration for separate review. Psychological reconstructions are considered a part of the CQI Program and are only one component of the clinical mortality review in the event of a suicide.

ETHICAL CONSIDERATIONS

Completion of a psychological reconstruction may raise concerns regarding the conditions of confinement and/or the inmate's access to necessary care. Staffing limitations may require the treating clinical psychologist or licensed mental health professional to complete the psychological reconstruction. Particularly in jail settings where the inmate may have been incarcerated only briefly, available data may be insufficient to develop an understanding of factors in the inmate's life that may have contributed to the suicide. The limits of data collection and data reliability need to be clearly articulated in the psychological reconstruction report.

It is possible that completion of a psychological reconstruction may reopen inquiry into whether the death was properly classified as a suicide as this process may suggest another possible cause of death. In correctional systems that do not develop psychological reconstructions following suicides, mental health staff should advocate for implementation of this process. Presenting psychological reconstruction findings to the treating staff may be particularly challenging when staff are traumatized by the inmate's suicide. In each case where an ethical consideration arises, these concerns should be addressed and resolved through consultation with supervisors and facility administrators. Centurion legal counsel should be consulted and should review the document prior to being finalized.

PROCEDURE

Recommendations: Psychological reconstructions should be completed by an independently licensed clinical psychologist or an independently licensed mental health professional, with substantial experience providing mental health services in correctional environments. Licensed mental health professionals completing the psychological reconstruction should not have been involved in the direct care of the inmate. An exception can be made if staffing does not permit alternatives (i.e., there is only one experienced licensed mental health professional providing services in the correctional system.) Independently licensed clinical psychologists or mental health professionals with less experience or those in training should complete psychological reconstructions only under the supervision of a senior

CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



licensed mental health professional. Psychological reconstructions require intensive effort, and licensed mental health professionals should be prepared to set aside significant time for this task.

- I. **Initiating the Reconstruction.** Proper authority for conducting the psychological reconstruction should be secured from the client prior to initiating the reconstruction. Communication of this authority should be provided to the facility, preferably in writing. Access to some necessary information will likely require permission from and coordination with facility security and departmental administration.
- II. **Review.** A complete psychological reconstruction should include a review of the inmate's life with specific attention paid to those factors which may have impacted the decision to commit suicide. It should include a review of all areas of the inmate's life including but not limited to: legal history, medical history, mental health history, psychosocial history, family history, trauma history, recent stressors, current course of treatment (medical and mental health), conditions of confinement, and the details of the death.
- III. **Sources of Information.** Licensed mental health professionals should attempt to use available sources of information in reconstructing the inmate's life. Sources of information that should be considered include: examination of the inmate's property (suicide note, letters, reading materials, collected items, artwork, photographs, etc.); examination of the inmate's living quarters or of photographs of same; health records; mental health records; court and parole records; institutional records (classification records, disciplinary reports, incident reports, requests for services, grievances, visitation logs, phone logs, etc.); interviews with cellmate(s), inmates on the housing unit or program sites, correctional officers, program supervisors/teachers, medical and mental health providers; and review of reports and findings related to the suicide (autopsy reports, internal investigations, administrative reviews, etc.). All interviews should be conducted as soon as possible after the inmate's death. Additional sources can be used as available. Contact with the inmate's family for purposes of completing the psychological reconstruction is discouraged and should only be sought after express authority is provided by the client and legal counsel. The attached interview guide can assist licensed mental health professionals in structuring individual interviews.
- IV. **Report Format.** Psychological reconstruction reports are a narrative description of the inmate's life leading up to the suicide. Any conflicting, contradictory and missing data should be clearly identified. Explicit documentation of the rationale for reaching conclusions is to be included. Alternative explanations for the events leading up to the suicide should also be included. Completed psychological reconstructions are to be reviewed by legal counsel prior to finalization. Using the attached template can assist in creating a comprehensive report. Once finalized, the report becomes part of the CQI program.
- V. **Communication of Results.** Relevant findings from the completed psychological reconstruction are communicated to treating staff as part of communicating the results of the clinical mortality review. It is recommended that findings be shared verbally. Verification of this communication can be documented in treatment team or CQI meeting minutes and maintained by the CQI program.

Interview Guide*

For Interviews Conducted in the Course of Completing a
Psychological Reconstruction of an Inmate's Death by Suicide

Name of Interviewee:	Date of Interview:
Relationship to Decedent:	Time of Interview:

Introduce yourself as needed. Explain purpose of interview and limits of confidentiality. Emphasize that the purpose of a Psychological Reconstruction is to establish as much as we can about the events leading up to the inmate's death, so that we can learn from the process and help prevent future deaths. For staff, point out that the Psychological Reconstruction is not a performance evaluation and is not going to be used to assign blame. Ask interviewee to repeat the purpose and limits of confidentiality in his/her own words, obtain informed consent, and record the interviewee's response below:

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Ask interviewee to describe his/her relationship to the decedent, including:

How long have you known the inmate?	
How frequently did you interact with the inmate?	
How frequently did you interact over the 4-6 weeks leading up to the death?	
What were your interactions like?	

* These guidelines should be regarded as suggestions and springboards for conducting interviews with the deceased's peers, correctional officers, treatment staff and family members. The guidelines are not intended to be exhaustive or prescriptive. Use of open-ended questions is recommended, as this format reduces response expectations and increases the breadth of inquiry and nature of data collected. Interviewers should pursue lines of inquiry as needed, using follow-up probes to obtain details and not limit themselves to the questions contained in this Interview Guide.

Describe the inmate. What was he/she like?

Describe the inmate's strengths and vulnerabilities. How did he/she cope with stress?

Did the inmate have any other features or characteristics that stand out in your mind or struck you in some way?

How did the inmate spend his/her time?

How did the inmate interact with others?

Were there any recent events, changes in confinement status, changes in relationships or changes in behavior that you noticed?

Did the inmate say anything about death or dying? Did he/she talk at all about future hopes? What specifically do you remember?

Did the inmate have any debts or enemies?

CQI Document: DO NOT FILE
in Inmate's Health Record



Did the inmate talk at all about revenge or getting back at someone?

Did the inmate have a history of using drugs or alcohol? Was he/she hurting?

Did the inmate give away belongings, write a will, or write a suicide note?

Any other negative developments, bad news or pertinent issues that you can think of?

**CQI Document: DO NOT FILE
in Inmate's Health Record**



Did the inmate have or show any of the following risk factors? (For each risk factor, try to obtain specific examples and when they occurred.)		
Risk Factor	Specific Example	When Did this Occur?
Hopelessness		
Sleeplessness or Sleeping Too Much		
Loss of Interest		
Loss of Appetite		
Crying		
Anger		
Guilt or Shame		
Agitation or Restlessness		
Anxiety or Panic		
Social Isolation or Alienation		
Talking about Death or Dying		
Other Unusual Behaviors or Symptoms		
Physical Pain/ Deterioration in Health		

**Centurion
PSYCHOLOGICAL
RECONSTRUCTION**

Inmate Name:

ID #:

Institution:

Date:

CQI Document: DO NOT FILE in Inmate's Health Record

DEMOGRAPHIC INFORMATION

Ethnicity:

Religion:

Marital Status:

Length of Sentence:

DOB:

DOD:

DETAILS OF THE DEATH: (Date/Time, Description, Location)

CURRENT COURSE OF TREATMENT

SOCIAL/FAMILY HISTORY

LEGAL HISTORY

SUBSTANCE ABUSE HISTORY (Including any current use)

TRAUMA HISTORY

RELATIONSHIP HISTORY

MEDICAL HISTORY

PSYCHIATRIC HISTORY

Records Review

Clinical Staff Interview

INSTITUTIONAL FUNCTIONING

PREDISPOSING FACTORS AND PRECIPITANTS

Long-standing (historical) risk factors

Recent Stressors

CLINICAL FORMULATION

Diagnostic hypotheses

Articulation of personality characteristics and dynamics

MOTIVATIONAL ANALYSIS

Consider *how* the death occurred, *why* the death occurred, and why the death occurred at that time (*when*). Motivational analysis may include any of the following:

- Was the death intentional, accidental, or "sub-intentional" (mixed)?
- Was the death motivated by a desire for escape, punishment and/or revenge?
- Was the death motivated by shame, rigid social circumstances and/or lack of perceived alternatives?

SUMMARY (AND RECOMMENDATIONS, if applicable)

SOURCES OF INFORMATION

Printed Name

Signature

Title

Date

CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



Critical Incident Education for Staff

The following Guidelines are intended to assist Centurion mental health staff in responding to requests for interventions with facility staff following a traumatic event, such as an inmate's death or a natural disaster.

NCCHC requires debriefings to be available and offered to affected inmates and personnel following an inmate suicide. In most correctional systems where Centurion provides services, debriefing for staff is completed by the client and is the responsibility of the client. If Centurion staff are requested to provide these services to co-workers, it is essential that the services provided do not compromise ethical and practice standards.

These Guidelines are intended to assist Centurion staff in providing affected personnel with education and information regarding how to access services following a critical or traumatic event, such as an inmate death or a natural disaster. These Guidelines facilitate Centurion staff in providing affected personnel educational support, in the form of the attached handout. They are not intended to facilitate Centurion staff in engaging in direct debriefing or treatment of staff members. Unless Centurion staff are specifically identified as members of a debriefing response team by the client and/or facility, such direct debriefing and/or treatment of staff should not be undertaken. When Centurion staff are identified as members of a debriefing response team, they must have all the necessary training required to participate on such teams. Inclusion of Centurion staff in the debriefing response team should be explicitly indicated in the contract with the client or within local policy.

DEFINITION

Critical Incident Education for staff involves reviewing written information regarding stress reactions and possible methods of decreasing stress reactions of affected staff members.

LIMITS OF SCOPE AND INTENT

Critical Incident Education is not Critical Incident Stress Debriefing. It does not include the provision of psychotherapy of any kind, and does not imply a professional relationship between mental health staff and any affected staff member. Any staff requesting information should be made aware of these limitations at initiation of contact with and/or request for assistance from mental health staff.

ETHICAL CONSIDERATIONS

Mental health staff need to avoid entering into dual/multiple relationships, including providing clinical services to co-workers. Provision of Critical Incident Stress Debriefing to colleagues is permissible only when staff have received training and are members of a formal debriefing response team authorized by the client.

PROCEDURE

- I. **Response to Request.** If a Centurion staff member is approached and asked to provide support services to another staff member affected by a critical incident, and if the Centurion staff member is not part of a formal debriefing response team, the response should include a statement that, as a mental health staff member within the correctional facility, providing clinical services to co-workers is prohibited. What can be provided is the review and discussion of an educational handout that may assist the staff member in seeking appropriate services and support. If the Centurion staff member is part of a formal debriefing team, the response to a request for assistance should follow the facility's protocol.
- II. **Provision of Educational Materials.** Once the above limitations have been explained, the attached Critical Incident Education Sheet should be reviewed with the staff member(s). Affected staff should be encouraged to read the document and to share it with healthy supports, such as friends and family members. Affected personnel can also be reminded of the Employee Assistance Program and debriefing response team contact information, where these resources are available.

CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



- III. **Reporting.** Unless otherwise indicated in local policy, there is no expectation for formal documentation of interactions with staff members requesting support or information. Verbal notification of all such interactions should be made to one's direct supervisor.

CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



CRITICAL INCIDENT EDUCATION SHEET

(based on information from the *International Critical Stress Foundation, Inc.* ©)

GENERAL INFORMATION REGARDING EXPOSURE TO A CRITICAL INCIDENT

You have been through or witnessed a traumatic event or an incident that has caused strong emotional reactions. Such incidents and your reactions to these incidents may get in the way of your ability to function the way you usually do. Even though the event is in the past, you may be experiencing (or could experience in the future) difficult emotional or physical reactions because of the event. It is very common, and in fact quite normal, for people who have been through what you have been through to experience significant emotional, behavioral and physical changes. Sometimes, these changes or stress reactions occur immediately after the event. Other times, these reactions take hours or days to surface. For some people, weeks or months may go by before they experience these changes and reactions.

The important thing for you to know is that stress reactions to events like the one you experienced are common. These reactions may be unpleasant for you and may make you question your ability to handle things. These reactions are a normal response to an abnormal event. Trauma and other critical incidents are *not* normal. They are not expected or predictable. When they happen, your mind and body have to respond in ways that may feel abnormal, because you are responding to abnormal events. In fact, your reactions may be quite normal. Think about a sneeze. When you sneeze, the muscles in your body contract in order to expel abnormal material from your lungs and nose. When you think about it, a sneeze is not common behavior. It is not something that we do all the time. Yet, a sneeze is quite normal in the sense that it is a normal reaction for your body when something abnormal gets in your nose.

Stress reactions are similar. In fact, many reactions are predictable and are the reactions that people naturally experience following a traumatic or critical incident. Examples are included below along with examples of strategies that can help you get through the experience. Not all strategies work for all people, so keep trying until you find what works for you.

COMMON STRESS REACTIONS

<u>Physical*</u>	<u>Emotional</u>	<u>Behavioral</u>	<u>Cognitive</u>
Nausea/Vomiting	Fear	Problems with Sleep (too much or too little)	Confusion
Sweating	Guilt	Withdrawing from Others	Hypervigilance
Difficulty Breathing	Grief	Inability to Rest or Calm Down	Intrusive Thoughts/Images
Fainting	Panic	Emotional Outbursts	Poor Attention
Twitching	Denial	Pacing	Poor Problem Solving
Muscle Tremors	Feeling Numb	Jerky Movements	Nightmare
Headaches	Anxiety	Easily Startled	Poor Concentration
Dizziness	Agitation	Change in Social Activity	Poor memory
Weakness	Irritability	Loss or Increase in Appetite	Disorientation
Chest Pain	Depression	Being Hyperalert	Loss of Time
Chills	Intense Anger	Increased Substance Use	Suspiciousness
Thirst	Uneasiness	Change in Speech Patterns	Unsure of Perceptions
Fatigue	Emotional Shock	Antisocial Acts	Loss of Trust for Others/Self
Increased Blood Pressure	Feeling Overwhelmed	Being Violent or Destroying Property	Poor Self-Image
Increased Heart Rate	Loss of Emotional Control	Reckless Behavior	
Problems with Vision	Unfitting Emotional Responses		
Grinding of Teeth			
Symptoms of Shock			

(*persistent or serious physical symptoms may require medical attention)

POSSIBLE COPING/STRESS MANAGEMENT TECHNIQUES

CLINICAL GUIDELINES FOR MENTAL HEALTH SERVICES



<p>Balance appropriate physical exercise with relaxation</p> <p>Get plenty of rest</p> <p>Structure your time, keep busy</p> <p>Maintain a normal schedule</p> <p>Eat healthy foods; don't overeat or avoid eating</p> <p>Remind yourself that you are having natural and predictable reactions; don't label yourself as "crazy"</p> <p>Talk to friends/family</p> <p>Avoid overuse of alcohol and drugs; these will not help numb the feelings and will only complicate things</p> <p>Don't make any big life changes or major decisions</p>	<p>Spend time with others</p> <p>Give yourself permission to feel bad and share your feelings with others</p> <p>Provide support to other co-workers who may feel similarly</p> <p>Keep a journal</p> <p>Do things that feel good to you</p> <p>Don't avoid making decisions; maintain control over your life</p> <p>Let your family and friends know when you need private time, but don't overuse it or isolate yourself</p> <p>Remind yourself that intrusive thoughts and images are natural reactions and will decrease over time</p>
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CQI DON/H.S.A. TRAINING

Continuous Quality Improvement (CQI)
How to manage an Effective Program

April 2022



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Learning Objectives

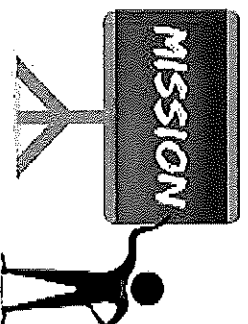
- Increase understanding of CQI as process of change and improvement
- Increase awareness of steps in the CQI process
- Understand the role of site leadership in CQI process
- Learn how to manage an effective CQI program



Centurion CQI Mission Statement



- Make our CQI program a proactive, systematically reviewed, quality-driven program
- Make sustained changes that improve whole process

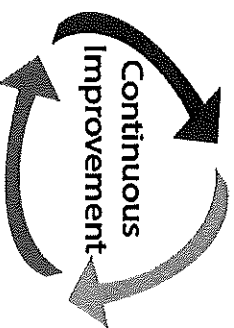




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What is CQI?

Continuous Quality Improvement is an ongoing process that organizations utilize to improve quality of products, services or processes, to increase efficiency and to improve internal/external satisfaction.



It is an ongoing process that evaluates how an organization works

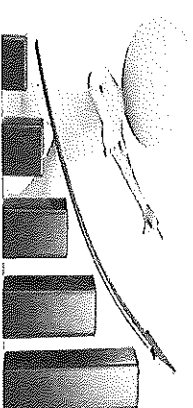


Why is CQI Important?



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- Provides proactive method to identify problems and brainstorm ideas for improvements
- Provides ongoing process of identifying, describing and analyzing system strengths and weaknesses
- Identifies and monitors health care needs of patients
- Identifies and monitors high risk scenarios; patient safety

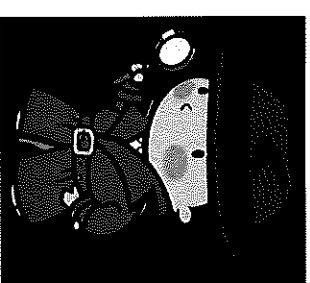




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Why is CQI Important?

- Empowers staff to become vested in problem solving and finding solutions
- Provides measurable data for program evaluation
- Tracks trends
- Provides evidence for key stakeholders
- Takes credit for our successes!
- Identifies training and education opportunities

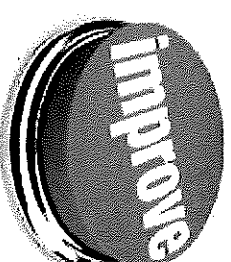


Impact of CQI

- Improves patient care
- Improves processes
- Improves outcomes
- Improves safety for patients and staff



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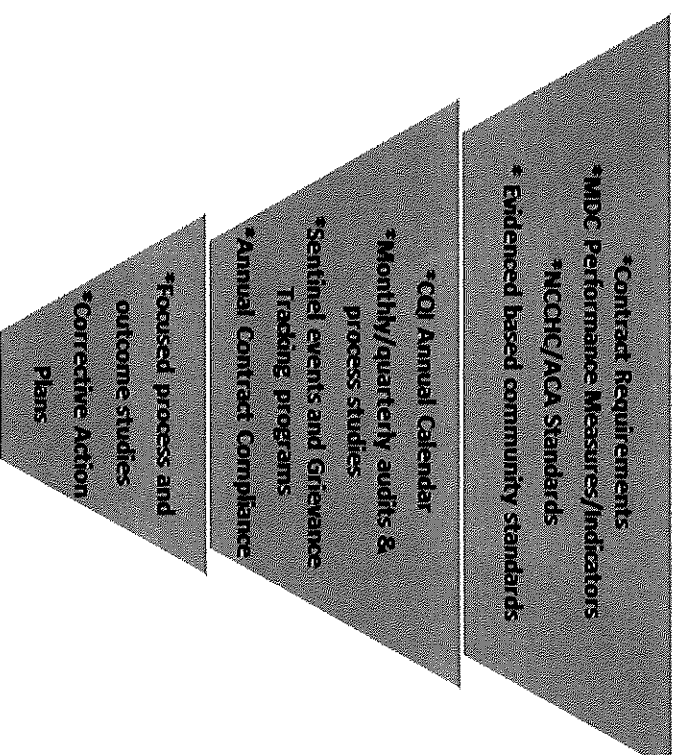
Drivers of CQI Initiatives

There are many ways initiatives are identified:

- Contract requirements/scope of services
- Contract performance measures
- Client Contract monitoring results
- ACA, NCCHC surveys
- Centurion CQI audits
- Grievance tracking
- Staff complaints that a process is not working



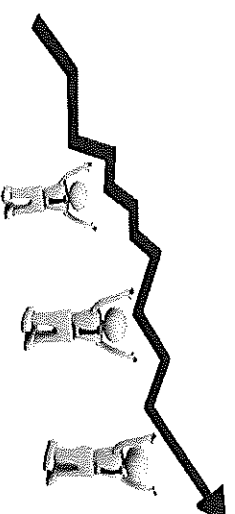
Components of CQI Program



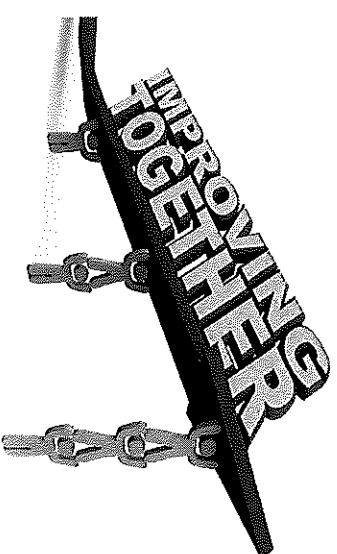
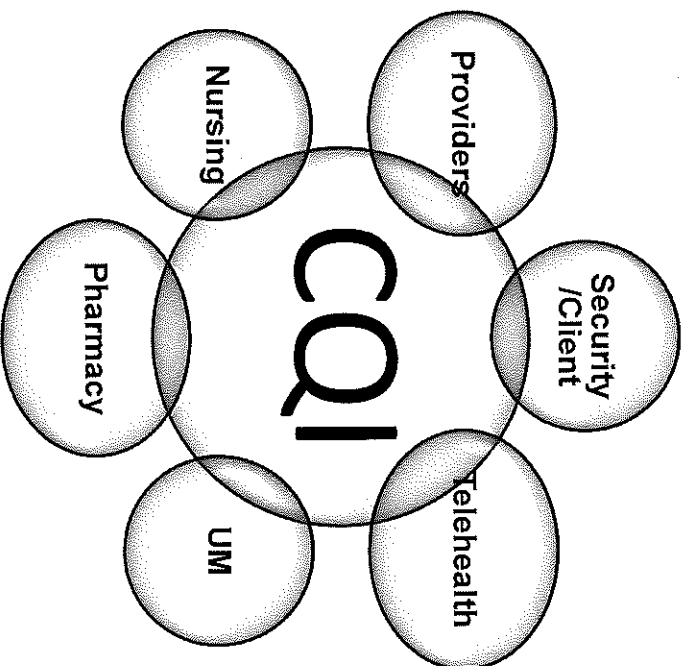
Components of CQI Program



- Medical, Mental Health, Dental and Pharmacy Services
- Morbidity & Mortality/Sentinel Events
- Medical Records Review
- Grievances Review
- Peer Review
- Utilization Management Review
- Infection Prevention and Control
- Environmental Health and Safety Management



Collaboration is Key



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Site Leadership's Responsibilities

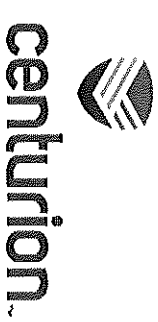


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- Participate in CQI initiatives - i.e. annual calendar, process and/or outcomes study topics, site specific audits/studies, monthly grievance reports, oSEL entries, SE/Mortality reviews
- Collaborate with Clinical Director, Staff to identify areas for improvement
- Involve line staff in conducting audits/studies



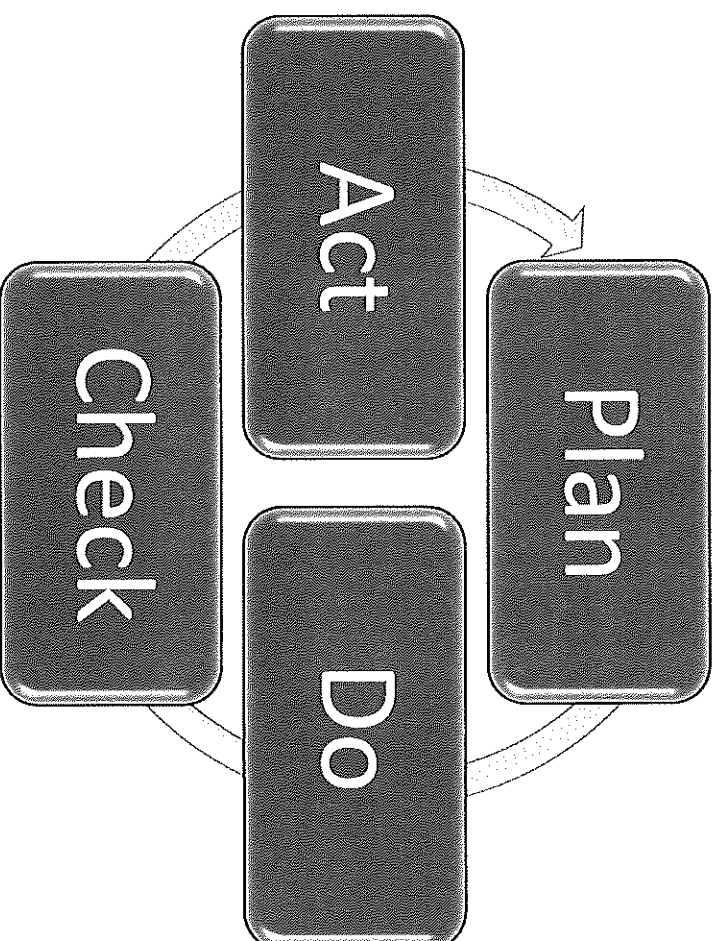
Site Leadership's Responsibilities



- Participate in developing/monitoring Corrective Action Plan (CAP)
Involve line staff - Delegate CAP action steps
- Monitor/Evaluate outcomes of action steps
- Provide feedback to staff
- Actively Participate in site level/Regional level CQI Committee(s)



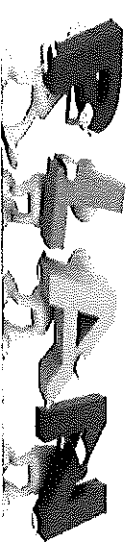
PDCA Model



Steps to Achieve an Effective CQI Program



1. Review your current processes
2. Set your benchmarks/goals with team
3. Assist with conducting studies/audits (involve line staff in auditing activities) - Regional CQI Coordinator will send out monthly studies that are due
4. Review audit/study results



Steps to Achieve an Effective CQI Program



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5. Conduct analysis of **WHY** the problem is occurring (root cause analysis)
6. Brainstorm improvement ideas with Clinical Director and staff
7. Coordinate development of Corrective Action Plan
8. Continue to monitor CAP to ensure that an improvement to the process and compliance is met

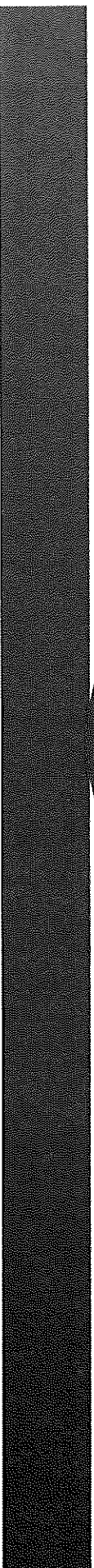
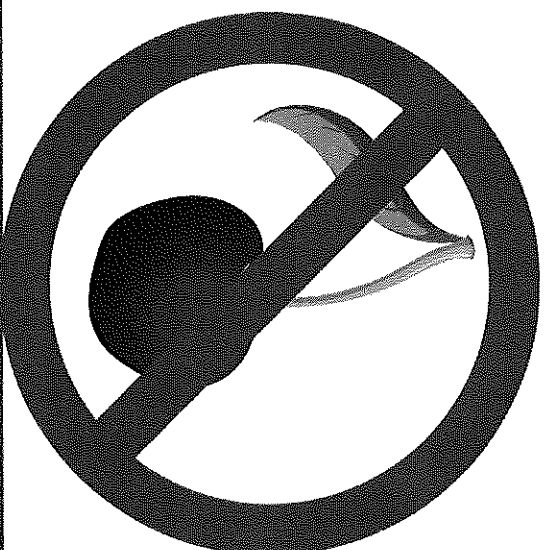




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IMPORTANT NOTE

DO NOT “CHERRY PICK” RESULTS!!



Corrective Action Plan Example



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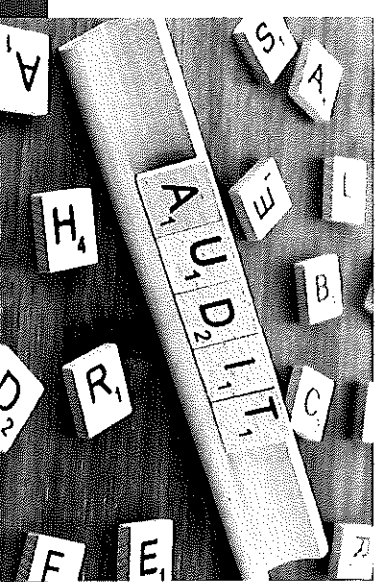
USE ONE CORRECTIVE ACTION PLAN FOR EACH PROCESS AND IT'S INDICATORS (i.e. a separate one for Sick Call, Segregation, Medication, etc							
Area Reviewed	Indicator#	Statement of Finding	Plan/Actions Taken	Person(s) Responsible for Action	Date CAP approved	Target Date	Completion Date
sick call	XX	Nursing did not triage within 24 hours - compliance score of XX	**100% - There will be a nurse assigned to complete triage of S/C slips everyday. **100% - Nurses will receive training on compliance requirements and how to complete triage correctly.	Sick Call nurse (name) and DON (name)		60 days	
sick call	XX	nursing did not use a nursing protocol - compliance score of XX	** 100% - Nurese will receive training on appropriate use of nursing protocols	DON (name)		120 days	



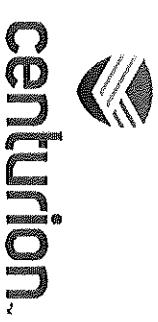
Steps to Achieve an Effective CQI Program



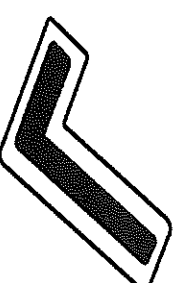
1. Delegate CAP action items to appropriate line staff
2. Coordinate training sessions if training needs identified in CAP
3. Monitor action items and timelines
4. Submit CAPs in a timely manner on Centurion Central site



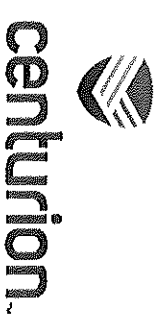
Steps to Achieve an Effective CQI Program



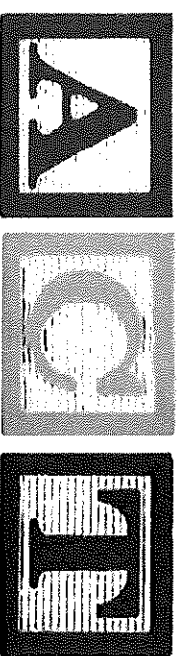
1. Re-audit between 30 days after improvements items have been put in place
2. Review re-audit results with all staff
3. Determine next steps (continue with CAP items, re-audit next month, regroup and edit current CAP, monitor for sustained changes)



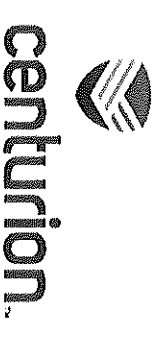
Steps to Achieve an Effective CQI Program



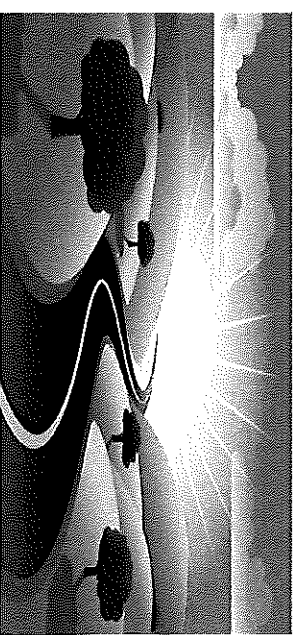
- Continue cycle until threshold is reached (Centurion's default threshold is 90%) and it is sustained for timeframe specified in action plan
- Training classes or new hire orientation may need to be updated



Take Home Points



- CQI helps us understand what we are doing
- CQI helps us understand how to do it better
- **YOU** are an important part of your sites CQI program
- Corrective Action Plan (CAP) is our Success guide to improvement!



Continuous Quality Improvement



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