

POLICY

SUBJECT: Internal Review and Quality Assurance for Health Care Services
NUMBER: HC-330-18
APPLICABLE TO: Somatic Health Staff

APPROVED: _____ /s/ signature on original
Sam Abed, Secretary
DATE: _____ 7/20/18

I. POLICY

The Department of Juvenile Services (DJS) shall ensure the development and implementation of a system to review and monitor health care services. The necessary elements of the system shall include an annual review by the Health Administrator of each policy and procedure in the health care delivery system and revision, if necessary.

II. AUTHORITY

- A. Md. Code Ann., Hum. Srvs., §9-203 and §9-204
- B. American Correctional Association (ACA) Standards, 4-JCF-4C-39 and 4-JCF-4C-60

III. DIRECTIVES/POLICIES RESCINDED

None

IV. FAILURE TO COMPLY

Failure to comply with the Department's Policy and Procedures shall be grounds for disciplinary action up to and including termination of employment.

V. STANDARD OPERATING PROCEDURES

Standard operating procedures have been developed.

VI. REVISION HISTORY

DESCRIPTION OF REVISION	DATE OF REVISION
New policy issued.	7/20/18

PROCEDURES

SUBJECT: Internal Review and Quality Assurance for Health Care Services

NUMBER: HC-330-18

APPLICABLE TO: Somatic Health Staff

APPROVED: _____ /s/ signature on original

Linda McWilliams, Deputy Secretary

DATE: _____ 7/19/18

I. PURPOSE

To ensure systems are in place to monitor and audit health care services and ensure the provision of equipment, supplies and materials for health service delivery.

II. DEFINITIONS

Audit is the examination or observation of an item, process, or operation to determine its compliance with applicable standards or law.

Audit Review means an executive management team that reviews annual audit reports, corrective action plans, and other quality assurance matters.

Compliant means an observation or result that meets or exceeds the established standard.

Corrective Action Plan (CAP) means a detailed remedy to correct deficiencies within a prescribed period of time.

Non-compliant means an observation or result that fails to meet the established standard.

III. PROCEDURES:

A. **Quarterly Audits**

1. The Director of Nursing in collaboration with the Regional Nurse Manager shall establish a schedule and conduct quarterly audits of facility health operations and the delivery of health care services at each facility. The audit process shall be completed using the **Health Services Quality Assurance Quarterly Audit Tool (Appendix 1)**. The audit shall consist of five (5) youth health records per 50 youth or less and adding one more for every 10 youth over 50.
2. The audit shall include a review and evaluation of medical data, including health records, logs and reports. Such health records, logs, and reports should contain information on the following:
 - a. Prescription and medication administration practices;
 - b. Complaints and grievances;
 - c. Outcome measures and statistical reports;
 - d. Contagious-disease management;
 - e. Suicide attempts or suicides; and
 - f. Deaths.
3. The audit process shall consist of the following:
 - a. an entrance conference with the Nursing Supervisor to discuss the process, procedures and audit documents.
 - b. a site visit to observe facility operations, interview youth and staff, collect data, perform analysis, review records and examine the services delivered to youth.
 - c. an exit conference with the Nursing Supervisor to report the preliminary findings of their audit.

B. **Monthly Supervisory Review**

1. The Nursing Supervisor shall complete the following monthly:
 - a. inventory and test equipment to ensure that it is in good working order and document on the **Monthly Inventory Checklist (Appendix 2)**;
 - b. ensure equipment is stored away from youth access;
 - c. inventory supplies and materials to ensure adequate amount for health services delivery;
 - d. check supplies and material expiration dates to ensure removal and replacement, as needed; and
 - e. review a minimum of 10 youth health records using the **Youth Health Record Checklist (Appendix 3)**.
2. The Regional Nurse Manager shall conduct a site visit to review the **Monthly Inventory Checklist (Appendix 2)** and the **Youth Health Record Checklist (Appendix 3)** completed by the Nursing Supervisor.

C. Quality Improvement Committee

1. Each facility shall establish a multidisciplinary quality improvement committee. The department heads committee may serve to meet this requirement.
2. The committee will review the outcomes of the quarterly audit presented by the Nursing Supervisor or designee. The committee shall be responsible for the following:
 - a. Develop a corrective action plan based on the findings to address and resolve identified problems and concerns, including educational and training activities;
 - b. Re-evaluate problems or concerns to determine whether the corrective action plans have achieved and sustained the desired results; and
 - c. Issue a quarterly report to the Superintendent and Health Administrator of the findings of health care review activities.
3. The Director of Nursing and/or the Regional Nurse Manager shall conduct a follow-up audit to assess the facility's resolution of problems and the implementation of strategies identified in the corrective action plan.
4. The Health Administrator, Medical Director and Director of Nursing shall review health care policies and procedures **annually** and submit recommendations for revisions to the Office of the Deputy Secretary for Operations.

IV. RESPONSIBILITY

The Director of Nursing, Health Administrator, and Medical Director are responsible for implementation and compliance with this procedure.

V. INTERPRETATION

The Deputy Secretary for Operations and Health Administrator shall be responsible for interpreting and granting any exceptions to these procedures.

VI. LOCAL OPERATING PROCEDURES REQUIRED

No

VII. DIRECTIVES/POLICIES REFERENCED

No policies referenced.

VIII. APPENDICES

1. Health Services Quality Assurance Quarterly Audit Tool
2. Monthly Inventory Checklist
3. Youth Health Record Checklist



DJS POLICY AND STANDARD OPERATING PROCEDURES

Statement of Receipt and Acknowledgment of Review and Understanding

SUBJECT: Internal Review and Quality Assurance for Health Care Services
NUMBER: HC-330-18
APPLICABLE TO: Somatic Health Staff

I have received and reviewed a copy (electronic or paper) of the above titled policy and procedures. I understand the contents of the policy and procedures.

I understand that failure to sign this acknowledgment form within five working days of receipt of the policy shall be grounds for disciplinary action up to and including termination of employment.

I understand that I will be held accountable for implementing this policy even if I fail to sign this acknowledgment form.

SIGNATURE

PRINT FULL NAME

DATE

WORK LOCATION

SEND THE ORIGINAL, SIGNED COPY TO THE DIRECTOR OF THE DJS OFFICE OF HUMAN RESOURCES FOR PLACEMENT IN YOUR PERSONNEL FILE.

Department of Juvenile Services

Health Services Quality Assurance Quarterly Audit Tool

Site Location: _____ Date/Time: _____

Name of Nurse Completing Audit: _____

General Survey Questions:	Yes	No	Comments/Areas of Concern/Plan of Correction if Applicable
Was Health Suite clean, neat and organized?			
Were the staff cooperative/courteous			
Was the visit announced?			

Log Book Audit:	Yes	No	Comments/Areas of Concern/Plan of Correction if Applicable
Log Books up to date/legible			
<ul style="list-style-type: none"> ● Admission Log ● Health Status Alert Log ● Off Grounds Health Care 			Present? _____ In health suite/ _____ on the units. Updated and checked weekly Y/N? _____
<ul style="list-style-type: none"> ● Laboratory Log 			
<ul style="list-style-type: none"> ● Communication Log 			
<ul style="list-style-type: none"> ● Sharps Log 			
<ul style="list-style-type: none"> ● MAR notebook <ol style="list-style-type: none"> 1. Pictures present 2. Interim Stock Shift Counts 3. Sharps & CPS Shift counts completed 			
<ul style="list-style-type: none"> ● Controlled Drug Medication Book & Interim 			
<ul style="list-style-type: none"> ● Med Cart Clean/organized 			
<ul style="list-style-type: none"> ● First Aid check completed ● Emergency Bag 			
<ul style="list-style-type: none"> ● Check lists complete and up to date? 			
<ul style="list-style-type: none"> ● Referral Log ● Sick Call Log 			
<ul style="list-style-type: none"> ● PPD Log ● GC and Chl Log ● Youth Grievance Log 			

Department of Juvenile Services
Health Services Quality Assurance Quarterly Audit Tool

Demographic Information

Number Corresponding to Audit	Youth Name	DOB	Date of Admission	Date of Discharge	Date Of Chart Audit
#1					
#2					
#3					
#4					
#5					
#6					
#7					
#8					
#9					
#10					

Audit of Health Care Records (5 files per 50 youth or less, add one for every 10)

Outside of Chart

Y-Yes N-No	1	2	3	4	5	6	7	8	9	10
Name Spelled Correctly										
Assist # on Chart										
Allergy Sticker										
Confidential Sticker										
Lg. Sticker completed										

Comments: _____

Department of Juvenile Services
Health Services Quality Assurance Quarterly Audit Tool

Section 1 Orders, Consents, Insurance

Y-Yes N-No	1	2	3	4	5	6	7	8	9	10
Tracking and Referral Forms										
Immunization Section										
All Referrals listed And dates completed.										
Insurance information listed										
<u>MD/NP Order</u>										
<u>Sheets:</u>										
• <u>Name</u>										
• <u>DOB</u>										
• <u>Assist #</u>										
• <u>Allergies</u>										
• <u>Diet</u>										
• <u>Location</u>										
• <u>Current Orders</u>										
• <u>Orders Complete</u>										
• <u>Orders Timed</u>										
• <u>Orders Signed/Co-signed</u>										
• <u>Orders Signed off by RN</u>										
•										
<u>Consents:</u>										
• Medical										
• Psych										
• Current Court Orders										
<u>Insurance:</u>										
• Medical Insurance Filled In										
• Sheet Faxed to Pharmacy										
• Face Sheet on Chart										

Department of Juvenile Services
Health Services Quality Assurance Quarterly Audit Tool

Comments: _____

Section 2 Problem List, Progress Notes

Y-Yes N-No	1	2	3	4	5	6	7	8	9	10
Picture of Youth Present										
Problem List <ul style="list-style-type: none"> • Name present • DOB • Facility name • Problems Current • Problems Complete • Special needs Tx Plan 										
Progress Notes <ul style="list-style-type: none"> • Name • DOB • Nursing Admission Progress Note • Dated , Timed, and Signed 										
Nursing Report of Youth Injury Completed to include pictures										

Note: Section 2 may also include Sick Calls completed in chronological order within the Progress Notes.

Department of Juvenile Services
Health Services Quality Assurance Quarterly Audit Tool

Comments: _____

Section 3: PE, Nursing Assessment, Vaccines

Y-Yes N-No	1	2	3	4	5	6	7	8	9	10
Physicians Exam										
• PE Current										
• Name										
• DOB										
• Age										
• Sex										
• Admit Date on PE										
• PE signed by MD										
• PE Dated										
• V/S with Date										
Vision screen completed and dated										
Dental screen completed on PE by MD/NP										

Comments: _____

Department of Juvenile Services
Health Services Quality Assurance Quarterly Audit Tool

Y-Yes N-No	1	2	3	4	5	6	7	8	9	10
Nursing Assessments										
• Name on All pages										
• DOB on All Pages										
• VisionScreen Completed										
• PPD Current/Date Completed										
• TB Screening Form Complete/Date										
• Labs Recorded and Current										
• Vitals Recorded/Date										
• Assessment Signed by Nurse										
• Assessment Signed by MD										
• All pages completed										

Comments: _____

Department of Juvenile Services
Health Services Quality Assurance Quarterly Audit Tool

Section 4: Psych Records

Y-Yes N-No	1	2	3	4	5	6	7	8	9	10
Psychiatric Evaluations and Follow-up										
• Name on Evaluations										
• DOB on Evaluation										
• Date on Evaluation										

Comments: _____

Section 5: Labs and Referrals

Y-Yes N-No	1	2	3	4	5	6	7	8	9	10
• Lab results Present with MD/NP signature they were reviewed										
• Referrals completed with MD/NP signature they were reviewed										

Comments: _____

Department of Juvenile Services
Health Services Quality Assurance Quarterly Audit Tool

Section 6: MAR/MISC/Discharge Summary/Sick Calls

Y-Yes N-No	1	2	3	4	5	6	7	8	9	10
• Sick Call signed and dated by youth *										
• Sick Call signed and dated by Nurse *										
• Sick Call requests addressed *										
• Completed MAR present										
• HSA forms related to special needs TX Plan										
• Request for Auxiliary Aid Services sheet if applicable										
• Chart Order Correct										
• Summary of Care Letter Present										
• Discharge Summary Completed and Present										
• 30 Day Review										

NOTE: * May be included in chronological order in Progress Notes Section 2.

Comments: _____

**Department of Juvenile Services
Health Services Quality Assurance Quarterly Audit Tool**

CORRECTIVE ACTION PLAN: Shall be based on findings of Health Services Quality Assurance Quarterly Tool with problems and concerns identified, to include any educational and training activities. (Report to be attached and to be submitted per Policy at the conclusion of the QA Audit performed.)

RE-EVALUTATION of the CORRECTIVE ACTION PLAN – to be completed to determine if the corrective measures have been achieved and sustained.

(Report to be attached and to be submitted)

Monthly Inventory Checklist

Month/Year: _____

The Nursing Supervisor must complete this form.

Inventory Items	Compliant	Non-Compliant	Comments
Admission Log Book			
AED check			
AED contents check			
Backboard			
Chart stickers			
Controlled Med Book			
Disaster Bag			
Emergency bag			
Expired meds and lab supplies			
First Aid Kits			
GC/CHL Log Book			
Glucometer			
Health Status Alert Books			
Lab Log Book (up to date)			
Lab supplies- stocked			
MARS notebook			
MED CART cleanliness & Check for expired meds			
Nebulizer			
O2 tank check			Expiration date: _____
PPD Log book			
Referral Log Book			
Sharps Log Book			
Special Needs list			
30 Day Review Tracking			

Nursing Supervisor: _____

Date: _____



**YOUTH HEALTH RECORD
CHECK LIST**

Date Checked: _____ Nurse's Initials: _____ Date of Admission: _____

Youth's Name: _____ DOB: _____ Date of Discharge: _____

Outside Of Chart

Name spelled correctly _____
Allergy sticker _____
Lg Sticker complete _____

Assist # on chart _____
Confidential sticker _____

Section 1 Orders, Consents, Insurance

Immunization /Referral Tracking Form

Immunization section _____
All Referrals listed _____
Insurance information listed _____

Order Sheet

Name _____
DOB _____
Assist # _____
Allergies _____
Diet _____
Location _____
Orders current _____
Orders complete _____
Orders timed _____
Orders signed / co-signed by MD _____
Orders signed off by nurse _____

Consents

Medical consent signed _____
Psych consent obtained _____
Current court order _____

Insurance

Medical Insurance filled in _____
Sheet faxed to pharm. _____
Face Sheet on Chart _____

**YOUTH HEALTH RECORD
CHECK LIST**

Section 2 Problem List, Progress Notes

Picture of Youth _____

Problem List

Name on problem list _____

DOB on problem list _____

Facility on problem list _____

Problems updated _____

Problems completed _____

Special Needs Tx Plan _____

Progress Notes

Name on progress notes _____

DOB on progress notes _____

Nursing report of youth injury _____

Section 3 PE, Nsg Assessment, Vaccines

Physicians Exam

PE current _____

Name on PE _____

DOB on PE _____

Age on PE _____

Sex on PE _____

Admission date on PE _____

PE signed by MD _____

PE dated _____

Vital signs _____

Vision Screen _____

Dental screen completed _____

Nsg Assessment

Name on all pages _____

DOB on all pages _____

Assessment complete _____

Vision screen complete _____

PPD current _____

TB screening form completed _____

Labs recorded & current _____

Vitals recorded _____

Assessment signed by nurse _____

Assessment signed by MD _____

Immunizations

Vaccine record in chart _____

Vaccine record reviewed by MD/NP _____

**YOUTH HEALTH RECORD
CHECK LIST**

Section 4 Psych Records

Psych Evals and Follow Ups

Name on evals _____

DOB on evals _____

Date on evals _____

Section 5 Labs

CBC current _____

MMRV current _____

RPR current _____

GC/Chly current _____

Other tests _____

Referrals

Referrals reviewed by MD/NP _____

Section 6 MARS, Misc., D/C Summary, Sick Call

*Sick call signed and dated by youth _____

*Sick call signed and dated by nurse _____

*Sick Call requests addressed _____

Completed MARS present _____

HSA Forms and special needs tx plan _____

Request for Auxillary Aid Services sheet if needed _____

Grievances and complaints _____

Chart order correct _____

Summary of care letter _____

Discharge Summary completed _____

Note* maybe included in Section 2

COMMENTS _____

