IHSC Health Systems Assessment Guide

February 2021

ICE

ICE Health Service Corps

Foreword

This U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) Health Systems Assessment (IHSA) User Guide supplements the following IHSC Directive 11-09, *IHSC Health Systems Assessment*.

The Medical Quality Management Unit (MQMU) developed and maintains the guide. Its intended audience includes the MQMU IHSA program analyst, facility health care program managers, IHSA pre-audit reviewers, IHSA on-site reviewers, and Health Operations Unit staff.

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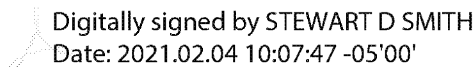

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Date

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I. Introduction

A. Purpose

This guide outlines the procedures to complete an IHSC Health Systems Assessment, which includes five phases. Procedures outlined are applicable to on-site and self-assessments unless otherwise specified.

The U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) Medical Quality Management Unit (MQMU) oversees IHSC Health Systems Assessment (IHSA) Program. The IHSA Program assesses IHSC clinic compliance with applicable correctional health care standards that include Performance-Based National Detention Standards (PBNDS), American Correctional Association (ACA), and National Commission on Correctional Health Care (NCCHC). The assessment prepares them for external audits against these standards.

The IHSA Program conducts on-site assessments (unannounced) or self-assessments (announced). Designated IHSC personnel conduct both types to determine whether the services provided at the facilities are within standards, based on IHSC policies and accreditation bodies. The IHSA consists of five phases: (a) pre-audit review, (b) pre-audit meeting, (c) on-site review (observations), (d) leadership review, and (e) data analysis.

B. The Medical Quality Management Compliance Program

An organizational component within the IHSC Health Care Compliance Division, MQMU is responsible for all internal assessments and audits of IHSC-staffed facilities. The MQMU Compliance Program oversees the IHSA Program and manages IHSC's patient education and accreditation functions.

II. Policy

IHSC internally assesses and audits the administrative and clinical services the agency provides within IHSC-staffed facilities annually. All IHSC-staffed facilities must complete an annual health system assessment in collaboration with MQMU. Facility Exemption: IHSC facilities open for one year or less are exempt from the IHSA audit. However, MQMU conducts an initial pre-audit and on-site audit within 18 months from the initial opening date.

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III. Program Procedures

A. Pre-Audit Review

Prior to the facility observation, the IHSA team lead and co-lead (referred to as on-site reviewer for the purpose of this guide) obtains site demographic information. This information includes accreditation findings, grievances, incident report information, and any pertinent action plans related to root cause analyses or corrective action plans submitted to MQMU. The IHSA team leads should obtain this information prior to the on-site review from the sources noted in appendix 3.

The pre-assessment review team completes the pre-audit tracker and chart reviews. The pre-assessment review team uses the tracker to document charts reviewed, findings, thresholds and improvement plan (IP) levels. The team reviews ten charts per section; charts subject to review include those documented in eClinicalWorks (eCW) within a 3-month period. If ten charts are not available within the 3-month period, the reviewer extends the review to a 6-month time frame. If ten charts are not available during the 6-moth time frame, the reviewer then performs a review of all charts available within the 6-month time frame. If there are 5 or more charts that failed in compliance in 2 areas, the pre-assessment team member will review 25 charts for the section. Reviewers must complete and document all chart reviews in the IHSA SharePoint tool (SP) and pre-audit excel tracker no later than one week prior to the pre-audit meeting. The reviewers also document a thorough synopsis of findings in the “findings” box of the IHSA SP tool for the section reviewed.

B. Pre-Audit Meeting

The IHSA team on-site reviewers schedule a pre-audit meeting 1-2 weeks prior to the facility visit. Meeting attendees should include the pre-audit chart reviewers and the IHSA program analyst. Participants should discuss all information related to chart review findings and facility demographic information (e.g., grievances, accreditation findings, and RCAs) during the meeting. The on-site reviewer must complete and save the pre-assessment Excel tracker within the facility folder located within the IHSA SharePoint Tool. Additionally, the on-site reviewer must document all pre-assessment demographic information in the IHSA SharePoint Tool prior to the on-site review.

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C. On-Site Review (observations)

Designated IHSC personnel conduct the on-site review within three to five days. The on-site reviewer utilizes the on-site observations review template to conduct observations of the facility during the visit. The lead on-site reviewer and/or co-lead discusses findings, threshold values, and applicable improvement plan(s) with the facility leadership (healthcare program manager (FHPM), health services administrator (HSA), assistant health services administrator (AHSA), nurse manager (NM), and clinical director (CD), or designees). Improvement plans will be established when threshold values are not met.

D. IHSA Improvement Plans (IP)

Implementing an IP is essential to improving health care quality. On-site reviewers identify areas that need improvement based on pre-audit and on-site observation thresholds. Thresholds are pre-determined percentage values used to evaluate the site's level of performance. Any facility that fails to meet the established thresholds of the IHSA, receives notification of the need for an IP. IPs address issues via incremental changes or promptly via breakthrough changes. The IHSA Program Analyst initiates IHSC Health System Assessment IPs through a three-level process based on the pre-audit and on-site observation findings.

Pre-review and observation findings documented in the "findings" box of the IHSA SP tool require review by the IHSA PA and/or review team lead. Improvement plans must be recommended by the IHSA PA or review team lead when an on-site assessment is completed. If findings do not meet predetermined threshold percentage values. The pre-review compliance thresholds are in the IHSA excel tracker. An IP is required when the established thresholds are not met and are indicated as a "fail" in the IHSA excel tracker. A description of the improvement plan is written in the IHSA SP tool in the "deliverables" box by the IHSA PA or review team lead. Facilities must address and document corrective actions within three months. The facility must provide supporting documentation to indicate CAP completion by uploading all action items and supporting documentation for ongoing CAPs into the facility's improvement plan folder within the IHSA SharePoint Tool. The MQMU IHSA Program Analyst will monitor the facility's progress in completing the actions outlined in the improvement plan. The IHSA PA notifies the facility and relevant staff of the closure of the CAP after the facility completes all required actions and has adequate processes in place to prevent recurrence of the deficiency.

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When a self-assessment is completed, the local facility triad, FHPM, and subject matter experts (if needed) develop the CAP, the facility regional triad and MQMU IHSA Program Analyst approves the CAP. Facilities must implement and complete the CAP within 90 days of the initiation date. Once the regional triad and MQMU receive an acceptable CAP from the facility, the MQMU IHSA Program Analyst will monitor the facility's progress in completing the actions outlined in the improvement plan. The regional health services administrator (RHSA) notifies the facility and relevant staff of the closure of the CAP after the facility completes all required actions and has adequate processes in place to prevent recurrence of the deficiency. The facility HSA/AHSA uploads all action items and supporting documentation for ongoing CAPs into the facility's improvement plan folder within the IHSA SharePoint Tool. Refer to Appendix 4 for review of steps to be taken.

E. Procedures of the Improvement Plan

Pre-review IP: The HSA/AHSA documents pre-review findings and associated compliance thresholds in the IHSA Excel tracker. An IP is required when the established thresholds are not met. The on-site reviewer identifies deficiencies that require an IP based on the findings and predetermined threshold percentage values. This information is discussed with the facility leadership (CD, HSA/AHSA, NM, FHPM, or designees). The facility leadership should notify their respective regional leadership regarding the findings and establish action plans in conjunction with subject matter experts. The on-site reviewer reserves the right to recommend corrective actions to be instituted and will notify the facility leadership of any recommendations. The facility leadership is given an opportunity to review the recommendations and provide feedback on recommended actions prior to initiation of the improvement plan. Facility leadership feedback must be received within 3 business days of notification.

On-site review IP: During the visit, the on-site reviewer identifies issues based on observations and initiates improvement plan actions outlined in Appendix 4. Although improvement plans are a three-tier process, there may be circumstances that warrant the on-site reviewer and/or IHSC designated personnel to skip one or more tiers and proceed directly to the third tier and request a uniform corrective action plan. The escalation of improvement plan tier is discussed in detail with the facility leadership.

The facility leadership should notify their respective regional leadership regarding the findings and establish action plans.

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Action plans are recommended for development in conjunction with subject matter experts if required. The on-site reviewer reserves the right to recommend corrective actions and tier selection. The facility leadership is given an opportunity to review the recommendation(s) and provide feedback on suggested actions prior to initiation of the improvement plan and finalization of the tier. Facility leadership feedback must be received within 3 business days of notification of the escalated tier.

Completion: The facility HSA sends an email to the regional triad and MQMU IHSA Program Analyst after the facility completed all CAP action items. The regional triad and MQMU review the CAP for completeness and provide feedback if necessary.

Corrective Action Plan Extension Process: If the regional triad and/or MQMU determines the CAP documentation provided or process changes are unacceptable, the IHSA PA annotates the CAP as unapproved and requests additional updates. The regional triad identifies the deficiencies and may approve an extension of up to thirty days. During the extension period, the facility must complete and document action items; the HSA must provide the documentation needed to close out the CAP; and MQMU IHSA Program Analyst and MQMU Senior Compliance Program Manager must approve its completion. The IHSA PA sends an email notification of the extension to the facility triad. Once updates are complete, the facility HSA emails the regional triad and MQMU of CAP completion for their review.

Regional Triad Post-CAP Site Visit: The facility HSA and the regional triad coordinate and decide upon a predetermined date to conduct a subsequent site visit after CAP completion if deemed necessary. The Regional triad must conduct the visit within 30-60 days of CAP completion, if on-site follow up is needed and travel funds are available. The chief, Health Operations Unit, and the deputy assistant director (DAD) of clinical services must approve extensions if the regional triad requires addition time to complete their repeat post-site review.

F. Leadership Review

IHSC program, unit, division, and senior leadership review IHSC Health Systems Assessment reports as follows:

On-site Assessments: The IHSA program analyst, senior compliance program manager (SCPM), MQMU chief, and DAD of health care compliance review the all IHSA reports in its entirety. The IHSA program analyst documents findings via an executive summary for review by the IHSC DAD of health systems support, DAD of clinical services, DAD of administration, chief of staff (CoS), and IHSC assistant

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director (AD). The facility and regional triads are carbon copied on the SharePoint email containing the final report. Sites are expected to discuss any local findings, corrective action recommendations, and improvement plan recommendations with their regional triad to ensure transparency of results and appropriate follow up on issues noted.

Self-Assessments: The RHSA, IHSA program analyst, senior compliance program manager, and MCMU chief review all IHSA reports. IHSC senior leadership (DADs, CoS, and AD) do not review self-assessment reports unless findings are egregious and warrant immediate notification and process changes. The facility regional triad is carbon copied on the SharePoint email containing the final report. Sites are expected to discuss any local findings, corrective action recommendations, and improvement plan recommendations with their regional triad to ensure transparency of results and appropriate follow up on issues noted.

Each reviewer concludes their review of the report within three business days of receiving it and document their review by commenting in the "leadership review" comments book in the SharePoint tool. All IHSA report reviews must be completed electronically within 12 business days on the IHSA SharePoint Tool (Appendix 5 and 6). Reviewers should direct their questions about the assessment findings or action plans to the RHSA or designated on-site reviewer via email. The on-site reviewer or RHSA liaise with the site's HSA, if needed, to answer the questions and provide feedback as soon as possible.

G. Data Analysis

IHSC Data Analytics Office analyzes data from IHSA reports for all sites. Senior leadership and IHSA committee members review this data annually. The IHSA program analyst, who monitors national trends and implementation of action plans compares, as appropriate, data from individual site reports to national averages derived from data analysis of IHSA findings and trends.

The IHSA Committee consists of members from the Medical Quality Management Unit; Health Operations Unit; Clinical Services Division; Public Health, Safety, and Preparedness Unit; Behavioral Health Unit, and the Nursing Services Unit. The committee meets as needed to discuss IHSA measures and decide whether to change IHSA measures and/or update patient care policies. Member roles are specified below in the corresponding table.

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IHSA COMMITTEE	
Unit	**Role**
MQMU (IHSA PA/SCPA)	• Committee lead(s) • Responsible for administratively scheduling committee meetings, creating meeting agendas, and completing meeting minutes • Follows up with committee members assigned to project areas for updates through closure (unless the project is released for oversight by the applicable IHSC unit or division)
BHU **(1 Regional Behavioral Health Provider or designee)** **HOU** (1 Regional HSA or designee) **MSU** (1 Regional: APP, CD, Dentist, Pharmacist or designee for any mentioned role) **NSU** **(1 Regional Nurse Manager** or designee**)** **PHSP** (1 Regional Infection Prevention Officer/1 Health and Safety Officer, or designee)	• Attends meetings or selects a designee to attend in their absence. • Reviews all measures applicable to PHSP/BHU/NSU/HOU and updates the measures as needed. • Utilizes IHSA findings to provide recommendations for updates of all applicable policies or guides when needed. • Communicates all updates and project statuses to MQMU. • Tracks all projects assigned through closure.

IV. Terms and Definitions

Definitions for this policy are listed in the IHSC Glossary.

V. Implementing Tools (Forms and Worksheets)

A. IHSC Uniform Corrective Action Plan (UCAP) Form

The IHSC UCAP Form is accessible via the MQMU IHSA SharePoint page in the resources folder. IHSC uses this form to document formal corrective action plans (Level 3 improvement plans). Once complete, it becomes a historical document that IHSC archives to track improvement plan initiation and closures. Facility information, facility points of contact, corrective actions, and designees responsible for completion are identified using this form. See Appendix 4 to review a copy of the form.

B. IHSA Pre-Audit Review Excel Tracker

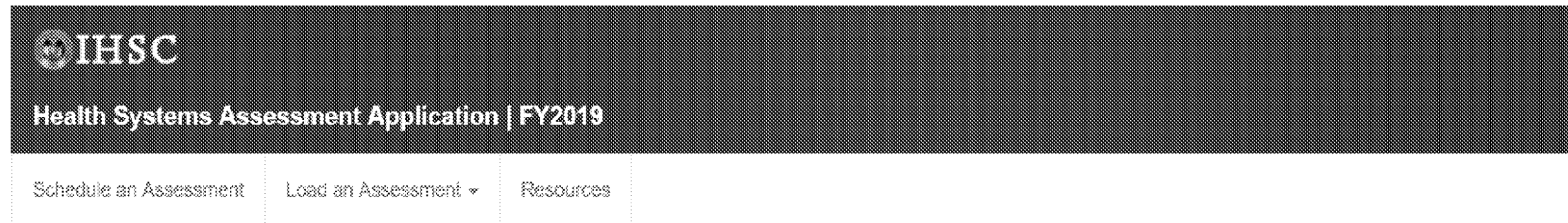
The IHSA Pre-Audit review tracker is available on the IHSA SharePoint page within the IHSA resources folder under IHSA Pre-Audit Excel Tracker. The tracker is utilized during the pre-arrival review phase of the audit to access the facility's patient care performance before performing clinical area observations. The tracker contains patient care areas reviewers will audit by selecting 25 random charts. The IHSA Pre-Audit and On-site Assessment User Manual is used to guide reviewers on areas of the electronic health record (eClinicalWorks) to access for information needed. The excel pre-audit tracker has been formulated to tabulate values for transcribing into the IHSA SharePoint Tool. The document should be maintained for data analysis regardless if an on-site or self-assessment is completed. A sample of the Excel worksheet is provided in the appendix 2 to this guide.

C. IHSA SharePoint tool

Reviewers can access the IHSA SharePoint tool via IHSC SharePoint page link on the MQMU SharePoint site. The IHSA SharePoint tool is used to document pre-audit review data and on-site observation data. Data entries are completed by selecting the section for completion, then selecting "edit this section." Pre-audit data recorded on the pre-audit review Excel tracker is transcribed into the IHSA SharePoint tool. Pre-audit and on-site data are saved in each section by selecting "save." A sample of the IHSA SharePoint tool is provided in the appendix 1 to this guide.

VI. APPENDICES

A. Appendix 1: IHSA SharePoint Tool



U.S. Immigration
and Customs
Enforcement

Welcome to the **IHSC Health Systems Assessment** application for Fiscal Year 2019.

- Select an assessment from the *Load an Assessment* dropdown menu to load and view/edit as necessary.

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B. Appendix 2: IHSA Pre-Audit Review Tracker

Date of encounters	Time of encounter	A number	Did the hunger strike record have I&O's tracked via Hunger Strike Monitoring Form (IHSC 839) or electronic equivalent (approved eCW forms included) in the health record?	Did the hunger strike record indicate that the patient was educated with documentation on the adverse effects of a hunger strike?	Did healthcare provider counsel detainee on termination of hunger strike and document this counseling in the detainee's health record ?	Was the patient evaluated by a mental health provider?	Did this hunger strike record have complete medical history, orthostatic vital signs, height, weight, urinalysis, mental health evaluation, physical assessment, clinically necessary laboratory tests deemed appropriate, and modification or augmentation of standard treatment protocols when medically indicated during the initial evaluation or refusal form . (All or nothing)?	Did this hunger strike record have orthostatic vital signs including weight taken every 24 hours?	Was this hunger strike discontinued after IHSC healthcare personnel offered detainee appropriate follow-up with behavioral health and medical care indicated in detainee's chart?	Was this hunger strike record with special needs to include restriction of commissary items?	Comments
12/29/2018	10:30:00 AM		Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	they attempt VS detainee refused. Didn't see special need restrictin form
10/12/2018	6:51:00 AM	000-000-001	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	
		000-000-002									
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Consents | TB-Transfers | General -Transfers | Intake | Sick Call | Chronic Care | Physical Exams | Segregation | MHU Full Adm. | Suicide Watch | Hunger Strike | Language Access | ECW Data Monitoring

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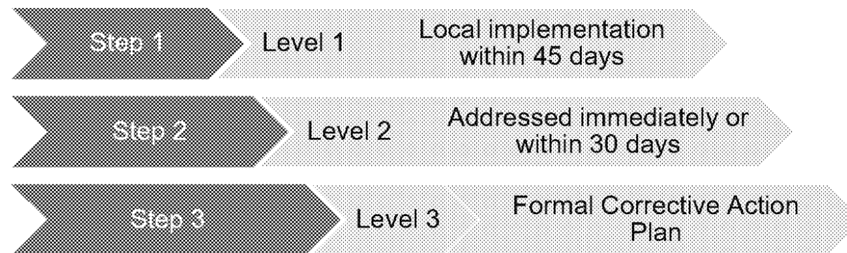
C. Appendix 3: IHSA Pre-arrival Point of Contact and Reports

PRE-ARRIVAL INFORMATION	ITEMS NEEDED	POINT OF CONTACT (POC)
Accreditations	Most recent NCCHC, ACA, and PBNDS findings and/or associated Corrective Action Plans (CAP), Uniformed Corrective Action Plans (UCAP), or responses	MQMU Accreditations Manager
Grievances	Joint Intake Center (JIC)/ Detention Reporting and Information Line (DRIL) grievances	IHSC Taskings Manager (Can also be obtained on-site)
Incident reports	Incident report data trends within the last quarter	MQMU Quality Improvement (QI) Program and/or Risk Management Program
Root Cause Analysis	Information regarding action plans completed or pending within the last fiscal year (FY)	MQMU Regional Compliance Specialist (RCS) and/or facility Risk Manager (RM)
Pre-audit excel tracker	Pre-audit excel sheet with information regarding chart review findings. Will have findings from the last quarter (may have data from the past 6 months if needed)	IHSA Program Analyst or designee

*****The POC documents all information in the IHSA SharePoint tool, <u>except for grievances</u>, which the Regional Health Services Administrator or on-site reviewer enters.***

D. Appendix 4: Improvement Plan Levels



Step 1: Level 1 entails structured discussions with the facility about the cause(s) of the performance concern(s) and strategies to address findings. The discussion should include consultation with the HSA, Clinical Services Division leadership (i.e. unit chiefs and/or regional leaders will be consulted via the appropriate chain of command), and subject matter experts (SME) as needed. The facility must address the issues of concern identified by the IHSC designated personnel within 45 days and provide documentation. If the on-site reviewer and/or IHSC designated personnel believe the facility is not progressing satisfactorily to resolve the issue, the performance issues may escalate to Step 2 (Level 2). Findings are issues that do not directly impact detainee safety or cause harm (i.e. missing language identification signs in the pre-screen area or inconsistent documentation of the translator number within charts reviewed).

Step 2: Level 2 entails a formal written notification that identifies the need for a detailed review of the activities that the facility has undertaken, and related Internal Quality Control (IQC) or Continuous Internal Quality Improvement Program (CIQIP) measures. Facilities should address identified concerns locally prior to the end of the Health System Assessment visit or within 30 days. If the IHSC designated personnel (i.e. IHSA review team lead, MQMU Compliance Program, and/or MQMU quality improvement program) and/or SME (facility regional leadership for behavioral health, nursing, advanced practice providers, etc.)believes the facility is not progressing satisfactorily to resolve the issue, performance issues may escalate to Step 3 (Level 3). Level 2 findings are issues that could potentially impact detainee safety or cause harm if not addressed (i.e. not following pill line medication verification process per policy or threshold not met for the documentation of Physical Exam-Complex for chronic care patients).

Step 3: Level 3 entails a formal corrective action plan (CAP) for processes that warrant immediate improvement or when facilities do not continue to progress and show improvements in the other levels. (Who) should urgently review and quickly address Level 3 plans with an immediate plan for implementation. The findings are of high priority and can cause patient harm or impact safety if not

abruptly addressed (e.g.   missing/expired BLS or chart audits results indicating that the site does not meet the threshold for daily mental health follow ups for patients on suicide watch).

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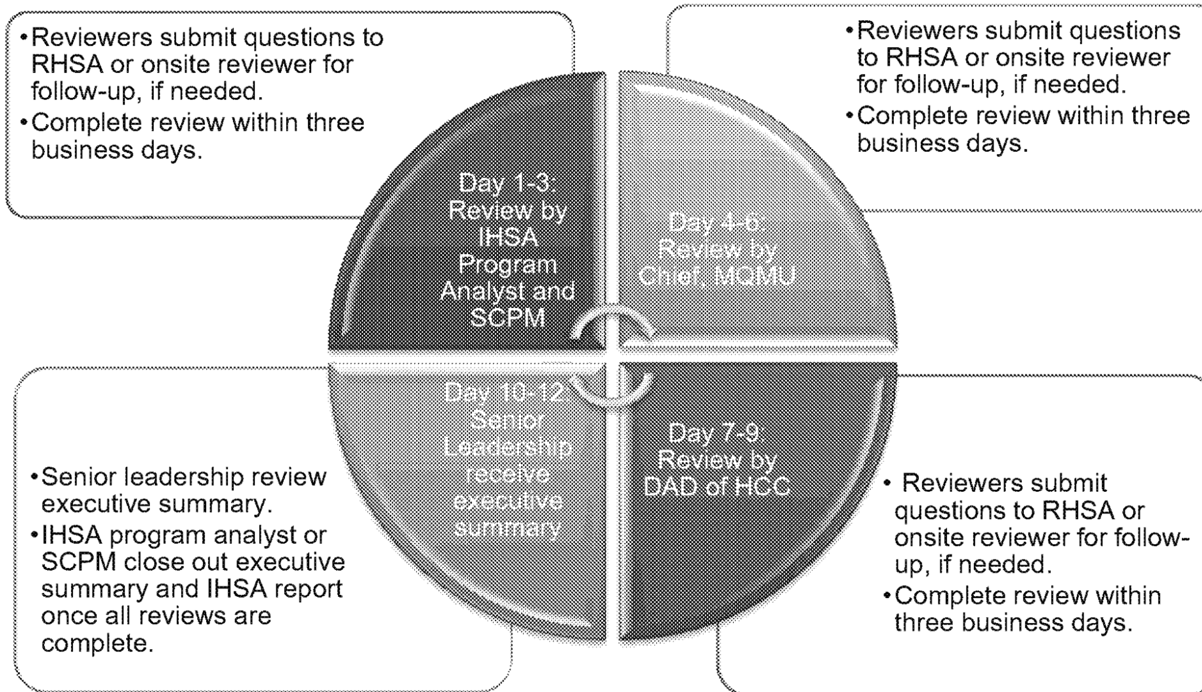
E. Appendix 5: On-site Assessment Leadership Review



On-site Assessments: The IHSA program analyst, senior compliance program manager (SCPM), MQMU chief, and DAD of health care compliance review the all IHSA reports in its entirety. The IHSA program analyst documents findings via an executive summary for review by the IHSC DAD of health systems support, DAD of clinical services, DAD of administration, chief of staff (CoS), and IHSC assistant director (AD).

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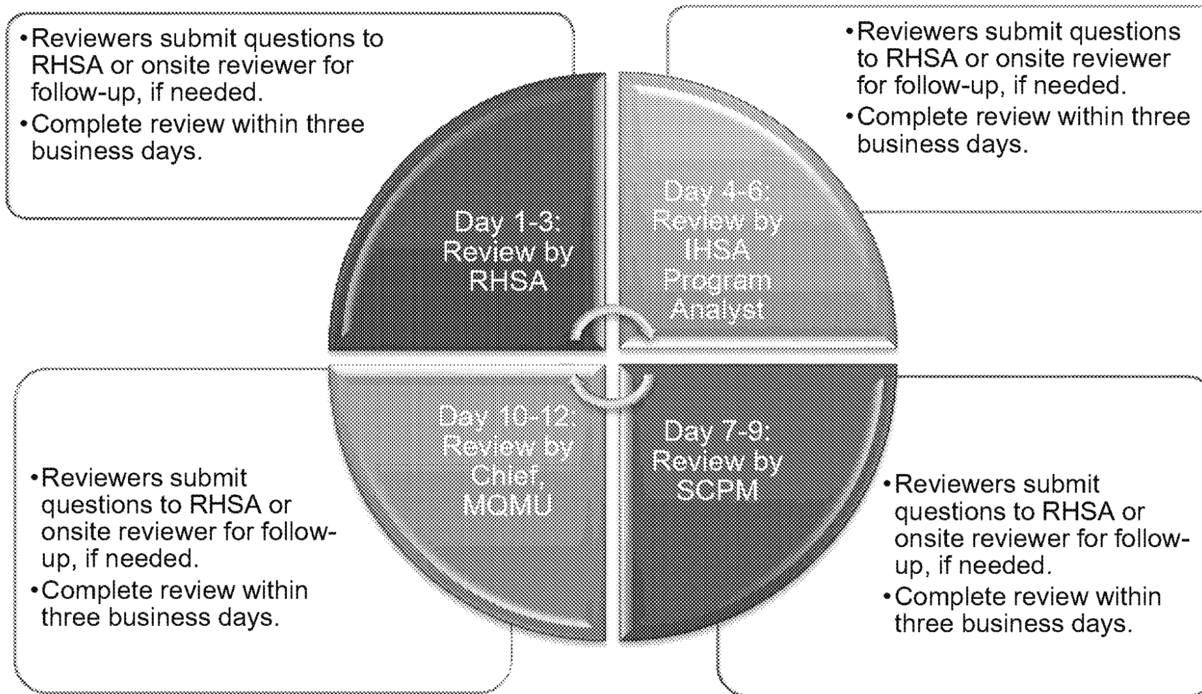
F. Appendix 6: Self-Assessment Leadership Review



Self-Assessments: The RHSA, IHSA program analyst, senior compliance program manager, and MCMU chief review all IHSA reports. IHSC senior leadership (DADs, CoS, and AD) do not review self-assessment reports unless findings are egregious and warrant immediate notification and process changes.

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G. Appendix 7: IHSA Pre-Audit and On-site Assessment User Manual

Accreditation

Evaluation Method		***Ask for reports of most recent accreditations. Pay close attention to the findings and recommendations. Ask HSA for evidence of recommendation implementation.***
Survey	Date	Findings / Recommendations
Last ACA Accreditation		
Last NCCHCC Accreditation		
Last Family Residential Standard (FRS) or PBNDS Accreditation		
Findings		
Comments		

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Grievances	
Evaluation Method:	***Review this section by interviewing the Facility Healthcare Program Manager (FHPM) (formerly known as Compliance Officer) or designee, (HSA or AHSA) or the grievance officer or alternate.***

Items to Review	Comments
Number of medical grievances reported through Quality Improvement/Joint Intake Center/Civil Rights Civil Liberties/Detainee Reporting and Information Line (QI/JIC/CRCL/DRIL).	• eBO 1228 Grievance Report lists medical grievances entered eCW; these entries should correspond with their manual grievance log.
Is there a local operating procedure (LOP) for managing grievances?	• Ask to see the LOP and ensure it covers the items outlined in National policy.
Is there an identified grievance officer?	• Ask who functions as the grievance officer. Ask to see an appointment letter.
Is the logbook kept and up to date?	• Ask to see grievance log. • Ensure it covers items outlined in National policy. • Look for grievances from the eBO report. • Ensure local operating policy is followed.
Number of medical grievances not addressed in a timely manner.	• Refer to the grievance log on-site.
Number of formal grievances.	• Refer to the grievance log on-site.
Number of informal grievances.	• Refer to the grievance log on-site.

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Incident Reports/Root Cause Analyses/Sequence of Events	
Evaluation Method:	***Review this section by interviewing the FHPM or designee (HSA or AHSA).***

Items to Review	Comments
Were there any trends noted from reported incident reports or RCAs for the current fiscal year (FY)?	Contact Risk Management Program and Quality Improvement Program of MQMU for information.
Are there any active root cause analyses (RCAs) or sequence of events (SOEs)?	
Was an RCA or SOE completed since October 1, of current fiscal year? If so, complete #4.	
Was a CAP initiated and/or completed for the RCA or SOE?	
If CAP initiated, note status and due date.	

Consent Forms-Chart Review	
Evaluation Method:	Review 10 records in eCW. ***NOTE: If there are 5 or more charts that have 2 areas which failed in compliance, then review 25 charts for the section.***

Items to Review	Comments
Of the general consent forms reviewed, how many were complete? (not missing detainee signature, witness, or date).	Randomly select detainees from the Intake Clinical Console and look in their scanned documents under "consents/refusals."

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Of the dental consent forms reviewed, how many were complete? (missing detainee signature, witness, or date).	Look at the Clinic Visit Console (CVC) for completed Dental Procedure encounters and then look in the scanned documents under the "dental" section.
Of the psychotropic consent forms reviewed, how many were complete? (not missing detainee signature, witness or date).	Get a list of all detainees on psychotropic medications from the regional pharmacy staff and look in their scanned documents under "consents/refusals".

Transfers-Chart Review	
Evaluation Method:	**Review 10 records in eCW. NOTE: If there are 5 or more charts that have 2 areas which failed in compliance, then review 25 charts for the section.**
Items to Review	Comments
Number of outgoing transfers authenticated appropriately (signed, stamped, and dated): For General Transfer Summary Questions	• Look at the Intake Clinical Visit Console (CVC) and randomly go into the scanned documents of detainees. Look under the "chart documents" folder to see if • the receiving facility received and authenticated a transfer summary.
Number of outgoing transfers completed by LVN or above. For General Transfer Summary Questions	• Look at the patient record for a discharge. • Go to the CVC and look at all completed transfers to see if only nurses completed them. Specifically compare this to a list of medical record technicians (MRTs) and licensed vocational nurses (LVNs) to ensure transfers are not completed by MRTs/LVNs. Specifically look at any transfers locked under Provider, facility.
Of the Transfer Summaries reviewed, how many listed detainee's chronic Medical Conditions if any? For General Transfer Summary Questions	• Look at the patient's current problem list and determine if the transfer summary documents all chronic conditions. The problem list is under the "Overview tab" of the right chart panel.
Of the Transfer Summaries reviewed, how many had current medications listed?	• Look at the right chart panel medications to verify if all meds are listed on the transfer summary. Verify currently prescribed meds via the "e-prescription logs" tab located on the patient hub.

For General Transfer Summary Questions	
Of the transfer summary records reviewed for tuberculosis (TB) clearance, how many correctly documented that patient was not currently taking TB treatment? For TB Transfer Summary Questions	• Look in the Current Medications section of the transfer summary and in eCW under Rx to verify whether anti-TB medications were ordered. See TB Transfer Summary. • Look to see if the following is documented: If the TB clearance section indicates, "Is the detainee/resident being treated for active TB disease" = "No," AND anti-TB medications ARE NOT listed under "Current Medications." • If the detainee is not being treated and no meds are listed, then the documentation is correct.
Of the transfer summary records reviewed for TB clearance, how many incorrectly documented that the patient was not currently taking TB treatment? (TB meds were listed) For TB Transfer Summary Questions	• Look in the Current Medications section of the transfer summary and in eCW under Rx to verify whether anti-TB medications have been ordered. See TB Transfer Summary. • Look to see if the following is documented: If the TB clearance section indicates, "Is the detainee/resident being treated for active TB disease" = "No," AND anti-TB medications ARE listed under "Current Medications." • If the detainee is not being treated but anti-TB meds ARE listed, then the documentation is incorrect.

Intake Screening Chart Review	
Evaluation Method:	**Review 10 records in eCW. NOTE: If there are 5 or more charts that have 2 areas which failed in compliance, then review 25 charts for the section.**
Items to Review	Comments
Number of intake screenings with detainee identified with at least two detainee identifiers.	• Intake encounter, usually in HPI section.
Of the intake records reviewed, how many used a translator	• Look at the intake record to see if translator use was documented. If it was not used, then the reason why should be documented (i.e. provider fluent in detainee's language).

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Of the intake screening records that used a translator, how many listed a translator name or ID number?	• Look at the intake record to see if translator use was documented. If it was not used, then the reason why should be documented (i.e. provider fluent in detainee's language).
Number of encounters in which documentation for not using a translator was provided?	• Look at the intake record to see if translator use was documented. If it was not used, then the reason why should be documented (i.e. provider fluent in detainee's language). "Non available" or "broken/poor English/Spanish" are not acceptable. If any of these, notify HSA.
Number of intake screenings with a complete pain assessment using the pain scale indicator.	• Pain assessment should be documented under the specified section. If no pain, the following should be documented: "Pain Assessment: Pain-Are you currently in pain? No."
Number of intake screenings with pain scale greater than 0.	• Pain assessment should be documented under the specified section. If no pain, the following should be documented: "Pain Assessment: Pain-Are you currently in pain? Yes." Pain should be rated.
Of the intake screenings with a pain scale greater than 0, how many were assessed?	• If pain is present, a plan should be documented to notate that it was addressed.
Number of intake screenings that used the eCW Intake Screening template.	• Tally the number of Intake encounters.
Number of intake screenings with clinically significant findings.	• Intake template should be utilized.
If the intake screening had a clinically significant finding, was it referred appropriately?	• Review Intake encounter for clinically significant findings. If present, then the assessment should include the following: "Abnormal intake screening, referred to provider.
Was the intake screening reviewed by an RN or above within 24 hours?	• Review the timestamp of the reviewing RN to ensure that it was completed within 24 hours. Located at the bottom of the encounter.

Chronic Care- Chart Review	
Evaluation Method:	**Review 10 records in eCW. NOTE: If there are 5 or more charts that have 2 areas which failed in compliance, then review 25 charts for the section.**

Items to Review	Comments
How many chronic care records were reviewed?	• From the CVC, look for detainees who had a CH appt or pull eBO 1193 for current detainees and the 1194 for all detainees regardless of custody status.
Of the chronic care records reviewed, how many had a PE-Complex completed within two business days?	• Look at the PE-C to determine if it was completed within 2 business days of the patient's arrival to the facility. Note: check the calendar to see if there were any federal holidays that may have delayed the PE-C being done within 2 days.
Of the chronic care records reviewed, how many had chronic conditions properly documented in eCW Problem List? (e.g., asthma, hypertension, etc.)	• Right Chart Panel, Overview Tab. • If condition is not there, look at History tab.
Of the chronic care records reviewed, how many detainees arrived at the facility on chronic medications?	• Look at meds listed under Intake Encounter; look at meds listed in the right chart panel. • If not there, look at provider progress note and right chart panel. • Can also look at e-prescription logs on patient hub to see if meds were ordered.
Of the chronic care records with medications, how many encounters indicated that medications were continued as clinically indicated??	• Look at meds listed under Intake Encounter; look at meds listed in the right chart panel. • If not there, look at provider progress note. • Look at progress notes and scroll through the encounters. • Can also look at Encounters window from the Patient Hub and compare medications on Right chart panel. • Can also look at e-prescription logs on patient hub to see if meds were ordered.
Of the chronic care records reviewed, how many detainees had psychiatric medications?	• Intake Encounter. • If not there, look at provider progress note. • Look at progress notes and scroll through the encounters. • Can also look at encounters window from the Patient Hub and compare medications on Right chart panel.
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by a physician,	• Look at progress notes and dates by scrolling through the encounters. • Look at reason for visit.

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psychiatrist, Psychiatric APP, or APP every 30 days for medication assessment or review?	
Of the chronic care records with psychiatric medications, how many encounters indicated that the detainee was seen by a physician, psychiatrist, or psychiatric APP every 90 days for chronic care management?	• Look at progress notes and dates by scrolling through the encounters. • Look at reason for visit.
Of the chronic care records reviewed, how many chronic care patients were identified as stable?	• Look at progress notes. • Look for chronic care templates and documentation of patient's stability. • The provider's documentation should be utilized to answer this question. Per policy, the patient's condition should be documented by the provider in the chronic care note.
Of the stable chronic care patients, how many encounters indicated that the detainee was seen within 90 days?	• Look at progress notes and dates by scrolling through the encounters. • Look at reason for visit.
Of the chronic care records reviewed, how many chronic care patients were identified as unstable?	• Look at progress notes • Look for chronic care templates and documentation of patient's stability or lack thereof. • The provider's documentation should be utilized to answer this question. Per policy, the patient's condition should be documented by the provider in the chronic care note.
Of the unstable chronic care patients, how many encounters indicated that follow-up appointments were scheduled earlier than 90 days?	• Look at progress notes and dates by scrolling through the encounters. • Look at reason for visit.
Of the chronic care records reviewed, how many had a global alert (IHSC 834 or electronic equivalent) completed?	• Look on right chart panel from patient hub. Global alert will be listed at the top of the "Overview" tab. • If not there, go to patient hub and select the "billing alert box," then click on "global alert".

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Physical Exams- Chart Review	
Evaluation Method:	**Review 10 records in eCW. NOTE: If there are 5 or more charts that have 2 areas which failed in compliance, then review 25 charts for the section.**

Items to Review	Comments
How many physical exam charts were reviewed?	• Progress note; usually HPI section.
Of the physical exam charts reviewed, how many used language services?	• Review PE-C progress note for translator documentation.
Of the physical examinations that used language services, how many contained identification of the translator or interpreter? (translator name, ID, etc.)?	• Review PE-C progress note for translator documentation.
Of the physical exam charts reviewed, how many were for juveniles?	• Tally number of juvenile PE-Cs reviewed.
Of the physical examinations for juveniles, how many were completed within 7 days of arrival to the facility?	• Scroll through progress notes to find Intake Encounter. Compare dates.
Of the physical exam charts reviewed, how many were for adults?	• Denominator-keep a record on the number of adult examinations performed in your chart reviews.
Of the physical examinations for adults, how many Physical exam-simple (PE-S) were completed within 14 days of arrival to the facility?	• Scroll through progress notes to find Intake Encounter. Compare dates.
Of the physical exam charts reviewed, how many had a pain assessment?	• Pain assessment should be documented under the specified section. If no pain, the following should be documented: "Pain Assessment: Pain-Are you currently in pain? Yes." Pain should be rated.
Of the physical examinations with pain assessment, how many were addressed?	• If pain is present, a plan should be documented to notate that it was addressed.
Of the physical exam charts reviewed, how many were reviewed by an MD? PE-C within 7 days.	• Look for signature in the progress notes, found at the bottom.

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Of the physical exam charts reviewed, how many were for adult females?	• Look for signature in the progress notes, found at the bottom.
Female only: Of the adult female physical exam charts reviewed, how many had a record of the last menstrual cycle?	• In Patient Identification section of the Progress note. • Look at Female-GYN section in progress note.

Sick Call -Chart Review		
Evaluation Method:	**Review 10 records in eCW. NOTE: If there are 5 or more charts that have 2 areas which failed in compliance, then review 25 charts for the section.**	
Items to Review		Comments
Of the sick call records reviewed, how many were the third time that the patient complained about the same issue?		• In CVC, do a search by facility, date range (90 days), encounter type (sick call) sort by detainee and review records of detainees with 3 or more sick call encounters.
Of the sick call encounters where the encounter was the third time that the patient has complained about the same issue, how many were referred to a provider?		• Open sick call encounters to see if the detainee was referred to a provider for the issue.
Of the sick call records reviewed, how many included a full set of vital signs? (blood pressure, respirations, pulse, temperature, and pain rating and, if appropriate, weight and O2 Sat).		• View vital signs section of the progress note.
Of the sick call records reviewed, how many had a pain scale greater than 0?		• Pain assessment should be documented under the specified section. If no pain, the following should be documented: "Pain Assessment: Pain-Are you currently in pain? Yes." Pain should be rated.
Of the sick call encounters with a pain scale greater than 0, how many indicated that the pain was addressed?		• If pain is present, a plan should be documented to notate that it was addressed.
Of the sick call records reviewed, how many included nursing protocols/guidelines referenced by name in the documentation?		• Look in Progress Note for nursing guideline used and ensure it is an approved guideline.
Of the sick call records reviewed, how many included the reason documented in the "Reason" field?		• Look in Progress Note for nursing guideline used and ensure it is an approved guideline.
Of the sick call records reviewed, how many had the reason for visit from an approved category?		• Look in Progress Note for nursing guideline used and ensure it is an approved guideline.

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Of the sick call records reviewed, how many were addressed by a nurse?	• Keep a tally of the number of RN encounters.
Of the sick call encounters addressed by a nurse, how many followed the SOAP format of documentation with appropriate nursing diagnosis?	• Documentation should include subjective, objective, assessment, and a plan.

Medical Housing Unit (MHU) Full admission	
Evaluation Method:	**Review 10 records in eCW. NOTE: If there are 5 or more charts that have 2 areas which failed in compliance, then review 25 charts for the section.**

Items to Review	Comments
How many MHU full admission records were reviewed?	• Look on Infirmary console for detainees that are currently housed in the MHU or pull eBO report 1141 MHU Bed Detail by admission date • Items are self-explanatory
Of the MHU full admission records reviewed, how many had admission orders?	• Look on Infirmary console for detainees that are currently housed in the MHU or pull eBO report 1141 MHU Bed Detail by Admission Date.
Of the MHU full admission records reviewed, how many had a documented PE within the past year?	• Look at date of last physical exam.
Of the detainees admitted to the MHU without a documented physical examination, how many received a physical examination within twenty-four (24) hours of admission to the MHU?	• Look at date of last physical exam to determine if it was completed within 24 hours of admission to the MHU.
Of the MHU full admission records reviewed, how many had a nursing care plan?	• Look for scanned nursing care plans in the documents scanned under the "pt documents" tab. • If no scanned documentation, look within the text to see if the nurse documented a care plan.
Of the MHU full admission records with a nursing care plan (SOAPE note, Nurse Care Plan initiation, and admission patient education), how many records indicate that the plan was addressed and reviewed daily?	• Look for scanned nursing care plans in the documents scanned under the "pt documents" tab. • If no scanned documentation, look within the text to see if the nurse documented a care plan. • Verify if the nursing care plan was updated daily within the areas noted in the above bullets.
Of the MHU full admission records reviewed, how many had patient education provided daily? (Patient education includes admission education, updated Nurse Care Plan.).	• Review RN documentation for patient education daily.

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Of the MHU full admission records with mental health diagnoses, did the detainee have an existing mental health diagnosis prior to the admission?	• Review patient encounters to determine if a mental health diagnosis was documented prior to the MHU admission.
Of the records that indicate that the patient was assessed on initial admission, how many re-evaluated in seven (7) days, or more frequently if indicated?	• Look at patient encounters to determine if the detainee was seen by a mental health provider every 7 days.
Of the MHU full admission records reviewed, how many records did not have a mental health diagnosis?	• Look at right chart panel to see if there is a mental health diagnosis documented; then look at MHU admission note to see if a MH diagnosis is present.
Of the MHU full admission records without mental health diagnoses, how many records indicate that the patient was assessed every 30 days by a BHP?	• Look at patient encounters to determine if the detainee was seen by a mental health provider every 30 days.

Suicide Watch-Chart Review	
Evaluation Method:	**Review 10 records in eCW. NOTE: If there are 5 or more charts that have 2 areas which failed in compliance, then review 25 charts for the section.**
Items to Review	Comments
Of the suicide watch records, how many had a patient evaluated for suicide risk by a behavioral health provider (BHP)or physician within 24 hours of being placed on suicide watch?	• Pull eBO report 1064 Suicide Watch Historical for a list of suicide watches. • NOTE TO ON-SITE REVIEWER: This should be compared to site's manual log during the on-site visit if they maintain a log.
Of the suicide watch records, how many had a patient assessed to determine if a safety gown and blanket was indicated via a Special Needs form?	• Look under CHS tab to view SNF. • Look in progress note if no SNF. • If gown was not documented via SNF, check behavioral health provider (BHP) note to see if it was not medically indicated

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Of the suicide watch records, how many had the need for finger food annotated via a Special Needs form?	• Look under CHS tab to view SNF. • Look in progress note if no SNF.
Of the suicide watch records, how many had a daily mental health assessment conducted and documented by a BHP, Psychiatrist, Psych APP, Physician, or APP?	• Look for MH encounters under "Encounters" tab on patient hub and review notes.
Of the suicide watch records, how many had a patient released from suicide watch by a BHP, Psychiatrist, Psych APP, or physician?	• Look for encounters under "Encounters" tab on patient hub and review discharge note for a MD discharge.
Of the suicide watch records, how many had a suicide risk assessment conducted prior to release from suicide watch?	• Look for SRA in encounters under "Encounters" tab on patient hub and review notes. • Look for the SRA smart form under "patient docs" (second verification if encounters are not labeled as SRA).
Of the suicide watch records, how many had checks conducted and documented at least every eight hours by health care staff?	• Look for SW encounters. • And view timestamp of encounters.
Of the suicide watch records, how many had checks conducted and documented at least every 15 minutes by custody staff?	• Look for SW LOG from custody staff and view timestamp of encounters.

Hunger Strike-Chart Review	
Evaluation Method:	**Review 10 records in eCW. NOTE: If there are 5 or more charts that have 2 areas which failed in compliance, then review 25 charts for the section.**
Items to Review	Comments
Of the hunger strike records reviewed, how many had I&O's tracked in the health record? {I&O's may be tracked via Hunger Strike Monitoring Form (IHSC 839) or electronic equivalent (approved eCW form included)}.	• Look for scanned document under "Patient docs" on the hub • Check flowsheet on the patient hub

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Of the hunger strike records reviewed, how many indicated that the patient was educated on the adverse effects of a hunger strike and education was documented in health record?	• Review HS notes for education.
Of the hunger strike records reviewed, how many indicated that the patient was counseled on termination of hunger strike and counseling was documented in health record?	• Review HS notes for counseling.
Of the hunger strike records reviewed, how many indicated that the patient was evaluated by a behavioral health provider?	• Review notes for MH evaluation.
Number of hunger strike records with complete medical history, orthostatic vital signs, height, weight, urinalysis, mental health evaluation, physical assessment, clinically necessary laboratory tests deemed appropriate, and modification or augmentation of standard treatment protocols when medically indicated during the initial evaluation or refusal form (All or nothing).	• Review encounters on pt hub for documentation of physical assessment, MH evaluation. • Look for lab tests under labs, urinalysis. • Check flowsheet on the patient hub for vital signs and orthostatic vitals. • Refer to the most current version of the Hunger Strike policy as it relates to orthostatic vital signs.
Of the hunger strike records reviewed, how many had orthostatic vital signs including weight taken every 24 hours?	• Review encounters on pt hub for documentation of orthostatic vital signs and weight or • Look for vital signs and weight on pt hub under "flowsheets" then click on "vital signs flowsheets."
Of the hunger strike records reviewed, how many were discontinued by the Clinical Director, or a physician?	• Review encounters on pt hub for documentation of physician discharge (i.e. physician note, physician co-signature of note, or telephone encounter).
Of the hunger strike records that were discontinued, how many indicated that IHSC healthcare staff educated the patient about access to emergency and routine behavioral and medical health care.	• Review notes for MH evaluation.
Of the hunger strike records reviewed, how many had special needs to include restriction of commissary items?	• Look under CHS tab to view SNF. • Look in progress note if no SNF.

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Segregation-Chart Review	
Evaluation Method:	**Review 10 records in eCW. NOTE: If there are 5 or more charts that have 2 areas which failed in compliance, then review 25 charts for the section.**

Items to Review	Comments
Number of segregation records that indicate the patient was medically cleared for segregation.	• Look at the CVC for SEG appointments and randomly choose records. • Look for RN encounters under "Encounters" tab on patient hub and review SEG notes for a clearance.
Number of segregation records where daily segregation rounds by nursing are documented.	• Look for RN encounters under "Encounters" tab on patient hub and review SEG notes.
Was sick –call services offered documented and noted whether detainee accepted or denied sick –call offer.	• Look for RN encounters under "Encounters" tab on patient hub and review SEG notes to see if sick call was offered. • Consider looking under SEG encounter, Segregation Rounds for the following questions: "Do you have any medical complaints or concerns at this time? Was referral made to clinical services (MD/APP, Dental, MH, Sick Call)?" If yes, look to see if the sick call issue was addressed.
Number of segregation records where the patient with no history of Mental Health Diagnosis mental health status was evaluated at least every 30 days.	• Look under "Encounters" tab on patient hub and review SEG notes to see if patient without a MH diagnosis (may consider verifying by looking at problem list on right chart panel) was patient evaluated every 30 days by MH • Look at Right chart panel to verify if pt has a MH diagnosis.
Number of segregation records where the patient with history of Mental Health Diagnosis was seen weekly by a behavioral health provider.	• Look under "Encounters" tab on patient hub and review SEG notes to see if patient with a MH diagnosis was evaluated weekly by MH.

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On-site Observations (Obtain this information upon arrival to facility)

Facility Overview: IHSC HEALTH SYSTEMS ASSESSMENT

Language Access

Evaluation Method:	**Review 10 (Intake or Pre-Screen) records in eCW. NOTE: If there are 5 or more charts that have 2 areas which failed in compliance, then review 25 charts for the section.**

Items to Review	Comments
Number of records where the patient was asked what language they speak. (needs to state that the language on intake was documented).	• Look at intake encounter for the following question: "What language do you speak? Interpretation provided?"
Number of records where the patient's primary language or language of choice is documented in their medical record.	• Randomly select medical encounters (i.e. chronic, sick call, acute, etc.) to see if the patient's primary language was documented and used. Check Intake encounter to see what the patient's primary language (i.e. Check chronic visit for interpreter use, then check intake encounter of the same chart to very whether or not the language used was the primary language of the detainee.).
Number of records where the interpreter use was addressed and documented (interpreter name or number, and language).	• Keep a tally of records where a translator use was documented • In encounter selected, look under the "Patient Identification" section to verify if translator use was documented. • If used, the interpreter name and/or number, and language should be documented.
Number of records where reasons for why an interpreter was not used was documented.	• Look for the following documentation under the "Patient Identification" section for the following question: "Interpretation Provided?" If an interpreter was not used, the reason should be documented. • NOTE: Documenting "Pt speaks broken English," "Pt able to communicate medical Spanish" is **not** a valid reason.

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Months:	3 months prior to site visit	Bed Capacity:	HSA provides	MHU Beds:	HSA provides

Daily Census:	Male:	Female:		Juveniles:	LOS:	Length of stay

Information above is an average for the previous 3 months

Average Number of Encounters

Category	Month 1	Month 2	Month 3	Average	% pop
Pre-screening					
Intake					
Physical Exams					
Vitals/Labs					
Sick call					
Pros/Imm	eBO 1146 Facility Workload Report HSA reports to Unit Chief				
Acute					
Chronic					
Mental Health					
Dental					

Staffing

	PHS	GS	CTR	Vacant	Total
AA/MRT					
CD/MD					
DA/DT					
DDS					
HSA/AHSA					
LVN/LPN	Staffing Model provided to HSAs by Health Operations Unit Chief HSA to provide list of vacancies				
MA/CNA					
BHP (					
APP (PA & NPs, Clinical Pharmacist)					
MRT					

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Emergent/Urgent				PharmD		
MHU				PharmTech		
Seg				Psych MD/physicians/DO Psych APP		
Admin				RDH		
Transfers				RN		
Totals				X-ray tech		
Pill-line passes	Pharmacy Staff			Totals		
RX (Pill-line + KOP)				Comments:		
Referrals / ER	eBO 1110-1112 Referrals Detail					

Medication Administration (pill line)-Observation	
Evaluation Method:	**Reviewer should observe at least two pill-line shifts. (Reviewed policy, check e MARS and Pill-Line lists)**

Items to Review	Comments
Is pre-pouring occurring?	• Are nurses placing medications in medicine cup prior to seeing the patient? • Observe multiple medication administrations on different shifts.
Are nurses adhering to the 6 rights?	• Are nurses verifying the 6 rights prior to medication administration.
Are mouth checks being conducted with every administration?	• Did nurse verify that the detainee did take the medication (observe for "cheeking").
Are all entries in the MAR/eMAR complete (allergies, staff initials,	• Look for "holes" on MAR; are there any missing entries or incomplete areas.
Are nurses documenting the document administration of medication immediately after the medication is administered?	• Observe nurse documenting that the medication was administered.
Number of all medication refusals documented on the MAR/eMAR	• Count number of refusals noted on a MAR.
Of the identified medication refusals from the MAR/eMAR, how many refusal form (If required)?	• Look in eCW to determine if refusals have a corresponding refusal form (see #6) • If not present, ask for specific site procedures regarding procedures (i.e. when are refusals scanned into chart, how are refusals documented).
Of the identified high-risk medication refusals, how many times were notified of the refusal in eCW.	• Look in eCW to determine if refusals (see #6) have a corresponding notification to providers. • If not present, ask for specific site procedures regarding notification procedures (i.e. when are providers notified, how is this documented).

Emergency Preparedness and Response- Observation	
Evaluation Method:	**Observe all areas noted below**

Items to Review	Comments

Is there documentation showing completed date and time of man-down drills (once per month for each operating shift)?	• Reviewer should look at 2 of each drill/scenario type and verify documentation meets requirements. • Reviewer should interview 1- 3 staff members if possible, regarding receipt of after-action debriefing. • The FHPM or designee should maintain this information and all emergency scenarios should be typed up and maintained.
Is there documentation showing completed date and time of fire drills (once a quarter for each operating shift)?	
Is there documentation showing completed date and time of mass casualty drills * (each shift) should have a complete drill within a three-year period)? *Tabletop/mock drills are acceptable replacements for drills not conducted facility wide.	
Are health care staff trained on emergency equipment?	
Do emergency scenarios vary? Yes/No??	
Are health care staff trained on emergency equipment? (AED, first Aid kits, fire extinguisher, etc.)	
Is the difference between a drill and an actual event evident in the write-up? ("Is it evident that the emergency incident was either an actual event, full drill, or tabletop exercise?").	
Is there a system in place to distribute an after-action report to all staff?	

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Is the contact information for all staff up to date for notification, accountability, or recall purposes prior to, during, or after an emergency event?	

Environmental Health -Observation

Evaluation Method	**Review policy and records, interview and staff.** Who was interviewed and title? If possible, interview the FHPM or designee.

Items to Review	Comments
Are clinic Safety Data Sheets (SDS) files complete, current, and accessible?	• Ask a staff member to define what SDS is, state the purpose of SDS, and where file is located. • Reviewer should observe to see if file has been reviewed within the last year • Reviewer use judgement in this scenario. • Reviewer should pull three solutions and verify that each has a corresponding SDS sheet in the book. • On the bottom of the checklist, there is a space for documentation of any items not in compliance and what the corrective action is as well as completion date. Review first and last 14 checklists for daily, 7 for weekly, 4 for quarterly, and the last annual checklist. • Look for signage on doors indicating Rooms are "Airborne, Infection and Isolation" (AII) Room.
Are hazardous chemicals (including cleaning supplies) labeled and securely stored.	
Are Public Health, Safety, and Preparedness Toolkit checklists maintained locally and documented (with FHPM/HSA Signatures or designee) to show corrective action with completion date?	
Observe 14 daily sequential checklists from the past 14 calendar days.	

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Observe 7 weekly sequential weekly checklists from the past 7 weeks.	
Observe 4 quarterly checklists for the past 4 quarters.	
Annual checklist – review the last annual checklist.	
Do Airborne, Isolation, and Inspection (AII) rooms and other isolation rooms requiring transmission-based precautions have appropriate signage for the required precaution(s).	
Is documentation of daily checks on AII rooms' negative pressures complete?	
Is the OSHA Form 300A Summary completed and posted in clinic from Feb 1st through April 30th each year?	

Pre-Screening-Observation	
Evaluation Method:	**Observe 5-10 Pre-Screenings when possible** (Observe and Interview Staff if Possible; Who was interviewed and title? Verify information charted in CVC - prescreens - randomly choose detainees)

Items to Review	Comments
Number of prescreen encounters observed.	• Tally number observed. • Observe 5-10 Pre-Screenings when possible.

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"Is appropriate language barrier designation applied when indicated? "	• Observe and check eCW chart to see if nurse documented a language barrier when appropriate.
Number of prescreens with documentation completed in eCW prior to intake screening.	• Observe and check eCW chart to see if nurse documented a prescreen prior to the intake.
Number of prescreening encounters prioritized to level 1 (One) when clinically indicated based on self-reported history or objective.	• Observe and check eCW chart to see if nurse prioritized the patient to be seen and documented the prioritization from the self-reported medical hx given.
Did detainee report a history of self-harm.	• Observe and check eCW chart to see if nurse documented the history of self-harm.

Intake Screening-Observation

Evaluation Method:	**Observe 10 "Intakes" if possible** (Keep a tally the numbers of records were reviewed on-site? Was staff interviewed? Who was interviewed and title? Preferable to interview nurse that is usually assigned to intake)

Items to Review	Comments
Number of intake screenings observed.	• Tally number observed (Observe 10 "Intakes" if possible)
Of the intake screen records reviewed, how many had detainee identified with at least two detainee identifiers?	• Review documentation of intake screening
Number of intake screening observations where the nurse reviewed the prescreen and transfer paperwork prior to initiating the intake screening.	• Observe nurse performing intake screening. Determine if nurse reviewed the prescreen and transfer paperwork • For example, no mention of LMP if pt is a male

Number of intake screening observations where a full set of vital signs (Blood Pressure, Respirations, Pulse, Temperature, weight, Pain Rating and (if appropriate) O2 Sat were taken.	• Observe nurse performing vital signs
Of the intake screen encounters that used language services, how many were appropriately documented?	• "Non available" or "broken/poor English/Spanish" are not acceptable. If any of these, notify HSA
Of the intake screen encounters observed, how many used language services?	• "Non available" or "broken/poor English/Spanish" are not acceptable. If any of these, notify HSA
Of intake screening observations where the patient was educated on access to care, upcoming PE appointment, and provided the grievance guide.	• Intake encounter. Review note. Ensure questions are appropriate for detainee. • For example, no mention of LMP if patient is a male

Chronic Care- Observation

Evaluation Method:	**Observe 5-10 chronic care encounters when possible** (Keep a tally the numbers of records were reviewed on-site? Was staff interviewed? Who was interviewed and title?)

Items to Review	Comments
How many chronic care encounters were observed?	• Observe chronic care visit in Clinic.
Number of chronic care encounters with observed treatment plan.	• Observe chronic Care Visit in Clinic, then review eCW chart to see if a treatment plan was documented.

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Physical Exam- Observation

Evaluation Method:	**Observe 5-10 PE-S or PE-C encounters when possible** (Keep a tally the numbers of records were reviewed on-site? Was staff interviewed? Who was interviewed and title? Preferable to interview nurse that is usually assigned to MHU?)

Items to Review	Comments
Of the physical exam encounters observed, how many included a full set of vital signs? (Blood Pressure, Respirations, Pulse, Temperature, weight, Pain Rating and (if appropriate) O2 Sat) taken.	• Observe a PE-S or PE-C visit in clinic. • Observe whether vital signs were obtained.
Of the physical exam encounters observed, how many were completed within the specified timeframe? (Two Business days for PE-Cs,7daysfor–juveniles and, 14-days for adults).	• Observe a PE-S or PE-C visit in clinic. • Check eCW chart to see if PE-C/PE-S was completed within the timeframe specified by policy.
Number of physical examination encounters that Snellen test was conducted during the physical exam.	• Observe a PE-S or PE-C visit in clinic. • Observe whether a Snellen test was conducted
Number of physical examination encounters referred to the next level of care as directed by IHSC policy.	• Observe a PE-S or PE-C visit in clinic. • Observe if a higher level of care was required and performed (i.e. RN PE-S being completed, but pt reports having a chronic or acute medical condition requiring referral to a provider).
Number of physical examination encounters with an abnormal vital sign that was addressed and/or referred to a higher level of care.	• Observe a PE-S or PE-C Visit in Clinic. • Observe if abnormal vital signs were addressed (i.e. pt with elevated blood pressure and provider orders meds/bp checks) and/or referred as needed (i.e. RN refers a detainee to a provider due to detainee having elevated blood pressure).

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Number of physical examination encounters properly designated as either PE-complex or PE-simple as per IHSC Directive on Health Assessments?	• Observe a PE-S or PE-C Visit in Clinic. • Review eCW documentation to ensure that exam was properly designated.

MHU Full Admission- Observation

Evaluation Method:	**Observe 10 MHU encounters when possible** (Preferable to interview nurse that is usually assigned to MHU)

Items to Review	Comments
Are all patients within sight or hearing of a qualified health professional?	• Observe MHU to see if patients are visible to staff and can be heard. • Question states qualified healthcare provider, but the patient can be within sight and sound of facility staff
2. How many nurses are in the MHU full admission at the time of observation?	• Observe MHU and count the number of nurses present and assigned to MHU. • Verify by reviewing local schedule if needed (state required ratio here).
3. How many patients are in the MHU full admission at the time of observation?	• Observe MHU setting and count the number of patients present. • Review infirmary console (under "CORRECTIONS" banner in eCW) in eCW to determine if this number is correct.
How many MHU full admission patients have a 24-hour chart review every day? (Review one 24-hour chart in detail to confirm review was done appropriately)	• Review MHU eCW "ENCOUNTERS" to see if MHU chart reviews are documented.

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MHU Full Admission- Observation	
How many MHU full admission patients have medications?	• Record the numerical value.
Of the MHU full admissions patients with medications, how many have all medications placed on pill line? (except KOP med exceptions see guide).	• Review MHU eCW encounters to verify if medications are ordered as pill line (KOP exceptions: nitro, rescue inhaler, etc.)

Suicide Watch-Observations	
Evaluation Method:	**Observe 10 Suicide detainees when possible** (Was staff interviewed? Who was interviewed and title?)
Items to Review	Comments
How many patients are on suicide watch?	• Keep a tally of the number of detainees observed on suicide watch.
Of the patients on observed suicide watch, how many had a nursing assessment performed within the past 8 hours?	• Check eCW charting to see is nursing assessments are being performed every 8 hours or as specified by orders if more frequent checks requested.
Of the patients on suicide watch or constant watch, how many were observed to have custody staff documentation of 1:1 observation?	• Check the eCW "Encounters" of the patient to see if a MH or medical provider has seen the patient every 24 hours.
Of the patients on suicide watch, how many have a restrictive environment compliant with current orders? (e.g., smock, finger food, activity, etc.).	• Observe environment to ensure that it is compliant with orders. • Check the SNF to determine what was ordered.
Of the patients observed on suicide watch, how many were undergoing constant one-to-one observation in the designated facility housing unit.	• Observe environment to ensure that it is compliant with orders.

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Hunger Strike-Observation	
Evaluation Method:	**Observe 10 Hunger Strike detainees when possible** (Was staff interviewed? Who was interviewed and title?)
Items to Review	Comments
How many patients were on a hunger strike at the time of observation?	• What number of patients on hunger strike observation have received a mental health evaluation in accordance with policy (i.e. 9 consecutive missed meals).
Of the patients on a hunger strike, how many was water available and offered for?	• Observe whether or not water was present.
Of the patients on a hunger strike, how many were offered meals? (If observation occurred during mealtimes)	• **Make sure day of hunger strike and # of missed meals have been documented.**
Of the patients on a hunger strike who were offered food, how much food was offered?	• Ask to review custody documentation of meals served.
Of the food offered, how much of the food was eaten?	• Ask to review custody documentation of meals served.
Of the special needs' patients on a hunger strike, how many records indicated that the needs were addressed?	• Ask for special needs form (SNF). • Compare observed findings to orders noted on the SNF.
3.Of the hunger strike records with special needs (i.e. housing, commissary restriction, fall risk), how many records indicate that the needs were addressed?	• Ask for special needs form (SNF). • Compare observed findings to orders noted on the SNF.
Of the patients on a hunger strike, how many had special needs?	• Review eCW for special needs form. Found under the CHS tab or scanned into patient docs. Provide a numerical value.

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Segregation Observation	
Evaluation Method:	**Observe 10 Segregation detainees when possible** (Was staff interviewed? Who was interviewed and title?)
Items to Review	Comments
1. Of the patients in segregation observed, how many records indicate that the RN or medical provider conducted daily rounds and the BHP conducted weekly behavioral health rounds in the SMU.	• Review documentation in segregation (i.e. look for RN or MH signatures. Interview RN and MH staff and inquire about how rounds are conducted and how often rounds are conducted).
2. Was sick call offered to detainees in segregation or other specialty housing units?	• Review eCW "Encounters" to see if patient was rounded on and if sick call concerns were addressed.

After-Hours Medication (Night Pharmacy)- Observation	
Evaluation Method:	**Review policy and records, interview staff.** Who was interviewed and title? When possible interview the pharmacist, pharm tech and a nurse.
Items to Review	Comments
1. Is a medication log in place and reflective of quantities of medication stored in the night cabinet?	• Count quantity of medications in the cabinet and verify (using log) if the quantity present is correct.
2. Do line entries contain the date, time, patient name, alien number, medication name, and quantity removed?	• Look at log documentation.

3. Is the after-hours verbal medication order entered in eCW by the prescriber upon return to duty?	• Look at medications logged, then check eCW medical record to see if the medication was ordered by the prescribing provider. • Can also consider looking on the hub under "EPRESCRIPTION LOGS" to see if the medication was sent to pharmacy.
4. Is the after-hours medication administration properly documented on the eMAR or in the electronic health record?	• Ask to pharmacist & verify.
5. Is the night cabinet, clean, stocked, and organized?	• Visually observe the status of the night cabinet for cleanliness, stock, and organization.
6. Is the After-Hours Cabinet physically inspected (by pharmacist or designee) on a monthly basis to ensure the absence of expired, recalled or deteriorated medications?	• Ask pharmacist & staff regarding process (Consider asking: is there a log of the checks? How often does it occur? When was the last check?) • Check AHC for expired medications.

Observe medical clinic areas		
Evaluation Method:	**Observe medical areas**	
Items to Review		Comments

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Are the "I Speak" posters and pocket guides readily available and posted in the clinic?	• Look for signs in all medical clinic/care areas (i.e. sick call, intake/pre-screening areas, medical treatment rooms, etc.).
Does the facility have a process in place to address accessing sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities?	• Ask HSA/AHSA/FHPM.

Diagnostic Services	
Evaluation Method:	**Observe 1-2 staff perform 5 radiography services** (How was this area evaluated? Who was interviewed? Interview Lab officer)
Items to Review	Comments
Are laboratory services provided in adherence with CLIA Waived testing?	Ask HSA or Lab officer for documents • Certificate should be in lab.
Is there a current certificate for CLIA-waived testing?	• Ask HSA or Lab officer for documents. • Certificate should be in lab.
Are radiation signs posted on all doors leading to areas with radiation producing equipment?	• Look for radiation signs (i.e. dental clinic, x-ray room, etc.).
Are dosimetry reports reviewed quarterly (monthly for declared pregnancies) by the FHPM or HSA?	• Ask HSA for policy.
Are staff seen wearing dosimeter badges while performing radiography services or while working in in an area with radiation producing equipment?	• Observe staff performing services. • Look for use of dosimeter.

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Are staff dosimeter badges and controls stored in a central location and not near a radioactive source?	• Ask to see the location of all dosimeter badges being stored. • Ask HSA for copies of exposure reports received from radiation contracting company and review for HSA signature (review last three quarters).

	Comments
	• Request and review logs • Keep a tally of logs reviewed
	• Review each temperature log • Ensure there are no "holes" or signatures missing
	• Review each temperature log • Ensure there are no "holes" or signatures missing
	• Ask pharmacist and verify • Review logs for actions taken
	• Count sharps and verify count
	• Review log for signatures

	• Observe security of narcotics (i.e. is a double lock present?) • Count sharps and verify count (review clinic and pharmacy supply)
	• Review log for signatures
	• Are there signatures, documentation of AED functionality, and expiration dates documented for the past 3 months?

Daily Assignment Sheet (DAS)-Observation	
Evaluation Method:	**Randomly review schedules from a 3-month timeframe** (Staff interviewed? who was interviewed?)
Items to Review	Comments
How many daily assignment sheets were reviewed?	• Keep a tally of the number of assignment sheets reviewed.
Of the daily assignment sheets reviewed, how many were archived appropriately?	• Keep a tally of the number of assignment sheets that were archived appropriately. • Ask about the process of archiving and verify. • Are sheets PDF'd and signed.
Of the daily assignment sheets reviewed, how many had at least one emergency team identified per shift?	• Review assignment sheet for emergency team. • Verify with staff if emergency team is known/identified.

Shift Report and Timecards

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Evaluation Method:	**Attend 1 or 2 shift reports. Different shifts** (Which timecards were audited? (name, discipline and type-CTR or Fed) Policy review? If Staff interviewed, who was interviewed?)
Items to Review	Comments
Are shift reports conducted?	• Attend shift report.
Are written changes verified (initials, signature) on timecards by the HSA or AHSA(s)?	• Review timecards. • Some facilities may also have Fed (PHS & GS) clock in.

Meetings

Evaluation Method:	**Review Two Monthly Staff Meetings and Two Quarterly ICE Meetings** (Request and review a copy of these minutes. Electronic is preferable)
Items to Review	Comments
Out of the two previous staff meetings, how many were conducted monthly and properly documented?	• Ask for documentation of last meeting (i.e. minutes and roster). • Each meeting should have a signature sheet. All staff should sign and date. Staff that did not attend the meeting still read the minutes do acknowledge they read them.
Of the 2 previous national Public Health, Safety, and Preparedness Committee monthly meetings, for how many had documented attendance by the FHPM and IPO, or HSA or AHSA, if no FHPM assigned?	• Ask for documentation of last meeting (i.e. minutes and roster) • Each meeting should have a signature sheet. All staff should sign and date. Staff that did not attend the meeting still read the minutes do acknowledge they read them.
Out of the two previous quality improvement meetings, how many were conducted monthly and properly documented?	• Ask for documentation of last meeting (i.e. minutes and roster) • Each meeting should have a signature sheet. All staff should sign and date. Staff that did not attend the meeting still read the minutes do acknowledge they read them.
Out of the two previous quarterly ICE/HSA meetings, how many were conducted and properly documented?	• Ask for documentation of last meeting (i.e. minutes and roster). • Each meeting should have a signature sheet. All staff should sign and date. Staff that did not attend the meeting still read the minutes do acknowledge they read them
Of the past 2 Local Governing Body meeting, how many had discussions of infection prevention and control, occupational health, environmental health, safety and security, and preparedness documented in meeting minutes.	• Request to review governing body meeting minutes and review to determine if the discussions were documented in the meeting minutes.

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Personnel and Credentialing Files- Observation	
Evaluation Method:	**Review 12 personnel and credentialing files (**Request folders from HSA. Which records were audited? (name, discipline and type-CTR or Fed)

Items to Review	Comments
Of the personnel and credentialing files reviewed how many were PHS Officers?	• Keep a tally of the number of PHS officer files reviewed.
Of the personnel and credentialing files reviewed how many were federal civil service?	• Keep a tally of the number of federal civil service files reviewed.
Of the personnel and credentialing files reviewed how many were contractors?	• Keep a tally of the number of contractor files reviewed.
Of the privileged staff records reviewed, how many were Licensed Independent Practitioners (LIPs)?	• Keep a tally of the number of LIP files reviewed.
Does the facility have a process for tracking requirements electronically?	• Ask HSA/AHSA/FHPM about process.
If any files reviewed were LIPs, how many had a competency assessment or peer review?	• Peer Review completed per local policy ○ Clinical performance ○ Appropriate use of resources ○ Technical skills ○ Clinical judgement ○ Participation in and results of performance improvement activities
Of personnel and credentialing files reviewed, how many contained a current and signed Declaration of Health?" Note: Annual requirement.	• Review file for signed HAF. • Look under Section I: Privileges-Health Statement.
Of the personnel files reviewed, how many contained a signed statement of confidentiality (one-time statement signed by staff)?	• Look under Section I: Privileges-Miscellaneous-Statement of Confidentiality (one –time statement signed).
Of the personnel files reviewed, how many contained signed statement of risks and responsibility (one time)?	• Look under Section I: Privileges-Miscellaneous-Staff risk and responsibility.

Of the personnel files reviewed, how many contained a signed release of information form (one time)?	• Look under Section I: Privileges-Release of information.
Of the 12 credentialing files reviewed, how many contained current, valid and unrestricted license?	• Look under Section II: Education-License Contact IHSC credentialing program for verification if needed. • System maybe electronic starting FY2020.
Of those that are USPHS Officers how many had at least two years of evaluations (COERs)?"	• Look under Section III: Experience and Current Competency.
Of the credentialing files reviewed, how many had current National Provider Data Bank information (renewable every 2 years)?	• Look under Section II: Education-National Practitioner Data Bank Inquiry. • National practitioner data band current and renewed every 2 years.
Of the files reviewed, how many contain **current** HCP Basic Life Support or CPR with AED certification?	• Look under Section II: Education-Certifications-CPR Certification.
Of the credentialing files reviewed, how many had a copy of a curriculum vitae or a resume?	• Look under Section IV: Personal Information-CV and Resume.
Of the personnel files reviewed, how many contained a signed statement of acknowledgement of understanding of local, national, and residential standards (one time)?	• Look under section IV: Experience and Current Competency (Personal Information)-Miscellaneous-Facility Orientation Checklist.
Of personnel and credentialing files reviewed, how many contained a signed release of information form?	• A signed release of information form is a one-time statement signed by staff.

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Workforce (Employee) Health Files -Observation

Evaluation Method:	**Review 12 files if available** (Request folders from HSA. Which records were audited? (name, discipline and type-CTR or Fed)

Items to Review	Comments
How many employee health files were reviewed?	• Keep a tally on the number of files reviewed.
Are staff health files kept separate from other files (yes/No)?	• Check file for documentation.
Is access to staff records limited to the Facility Healthcare Program Analyst (formerly FHPM), HSA, AHSA, and AA?	• Check file for documentation.
Of the staff health files reviewed, how many had past year's TB documentation (PPD or CXR)?	• Check file for documentation.
Of the staff health files reviewed, how many files had Hepatitis B vaccination or declination form?	• Check file for documentation.
Of the staff health records reviewed, how many files had yearly Ishihara Color Blind test (only required of personnel completing CLIA waived lab testing)?	• Check file for documentation. • Only required of personnel completing CLIVA waived lab testing.
Of the staff health records reviewed, how many files had yearly respirator medical clearance?	• Check file for documentation.
Of the employee health records reviewed, how many files had documentation of yearly respirator fit test?	• Check file for documentation.
Of the employee health files reviewed, how many had emergency contacts?	• Check file for documentation.
Are staff injuries and illnesses documented on the workforce injury tool?	• Check tool for documentation. • Verify with PHSP if needed.

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Training-Observation		
Evaluation Method:	**Review 12 files if possible** (Request folders from training officer. Which records were audited? (name, discipline and type-CTR or Fed	
Items to Review	Comments	
Of the training folders reviewed, how many had documentation of completed mandatory ICE trainings?	• Are copies of the following documents available: ○ Privacy Training for SharePoint Collaboration Site Users ○ Prevention of Sexual Harassment ○ ICE Ethics Orientation ○ DHS No FEAR Act Training ○ Operations Security (OPSEC) Basic ○ Information Assurance Awareness Training (IAAT) ○ Emergency plans and procedures (Mass Casualty/Evacuation plan) ○ Emergency Medical Procedures and Response (Written/Practical exam) ○ First Aid and Medical Emergencies and Health Related Emergencies ○ Occupational Health and Workplace Safety ○ Occupational Exposure Plan ○ PPE and Biohazardous Waste Disposal and Blood Borne Pathogens ○ Tuberculosis Overview Training on SharePoint	
Of the training folders reviewed, how many had documentation of the IHSC Mandatory trainings?	• Check file for documentation	
Of the training folders reviewed, how many had documentation of BLS for healthcare providers or CPR and AED certification?	• Check file for documentation	
Of the training folders reviewed, how many had an HSD-500?	Check file for documentation	

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Schedules-Observation	
Evaluation Method:	**Review 3 months of schedules** (Request from HSA. Which schedules were audited? (dates) (If staff interview, who was interviewed? If possible, review both nursing and ancillary schedules)

Items to Review	Comments
How many schedules were reviewed	• Keep a tally on the number of schedules reviewed
Of the schedules reviewed, how many had a legend to explain codes?	• Look to for legend with schedules reviewed
Of the schedules reviewed, how many had staff assigned 40 HRS per week (20 hrs./scheduling period)?	• Review schedule for 40 hours a week per scheduling period
Of the schedules reviewed, how many had provider coverage on weekend/holidays (i.e. on call or on-site)?	• Review schedule
Of the schedules reviewed, how many had actual work hours reflected for non-traditional shifts?	• Traditional shifts are D, D12, E, N, and N12. If anyone works hours other than those, the Contract Coordinator and HSA should have a written approval from RHSA
Of the schedules reviewed, how many had signed approvals for non-traditional shifts?	• Review schedule and request info regarding approval for non-traditional shifts
Of the schedules reviewed, how many had a PDF copy each time a change was made to the schedule?	• Once schedule is posted, it is to be PDF'd. Every time a change is made, the change is made in red. Schedule is to be PDF'd and named the date the change was made.

Sick Call - Observation	
Evaluation Method:	**Observe 10 Sick Call encounters when possible** (Keep a tally the numbers of records were reviewed on-site? Was staff interviewed? Who was interviewed and title? Preferable to interview nurse that is usually assigned to MHU?)

Items to Review	Comments
Is sick call offered face-to-face daily?	• Observe a Sick Call encounters in Clinic to seen daily. • Observe sick call log and review eCW charting to see if sick calls were seen daily.
Does site have a daily sick call process established (designated daily sick call times, designated Sick Call Area and, team approach being implemented)?	• Interview staff (RNs, FHPM, NM, etc.) to determine the sick call process.
Is interpreter service offered when appropriate during a sick call process?	• Observe a Sick Call encounters in Clinic. • Observe if language services are being utilized when needed.
Did RN utilize nursing protocols/guidelines during sick call encounters?	• Observe a Sick Call encounter in Clinic. • Observe if RN referred to RN guidelines.
Is a guardian present for any minor (<18 years of age) sick call?	• Observe a Sick Call encounter in Clinic. • Observe if a minor has an accompanying guardian present during the exam.
Is there a sick call log used to document all encounters?	• Request sick call log. • Compare sick call encounters in the Clinic Visit Console (CVC) to the log to see if all encounters were documented.

Summary Page

Recommendations from Facility	
Topic	Recommendation
Identify the section and item number.	• List the recommendation. • NOTE TO REVIEWERS: Recommendations are suggestions reviewers make to the facility. They are usually based on best practices or the reviewers' experience. They do not have to be implemented if the facility does not believe it will improve their processes.

Summary	
Topic	Comments Summarize the recommendations and deliverables from all sections above

Deliverables			
Topic	Items	Due	Lead
Identify the section and item number.	Deliverables are items that must be addressed to bring the facility into compliance or for patient safety.	Depending on the severity of the issue, the due date is set.	Who will provide guidance if needed and will follow-up with the facility?

			It is preferable to name an individual.

Additional Comments (include Section and item number)

• Use this space if you ran out of space on any section above.

• The facility may have suggestions/recommendations that they would like the reviewers to take to senior leadership to consider.
• Also list Best Practices here. • Include the name of the POC in case follow up to implement across facilities is needed.

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H. Appendix 8: IHSA Uniformed Corrective Action Plan (UCAP) Form

ICE Health Service Corps (IHSC Facilities)

ICE Uniform Corrective Action Plan

Facility Name
Address (Street and Name)
City, State and Zip Code
County
Type of audit/inspection
Complete and Return to ICE HQ (RHSA) No Later Than:

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Facility Corrective Action Plan Assigned to
Date of Final Submission:

<u>Instructions for the Corrective Plan of Action Response</u>

Provide a detailed description of the corrective actions the facility implemented to address each of the findings identified in the recent review/inspection. Please ensure each corrective action addresses the finding to the fullest extent possible, and it incorporates the recommendations. In the event the facility cannot implement a finding or recommendation within the authorized timeline, please include an explanation in the “Corrective Plan of Action” column. The explanation should include a work around solution while pending final resolution, and an approximate completion date.

Exceptions to this timeline may be granted by MQMU via the IHSA Program Analyst for necessary construction and staffing requirements but will require an estimated completion date and temporary “work around” as part of the approved UCAP. Serious life and safety issues must be corrected immediately.

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ICE Uniform Corrective Action Plan **Facility Name (AOR):**			
Assessment, Findings, and Improvement Plan Level	**Recommendations**	**Corrective Plan of Action**	**Completion Date**
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