	County of Sacramento **Department of Health Services** **Division of Primary Health** **Policy and Procedure**	Policy Issuer (Unit/Program)	**JCH**
		Policy Number	**A06-1403**
		Effective Date	**07-05**
		Revision Date	**07-19**
Title: **Continuous Quality Improvement Program**		Functional Area: **Governance and Administration**	
Approved By: Pamela Gandy-Rosemond, MSN RN CCHP Health Administrator Approved By: Scarlett Ong, a BSN RN, Clinic Manager			

Policy:

The quality, effectiveness and consistency of services provided by Juvenile Correctional Health (JCH) shall be continuously evaluated through a quality management program consisting of quarterly medical peer review, regularly scheduled internal auditing; weekly monitoring of services; documented reporting of all findings; development and implementation of corrective action plans; and re-evaluation.

Procedures:

A. Responsibility:

1. The Program Manager shall be responsible for assuring that the Quality Management Program is implemented and maintained in accordance with the JCH Management Plan.

B. Confidentiality:

1. The Lead Physician or designee and Clinic Manager shall be responsible for insuring the confidentiality of all patient record information, the audit process, all findings and reports. All patient identifiers shall be deleted from audit worksheets, reports and committee minutes. Maintenance of and access to all quality review management documentation shall be under the authority of the JCH Program Manager. Confidentiality of the quality review process shall be included in all staff orientation and in-service training sessions on quality management review.

    a. All Acute Care hospital admissions are reviewed by the Program Manager and lead physician. All medical emergencies are discussed within 1 hour of event to determine appropriateness of response and critique the performance of all involved in responding to the emergency.

    b. All in custody deaths are reviewed by a multidisciplinary teams as described in Probation Youth Detention Policy on Death/Suicide within the institution (see attachment).

C. Program Components:

1. External Peer Review – The on-site Lead Physician and the Program Manager will coordinate with the local Medical Society to schedule an independent external peer review by a qualified medical practitioner at least annually. The review will focus on medical practice, assessing appropriateness of medical decision-making and overall quality of care using objective clinical criteria applied by an independent physician of similar training and experience.

    a. The on-site Lead Physician and Program Manager will coordinate with the Medical Society; to arrange for a physician from the community who does not provide medical services in Sacramento Probation Juvenile Detention Facilities to perform an independent medical peer review of detention facilities health services at least annually.

    b. Focused review topics and objective clinical criteria may be collaboratively identified and developed by the on-site Lead Physician, Program Manager and the independent reviewer.

    c. The independent reviewer will select charts for the random review.

    d. A written report of audit findings will be submitted to the Quality Management Committee (QMC) which will outline a plan for corrective action to include a date for re-audit.

    e. Copies of peer review reports will be kept as part of the facility's quality management program documentation.

    f. All deaths, significant complications, and other unexpected clinical events with potentially adverse clinical consequences are referred for peer review.

D. Quality Management Committee (QMC):

1. Quality Management meetings shall be scheduled quarterly by the Program Manager. Attendance at these meetings may include; Program Manager, Clinic Manager, Lead Physician, Psychiatrist, Pharmacist, Dentist, Supervising Registered Nurse and a representative from Behavioral Health Services and Probation. The Quality Assurance Committee (QAC) is a multi-disciplinary forum for addressing juvenile facilities health services delivery quality issues, which impact custody administration an operations as well as detention facility, public and mental health services. The committee shall be responsible for identifying inappropriateness, deficiencies and/or problems in health services delivery, developing a corrective action plan and scheduled follow up evaluation and reporting. The QMC meeting agenda shall include, but not be limited to: reports by mental health, public health, dental and pharmacy; review of the incidence of infectious disease cases; report of the Probation Department concerns; and reports of results of external and internal audits and weekly monitoring activities. All committee deliberations and findings shall be documented in the meeting minutes.

E. Internal Monitoring of Services:

1. The Program Manager shall monitor service provided by non-physician health services staff via visual observations program planning meetings with internal customers, audit tools and employee evaluations. Findings of such monitoring may be reported at staff meetings, if applicable. Deficiencies identified may be subject to corrective or disciplinary action as appropriate. Correctional Health Services-J consulting pharmacist shall conduct annual review of pharmacy storage and administration practices. All monitoring findings are documented; all deficiencies, corrective action and follow up evaluation is documented and kept on file by the program manager. Results of internal monitoring activities are reported at the quarterly Quality Management Committee (QMC) Meetings.

F. Internal Audits

1. Regularly scheduled audits of medical records to measure the rate of compliance with established performance criteria for targeted service functions/tasks, e.g., use of dental and alcohol-withdrawal standardized procedures, shall be conducted. Focused medical record audits shall be completed at a minimum quarterly, by JCH staff and the QMC. Other audit methods will include process audits of routine health services functions, such as medication administration, to measure compliance with established policy and procedure. Such audits may include observation of actual task performance as well as review of chart and other documentation, e.g., medication administration would include auditing of medication cards in addition to medication administration record, chart orders and progress notes. Audit type (i.e., structure, process or outcome), subjects and performance criteria shall be developed by the medical director, program manager or his/her designee and the QMC. Audit criteria shall be predicated on JCH policy and procedure; California jail and health services standards and/or regulations; California Medical Association accreditation standards; and, the community standard of care and practice. Topic selection shall include areas of health services delivery, which are at high risk for untoward occurrences and litigation; are highly utilized and/or are identified as problem or potential areas. Focused audit topics shall reflect the status and need of the health services program. All staff performing chart audits shall be oriented and trained in the audit process through in-service training conducted by the Clinic Manager or designee. Quarterly reviews of the audit process including documentation, of findings, follow up and corrective action plans shall be conducted. Results of such reviews shall be documented and reported to the Clinic Manager, and Medical Director. Findings of regularly scheduled audits shall be reported at QMC and staff meetings, deficiencies and plan for corrective action identified and re-audit scheduled at a time deemed appropriate. The QMC Committee shall define corrective action and schedule for re-audit.

References:
Title 15, Section 1403

NCCHC Y-A-06

Attachments:
Sacramento County Probation Department Policy and Procedure – Juvenile Hall Death/Suicide Within The Institution- Title XV 1341

Coroner – Sacramento County in-Custody- Death

Information required for Death-In-Custody Reporting

Contact:
N/A

SACRAMENTO COUNTY PROBATION DEPARTMENT
POLICY AND PROCEDURE – JUVENILE HALL

DEATH / SUICIDE WITHIN THE INSTITUTION – TITLE XV 1341
Reviewed 01/08/2014 Approved by C. Kagel

Discussion:

The saving of a life is the priority in any emergency situation. Should a detainee death occur, documentation, preservation of the scene, and notification of the proper authorities is imperative.

In the event such an event does occur; the emotional backlash which follows for detainees and staff can be traumatic. It is important that those post-traumatic issues are acknowledged and addressed.

GUIDELINE: Duties and Responsibilities

A. Staff Discovering A Suspected Detainee's Death Shall:
    1. Immediately, activate the security alarm and summon other staff for assistance.
    2. Intervene to safe life, by administering C.P.R./First Aid unless immediate intervention jeopardizes the safety of staff or other detainees.
    3. Summon internal medical assistance, if available.
    4. Call 911 for emergency assistance.
    5. Lock down other minors for a minimum period and secure the area.
    6. Notify supervisors or other units appropriate.
    7. PRESERVE THE SCENE: The highest ranking staff shall preserve the scene and direct other staff as the need arises. Once the immediate emergency is defused, the entire area shall be secured. No individual shall change, alter or move any object, item, clothing, furniture, etc., until cleared to do so by the scene manager.
        a. Immediately collect and secure all records, logbooks, room/hall check sheets, casework file, bed chart, etc.
        b. Take photographs of scene, if possible.
        c. Maintain a time/actions sequence log. Initiate as soon as possible. Identify person responsible for maintaining.
        d. Get written statements of all involved staff and witnesses prior to their leaving facility.

B. Notifications:
    1. Sheriff's Department: In the event a detainee's death occurs, the circumstances and conditions surrounding the death shall be investigated by the Sheriff's Department and the Coroner's Office per Section 27401 of the Government Code.

2. Chain-of-Command: Once a death has been discovered, the shift supervisor shall immediately notify the next available person in the established chain of command until the Chief Probation Officer has been advised of the incident. Haste is critical. Skip over those not available and notify later when they are available. (Note: IDENTIFY A MEDIA CONTACT PERSON IN THIS PROCESS)
3. Parents: Arrangements must be made to notify the parents of the minor. This contact should be face-to-face. If timely arrangements can be made, a Mental Health staff member should accompany Probation staff.
4. Other Notifications by Telephone: Once the Chief Probation Officer has been notified, the Chief Probation Officer, or designee, shall notify by phone the following:
    a. Coroner's Office
    b. Presiding Superior Court Judge
    c. Presiding Judge of the Juvenile Court
    d. County Administrative Officer
    e. Chairperson of Board of Supervisors
    f. Risk Management
    g. District Attorney
    h. State Board of Corrections
    i. California's Attorney General's Office
    j. Minor's assigned Deputy Probation Officer
    k. County Counsel's Office
    l. Juvenile Justice Commission
    m. County Mental Health Crisis Team

C. Required Written Reports:

1. California Department of Justice, Bureau of Criminal Statistics, Statistical Data Center, P.O. Box 903427, Sacramento, CA 94203-4270, in writing within 10 days. Refer to California Government Code Section 12525.
2. State Board of Corrections, in writing within ten days. Refer to Section 1341 of California Code of Regulations, title 15, Page 38.
3. Reports shall also be forwarded to the Attorney General of the State of California in writing within ten days. The reports shall consist of the following:
    a. A form letter for detainee's death reporting (see attached).
    b. All departments' and investigating departments' reports.
    c. Coroner's autopsy report.
4. Written notification needs to be made to the Board following telephone notification.

D. Post-Trauma Counseling (Postvention):

1. If a detainee's death occurs, obvious feelings of frustration, anxiety, and sadness will result. This is an important time for staff and other detainees to have available counseling so they can express their feelings and sentiments regarding the incident. If requested, the resources will be provided. Immediate defusing should take place, as soon as possible after the incident. It is suggested that the staff most closely involved with the incident be removed to another area of the institution.
2. The "wind down" period is very important for staff to collect their thoughts and critique the incident. It also lends itself to an organized and consistent process for beginning the cumbersome task of investigating the incident and compiling reports. Outside assistance may be available through:
    a. Employee Assistant Program
    b. County Mental Health Teams
    c. Suicide Prevention
    d. Private Sources
    e. Chaplain: May be very helpful in assisting with detainee counseling.
3. There will be a medical and operational review of every in-custody death of a minor.
4. The review team shall include the Chief Deputy and/or Assistant Chief Deputy of Juvenile Hall, the Juvenile Hall Supervisors, and the County Medical Director, the Juvenile Hall Physician and other health care and probation staff relevant to the incident.

Attachments:

Coroner – Sacramento County in-Custody- Death

Information required for Death-In-Custody Reporting

Coroner Sacramento County In-Custody Deaths

Subject:

The procedure for the investigation and processing of an In-Custody death in a Sacramento County adult or juvenile detention facility.

Authority:

Coroner's Office Operations

Policy

All decedents, who die after being booked into a Sacramento County adult or juvenile detention facility, will be transported to the San Joaquin County Coroner's Office where an autopsy will be performed.

All deaths that are not determined to be Natural or Homicide during the initial investigation will be classified, as a Rule-Out Homicide.

The results of the Sacramento County Coroner's investigation will be forwarded to the chief of Correctional Health Services, who will share this information with the appropriate medical, mental health, and custody representatives.

Procedure

A. Investigation

1. The Sacramento County Coroner's Office will conduct a thorough investigation of all in-custody deaths in a Sacramento County adult or juvenile detention facility.
2. Copies of other agency reports, detention file and medical records (from hospitals or detention infirmaries) will be obtained during the investigation.
3. During the initial investigation, the Deputy Coroner will document in the report if the Sheriff's Department of Probation Department wants major case prints after the autopsy is completed.
4. During the initial investigation, the Deputy Coroner will document in their report if investigative agency representatives will attend the autopsy that will be performed at the San Joaquin County Coroner's Office.

B. Body Processing

1. The body will be moved from the detention facility or local hospital to this Office.
2. The Deputy Coroner will verify the identity of the decedent with custody staff and will ensure that the hospital staff correctly tags decedents who die in local hospitals.
3. The body will remain in the body bag and the Deputy Coroner will seal the bag.
4. The morgue attendants will start a morgue log but treat the case as a Rule-Out Homicide.
5. When the body is returned to this office from the San Joaquin County Coroner's Office, morgue staff will process it according to the Health & Safety body processing protocol.
6. NOTE: Detainees who were referred to San Joaquin County Hospital and subsequently die while in custody will be transported by San Joaquin County directly to the San Joaquin County Coroner's Office. Once an autopsy is completed, the body will be transported back to the Sacramento County Coroner's Office for processing as specified in this policy and procedure.

C. Evidence

1. The investigating Deputy Coroner will ensure that any evidence, blood samples, or any other items that are to accompany the body have been properly packaged and secured to the outside of the body bag prior to transport to the San Joaquin County Coroner's Office.
2. The San Joaquin County Coroner will retain toxicology samples and radiology films; all other evidence will be returned to this office with the body.
3. Evidence Receipts: An evidence receipt is to be completed by the investigating Deputy Coroner listing the body and evidence to be transported to San Joaquin County.
4. The receipt should be submitted to the Morgue desk.
5. The J. Morris Company driver will sign the evidence receipt before transporting the body to the San Joaquin County Coroner's Office. The receipt will accompany the remains to the San Joaquin County Coroner's Office and be returned to this office with the remains, bearing the signature of anyone who handled the body or evidence.

D. Decedent Information

1. The following information shall be faxed by the Assistant Coroner for Morgue Operations to the San Joaquin County Coroner's Office (209-468-5094) prior to autopsy.
2. Coroner's Investigative Report.
3. The following information will be listed on an evidence receipt and submitted to the morgue desk for transport with the body.
4. Jail or Probation Jacket (detention file).
5. Medical Records.
6. Investigative Agency reports (if other than Sheriff)

E. Body Transport

1. The Assistant Coroner for Morgue Operations will notify San Joaquin County (209-468-4300) the first business day after the death and coordinate the transport of the body to San Joaquin County.
2. The J. Morris Company will deliver and pick-up from the San Joaquin County Coroner's Office between 0800 and 1600 hours, Monday through Friday.
3. The San Joaquin County Coroner's Office will advise this office when the autopsy has been completed and the Assistant Coroner for Morgue Operations will coordinate the transport of the decedent back to this office.

F. Toxicology

1. The San Joaquin County Coroner will use the Institute of Forensic Sciences Technology Laboratory, 2945 Webster Street, Oakland, CA 94609 (510-451-1060). The results will be forwarded to the San Joaquin County Coroner. San Joaquin will then forward the results to this Office.

G. Special Instruction

1. A special request for body processing, autopsy instructions, or disposition of remains should be made in advance and approved by the San Joaquin County Deputy Coroner or Coroner.