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NATIONAL COMMISSION
ON CORRECTIONAL HEALTH CARE

# Health Services Accreditation Update Report

## Green Hill School
## Chehalis, WA

## Survey Date: March 23, 2021

## Report Date: June 17, 2022

Green Hill School, WA
Update Report
June 17, 2022

The National Commission on Correctional Health Care is dedicated to improving the quality of correctional health services and helping correctional facilities provide effective and efficient care. NCCHC grew out of a program begun at the American Medical Association in the 1970s. The standards are NCCHC's recommended requirements for the proper management of a correctional health services delivery system. These standards have helped correctional facilities improve the health of their inmates and the communities to which they return, increase the efficiency of their health services delivery, strengthen their organizational effectiveness, and reduce their risk of adverse patient outcomes and legal judgments.

On May 6-7, 2021 NCCHC conducted its virtual review for continuing accreditation of the Green Hill School under the NCCHC *2015 Standards for Health Services in Juvenile Detention and Confinement Facilities*. On August 5, 2021, NCCHC placed the facility on **probation**, and directed that compliance be assessed via a focused on-site survey to occur before December 15, 2021; this survey occurred on March 23, 2022. This report focuses primarily on issues that required corrective action for compliance with the standards and is most effective when read in conjunction with NCCHC's August 5, 2021 report.

## Essential Standards

There are 43 essential standards, 40 are applicable to this facility and 40 (100%) were found to be in full compliance. One hundred percent (100%) of the applicable essential standards must be met for to achieve accreditation. ***The Green Hill School has now met this condition.***

Listed below are standards that were not compliant, partially compliant, or not applicable.

Standard number and name not compliant:
None

Standard number and name partially compliant:
None

Standard number and name not applicable:
Y-C-08 Health Care Liaison
Y-G-03 Infirmary Care
Y-G-09 Counseling and Care of the Pregnant and Postpartum Juvenile

## Important Standards

There are 27 important standards; 26 are applicable to this facility and 26 (100%) were found to be in compliance. Eighty-five percent or more of the applicable important standards must be met. **The Green Hill School has met this condition.**

Listed below are standards that were not compliant, partially compliant, or not applicable.

Standard number and name not compliant:
None

Standard number and name partially compliant:
None

Standard number and name not applicable:
Y-G-08 Contraception and Family Planning Services

Decision: On June 17, 2022, NCCHC's Accreditation and Standards Committee awarded the facility accreditation.

| Y-C-04 Health Training for Child Care Staff (E). | | | |
|---|---|---|---|
| | *The compliance indicator is:* | | |
| | **Fully Met** | **Partially Met** | **Not Met** |
| 1. Child Care Staff who work with juveniles receive health-related training at least every 2 years. This training includes, at a minimum: | | | |
| a. Administration of first aid | X | | |
| b. Recognizing the need for emergency care and intervention in life-threatening situations (e.g., seizure or altered consciousness, cardiac event) | X | | |
| c. Recognizing acute manifestations of certain chronic illnesses (e.g., asthma, seizures), intoxication and withdrawal, and adverse reactions to medications | X | | |
| d. Recognizing signs and symptoms of mental illness | X | | |
| e. Procedures for suicide prevention | X | | |
| f. Procedures for appropriate referral of juveniles with health complaints to health staff | X | | |
| g. Precautions and procedures with respect to infectious and communicable diseases | X | | |
| h. Cardiopulmonary resuscitation | X | | |
| 2. An outline of the training including course content and length is kept on file. | X | | |
| 3. A certificate or other evidence of attendance is kept on-site for each employee. | X | | |
| 4. Child care workers assigned to outside programs (e.g., Outward Bound programs, forestry camps, or routine outdoor recreations) are current on CPR, first-aid training, and prevention of heat-related illness). | X | | |
| 5. While it is expected that 100% of the child care staff who work with juveniles are trained in all of these areas, compliance with the standard requires that at least 85% of the staff present on each shift are current in their health-related training. | X | | |

| | | | |
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| 6. All aspects of the standard are addressed by written policy and defined procedures. | X | | |

Comments:

Training did not include intoxication and withdrawal, adverse reactions to medications or recognizing signs and symptoms of mental illness.

The following corrective action is required for Compliance Indicators #1c and d:

Acceptable documentation includes:

- An outline of the course(s) content in the topics specified in the standard and the length of the course(s)
- Certificates, rosters, or other evidence of attendance **on the missing topics** of at least 85% of child care staff who work with juveniles
- A plan for how all required topics will be included in the future

Focused Survey Results:

The training has been updated, with the syllabus now including information on intoxication and withdrawal, adverse reactions to medications, and recognizing signs and symptoms of mental illness. Training records showed the following data for the completion of such training on each shift: day shift – 94.9%, swing shift – 91%, grave shift - 95.5%, and 100% of on-call staff. **The standard is now met.**

| **Y-D-03 Clinic Space, Equipment, and Supplies (I).** | | | |
|---|---|---|---|
| | *The compliance indicator is:* | | |
| | **Fully Met** | **Partially Met** | **Not Met** |
| 1. Examination and treatment rooms for medical, dental, and mental health care are large enough to accommodate the necessary equipment, supplies, and fixtures, and to permit privacy during clinical encounters. | X | | |
| 2. Pharmaceuticals, medical supplies, and mobile emergency equipment are available and checked regularly. | X | | |
| 3. There is adequate office space with administrative files, secure storage of health records, and writing desks. | X | | |
| 4. Mental health services are provided in an area with private interview space for both the individual and group treatment, as well as desks, chairs, lockable file space, and relevant testing materials. | X | | |
| 5. When laboratory, radiological, or other ancillary services are provided on-site, the designated area is adequate to hold equipment and records. | X | | |
| 6. When patients are placed in a waiting area for more than a brief period, the waiting area has seats and access to drinking water and toilets. | X | | |

| | | | |
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| 7. At a minimum, daily inventories are maintained on items subject to abuse (e.g., syringes, needles, scissors, other sharp instruments). | X | | |
| 8. If treatment and examinations take place on-site (as opposed to a community medical setting), the facility has, at a minimum, the following equipment, supplies, and materials: | | | |
| a. Hand-washing facilities or alternate means of hand sanitization | X | | |
| b. Examination table | X | | |
| c. A light capable of providing direct illumination | X | | |
| d. Scale | X | | |
| e. Thermometers | X | | |
| f. Blood pressure monitoring equipment | X | | |
| g. Stethoscope | X | | |
| h. Ophthalmoscope | X | | |
| i. Otoscope | X | | |
| j. Transportation equipment (e.g., wheelchair, stretcher) | X | | |
| k. Trash containers for biohazardous materials and sharps | X | | |
| l. Equipment and supplies for pelvic examinations if the facility houses females | NA | | |
| m. Oxygen | X | | |
| n. Automated external defibrillator | X | | |
| 9. Basic equipment required for on-site dental examinations includes, at a minimum: | | | |
| a. Hand-washing facilities or alternate means of hand sanitization | X | | |
| b. Dental examination chair | X | | |
| c. Examination light | X | | |
| d. Sterilizer | X | | |
| e. Instruments | X | | |

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| f. Trash containers for biohazardous materials and sharps | X | | |
| g. A dentist's stool | X | | |
| 10. The presence of a dental operatory requires the addition of at least: | | | |
| a. An X-ray unit with developing capability | X | | |
| b. Blood pressure monitoring equipment | X | | |
| c. Oxygen | X | | |
| 11. All aspects of the standard are addressed by written policy and defined procedures. | X | | |

Comments:

The medical clinic only counts syringe needles and scalpels. They do not count phlebotomy needles or butterflys, medical instruments, scissors, or laceration trays. Dental instruments are not documented as counted. The dental department only considers the set-up tray instruments as necessary to count, but these are counted as a set-up, not individually, and the set-up tray instruments were loose, rather than bagged awaiting use. There were also discrepancies in the dental needle count. Emergency supplies are not regularly maintained (see Y-E-08 Emergency Services)

The following corrective action is required for Compliance Indicators #2 and #7:

Acceptable documentation includes a plan by the RHA on how this standard will be corrected, including

- any policy and procedure changes and staff training. The plan should outline:
- how staff will be trained to conduct inventories according to the frequency as designated in the policy and maintain all items subject to abuse (e.g., syringes, needles, scissors, other sharp instruments), including dental items, and how the RHA will ensure compliance; and (b) how emergency supplies will be regularly checked

Focused Survey Results:

We reviewed the updated policies and procedures pertaining to the daily inventorying of items subject to abuse and the regular checks of pharmaceuticals, medical supplies, and mobile emergency equipment. We completed some random checks of dental inventory and found all counts to be accurate and properly documented. We also confirmed staff training had been completed on the revised policy and procedure. **The standard is now met.**

| **Y-E-05 Mental Health Screening and Evaluation (E).** | | | |
|---|---|---|---|
| | *The compliance indicator is:* | | |
| | **Fully Met** | **Partially Met** | **Not Met** |
| 1. Within 14 days of admission to the correctional system, qualified mental health professionals or *mental health staff* conduct initial mental health screening. | X | | |
| 2. The initial mental health screening includes a structured interview with inquiries into: | | | |

| | | | |
|---|---|---|---|
| a. A history of: | | | |
| i. Psychiatric hospitalization and outpatient treatment | X | | |
| ii. Substance use hospitalization | X | | |
| iii. Detoxification and outpatient treatment | X | | |
| iv. Suicidal behavior, self-injurious behavior, or self-mutilation | X | | |
| *v. Violent behavior* | X | | |
| vi. Victimization, including physical and sexual abuse, bullying | X | | |
| vii. Special education placement | X | | |
| viii. Cerebral trauma or seizures | X | | |
| ix. Sex offenses | X | | |
| x. Exposure to traumatic life events and losses | X | | |
| xi. Recent stressors (conflict with family or others, breakup, unstable living conditions, death of friend or family) | X | | |
| b. The current status of: | | | |
| i. Psychotropic medications | X | | |
| ii. Suicidal ideation | X | | |
| iii. Drug or alcohol use | X | | |
| iv. Orientation to person, place, and time | X | | |
| c. Emotional response or adjustment to incarceration | X | | |
| d. A screening for *intellectual functioning* (i.e., mental retardation, developmental disability, learning disability) | X | | |
| 3. The patient's health record contains results of the initial screening. | X | | |
| 4. Juveniles who present with psychological distress are referred to *qualified mental health professionals* for further evaluation in a timely manner. | X | | |

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| 5. The health record contains results of the evaluation with documentation of referral and initiation of treatment when indicated. | X | | |
| 6. Patients who require acute mental health services beyond those available on-site are transferred to an appropriate facility. | X | | |
| 7. All aspects of the standard are addressed by written policy and defined procedures. | X | | |

Comments:

The initial mental health screening does not include all inquiries, as noted.

The following corrective action is required for Compliance Indicators #2aii and #2aiii:

Acceptable documentation includes

- a revised initial mental health screening form, to include the missing inquiries,
- with evidence of its implementation.

Focused Survey Results:

We reviewed the revised mental health screening form and confirmed history of substance use hospitalization and detoxification and outpatient treatment are now being asked and documented in the health records. We also reviewed several health records and found consistent use of the revised form. **The standard is now met.**

| **Y-E-08 Emergency Services (E).** | | | |
|---|---|---|---|
| | *The compliance indicator is:* | | |
| | **Fully Met** | **Partially Met** | **Not Met** |
| 1. A written plan includes arrangements for the following, which are carried out when necessary: | | | |
| a. Emergency transport of the patient from the facility | X | | |
| b. Use of an emergency medical vehicle | X | | |
| c. Use of one or more designated hospital emergency departments or other appropriate facilities | X | | |
| d. Emergency on-call physician, mental health, and dental services when the emergency health care facility is not nearby | X | | |
| e. Security procedures for the immediate transfer of patients for emergency medical care | X | | |
| f. Notification to the person legally responsible for the facility | X | | |
| 2. Emergency drugs, supplies, and medical equipment are regularly maintained. | X | | |

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| 3. All aspects of the standard are addressed by written policy and defined procedures. | X | | |
| Comments: | | | |
| Emergency supplies are not regularly maintained. | | | |
| The following corrective action is required for Compliance Indicator #2: | | | |
| Acceptable documentation includes<br>• a plan by the RHA on how this standard will be corrected. In addition,<br>• documentation of regular checks for emergency drugs, supplies and medical equipment should be submitted. | | | |
| Focused Survey Results: | | | |
| We reviewed the updated policies and procedures and training records pertaining to the regular monitoring of emergency supplies and confirmed compliance with the revised monitoring methods. **The standard is now met.** | | | |

| **Y-E-09 Segregated Juveniles (E).** | | | |
|---|---|---|---|
| | *The compliance indicator is:* | | |
| | **Fully Met** | **Partially Met** | **Not Met** |
| 1. Upon notification that an juvenile has been placed in segregation: | | | |
| a. A qualified health care professional reviews the juvenile's health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation. Such a review is documented in the health record. Contraindications or required accommodations should be immediately communicated to the responsible health authority (RHA) and custody leadership. | X | | |
| b. When health staff are not on duty, the health staff member on call is notified. | X | | |
| 2. When on duty, qualified health care professionals monitor segregated juveniles daily by performing health checks. | | | |
| a. The daily health monitoring may be done by either medical or mental health professionals | X | | |
| b. Mental health staff see juveniles on their active case load at least weekly | X | | |
| c. Child care workers or program staff monitor juveniles in segregation at least every 15 minutes | X | | |
| d. On days when health staff are not on-site, health-trained child care workers or program staff alert health staff on call if a health problem is noted | X | | |

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| 3. Prolonged segregation more than 2 to 5 hours is not used except under documented exceptional circumstances. | X | | |
| 4. In the rare instance that a segregated juvenile's out-of-control behavior lasts more than 24 hours, qualified health care professionals should: | | | |
| a. Evaluate for a medical or psychiatric condition or contraindication to continued isolation that warrants further evaluation and treatment | X | | |
| b. Generate a written plan for urgent mental health assessment by a qualified mental health professional and/or the use of alternatives to segregation (e.g., return to living units under supervision use of medications, transfer to a mental health facility) | X | | |
| 5. Documentation of the segregation rounds is made on individual logs or room cards, or in the juvenile's health record, and includes: | | | |
| a. The date and time of the contact | X | | |
| b. The signature or initials of the health staff member making the rounds | X | | |
| c. A note as to whether findings were documented in the juvenile's health record | X | | |
| 6. Any significant health findings are documented in the juvenile's health record. | X | | |
| 7. A monthly report of the use of segregation is given to the RHA and facility administrator. This report should include information about the number of juveniles in segregation during the month, the number of days spent in segregation, and the health status of segregated juveniles. | X | | |
| 8. All aspects of the standard are addressed by written policy and defined procedures | X | | |
| Comments: | | | |
| There is no health records documentation that the qualified health care professional reviews it for possible medical, dental, or mental health needs that contraindicate the placement or require accommodation. We could not confirm that daily health monitoring was completed, nor was there evidence of a monthly report regarding the use of segregation for the RHA and facility administrator. | | | |
| The following corrective action is required for Compliance Indicators #1 and #7: | | | |
| Acceptable documentation includes a plan by the RHA on how this standard will be corrected, | | | |

including

- evidence of staff training and policy and procedure changes, and
- copies of the monthly report that contains all required elements for at least two months, with evidence that the report is provided to the RHA and facility administrator.

Focused Survey Results:

NCCHC defines segregation as those juveniles who are isolated from the general population and who receive services and activities apart from other juveniles. Following discussion on this topic and a review of records, it was determined individuals are not segregated at this facility. Short instances of room confinement (in the juveniles assigned room) may be used; however, those situations last for very short periods of time. Reports of room confinement situations may be queried in the facility's management system (ACT) for members of leadership to access at any time. Health center staff are notified when a juvenile is placed into these instances of room confinement and the staff then conduct a health record review for any contraindicators and notify custodial staff in the event any contraindicators. If no health center staff are on duty at the time of such placement, custodial staff contact the facility on-call health center member, which may be a provider, a nurse or the RHA, based on the on-call schedule at the time. Counseling staff are also assigned to each housing unit, so they are aware of these instances as well.

We confirmed staff had been notified on the revised policy and procedure to clearly document procedures for the health staff notifications and duties, as well as monthly report distribution.

Our review of health records showed progress notes in several randomly chosen health records, annotating such health staff member review.

An in-depth review of facility's generated monthly "Room Confinement, Isolation, and Restraints – Completion" reports for June 1, 2021 – January 31, 2022, showed individuals are confined to their room on average 2 hours and 22 minutes. Specifically, results for each month showed an average duration of room confinement as follows: June 2021 = 0:03:25; July 2021 = 0:02:45; August = 0:02:45; September = 0:01:47; October = 0:01:26; November = 0:02:40; December = 0:01:48; January = 0:02:33. **The standard is now met.**

| **Y-G-01 Chronic Disease Services (E).** | | | |
|---|---|---|---|
| | *The compliance indicator is:* | | |
| | **Fully Met** | **Partially Met** | **Not Met** |
| 1. The responsible physician establishes and annually approves clinical protocols consistent with *national clinical practice guidelines.* These clinical protocols for the management of chronic diseases include, but are not limited to, the following: | | | |
| a. Asthma | X | | |
| b. Attention-deficit/hyperactivity disorder | X | | |
| c. Diabetes | X | | |
| d. HIV | X | | |
| e. Hypertension | X | | |

| | | | |
|---|---|---|---|
| f. Seizure disorder | X | | |
| g. Sickle cell disease | X | | |
| h. Major mental illness | X | | |
| i. Tuberculosis disease or infection | X | | |
| 2. Documentation in the health record confirms that clinicians are following chronic disease protocols by: | | | |
| a. Determining the frequency of follow-up for medical evaluation based on disease control | X | | |
| b. Monitoring the patient's condition (e.g., poor, fair, good) and status (e.g., stable, improving, deteriorating) and taking appropriate action to improve patient outcome | X | | |
| c. Indicating the type and frequency of diagnostic testing and therapeutic regimens (e.g., diet, exercise, medication) | X | | |
| d. Writing appropriate instructions for diet, exercise, adaptation to the correctional environment, and medication | X | | |
| e. Clinically justifying any deviation from the protocol | X | | |
| 3. The responsible physician implements a system to ensure continuity of medications for chronic diseases. | X | | |
| 4. Chronic illnesses are listed on the master problem list. | X | | |
| 5. The facility maintains a list of chronic care patients. | X | | |
| 6. All aspects of the standard are addressed by written policy and defined procedures. | X | | |

Comments:

There was no evidence in the health record review that the patient's condition and status were recorded at visits, or frequency of follow-ups based on disease control were documented.

The following corrective action is required for Compliance Indicators #2a and b:

The following is acceptable documentation for compliance:

- results of a CQI process study that assesses clinicians' compliance in following chronic disease protocols. The CQI study should also include a sufficient number of charts to demonstrate compliance with the standard.

Focused Survey Results:

CQI studies of charts of all juveniles with a chronic illness showed improved compliance from 70% in October 2021 to 100% in November, 92% in December 2021, 95% in January 2022 and 100% in February 2022. A random chart review of juveniles being treated for chronic diseases showed consistent evidence the frequency for follow-up for medical evaluation based on

disease control being documented in the health records. Chart reviews also showed consistent documentation of the patient's condition and appropriate treatment plans/actions to improve patient outcomes. **The standard is now met.**

| **Y-G-05 Suicide Prevention Program (E).** | | | |
|---|---|---|---|
| | *The compliance indicator is:* | | |
| | **Fully Met** | **Partially Met** | **Not Met** |
| 1. A suicide prevention program includes the following: | | | |
| a. Facility staff identify suicidal juveniles and immediately initiate precautions | X | | |
| b. Suicidal juveniles are evaluated promptly by the designated health professional, who directs the intervention and ensures follow-up as needed | X | | |
| c. Acutely suicidal juveniles are placed on constant observation | X | | |
| d. *Non-acutely suicidal* juveniles are monitored on an unpredictable schedule with no more than 15 minutes between two checks. If, however, the non-acutely suicidal juvenile is placed in isolation, constant monitoring and observation is required. | X | | |
| 2. Key components of a suicide prevention program include the following: | | | |
| a. Training | X | | |
| b. Identification | X | | |
| c. Referral | X | | |
| d. Evaluation | X | | |
| e. Treatment | X | | |
| f. Housing and monitoring | X | | |
| g. Communication | X | | |
| h. Intervention | X | | |
| i. Notification | X | | |
| j. Review | X | | |

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|---|---|---|---|
| k. Debriefing | X | | |
| 3. The use of other juveniles in any way (e.g., companions, suicide-prevention aides) is not a substitute for staff supervision. | X | | |
| 4. Treatment plans addressing suicidal ideation and its reoccurrence are developed, and patient follow-up occurs as clinically indicated. | X | | |
| 5. The responsible health authority approved the suicide prevention plan; training curriculum for staff, including intake screening for suicide potential and referral protocols; and training for staff conducting the suicide screening at intake. | X | | |
| 6. All aspects of the standard are addressed by written policy and defined procedures. | X | | |

Comments:

There are four levels of suicide watch. There are no treatment plans developed for juveniles placed on suicide watch. Suicide watches are done as either one-to-one or on a staggered 10–15-minute watch, although some logs showed the watches were not staggered, but completed every 15 minutes. The designated suicide prevention specialist (DSPS, a facility assistant superintendent trained by the state to determine suicidality based on suicide screening) places a juvenile on watch and removes them. There is no evidence that the mental health associate is involved in releasing or lowering the suicide prevention status of juveniles.

The following corrective action is required for Compliance Indicator #1b and d, and #4

For Compliance Indicator #1b, the RHA should

- Submit a plan to ensure suicidal juveniles are evaluated promptly by the designated mental health professional, who will direct additional interventions and ensure follow-up as needed.
- Submit updated policies and procedures that illustrate designated mental health professionals are involved when patients are put on suicide watch

For Compliance Indicator #1d, the RHA should submit

- a plan addressing how non-acutely suicidal juveniles will be monitored on an unpredictable schedule with intervals not exceeding 15 minutes,
- including necessary changes in policy and training of staff. In addition,
- the results of a 60-day CQI study assessing the monitoring of non-acutely suicidal juveniles in accordance with the standard should also be submitted.
-

For Compliance Indicator #4, the RHA should submit

- a plan by the RHA on how this standard will be corrected, including any policy and procedure changes and staff training. In addition,
- a CQI study on the documentation of treatment plans addressing suicidal ideation and its reoccurrence should be submitted.

Focused Survey Results:

We verified that policies and procedures were revised, and training was completed to ensure all involved staff were aware of the new information. CQI studies were completed to address the compliance indicators cited, with results shared for December 2021, January, and February 2022. The results of these studies were as follows: December = 71% compliant; January =

82% compliant; February = 90% compliant. Improvement in conducting staggered checks was evident, and the 90% threshold identified/set by the facility was met with the February study; however, the facility will continue to monitor these items for sustained success, reporting inconsistencies to program managers for any corrections noted. **The standard is now met.**

| **Y-I-04 Informed Consent and Right to Refuse (I).** | | | |
|---|---|---|---|
| | *The compliance indicator is:* | | |
| | **Fully Met** | **Partially Met** | **Not Met** |
| 1. The policy and procedures specify circumstances under which risks and benefits of an intervention are explained to the patient. | X | | |
| 2. The informed consent of next of kin, guardian, or legal custodian applies when required by law. | X | | |
| 3. For invasive procedures or any treatment where there is risk and benefit to the patient, informed consent is documented on a written form containing the signatures of the patient legal guardian is required, and health staff witness. | X | | |
| 4. Any health evaluation and treatment refusal is documented and must include the following: | | | |
| a. Description of the nature of the service being refused | X | | |
| b. Evidence that the juvenile has been made aware of any adverse consequences to health that may occur as a result of the refusal | X | | |
| c. The signature of the patient | X | | |
| d. The signature of a health staff witness | X | | |
| 5. There is evidence of involvement of the legal guardian in cases of refusal when required by the laws jurisdiction. | X | | |
| 6. In the event the patient does not sign the refusal form, it is to be noted on the form by the health staff witness. | X | | |
| 7. All aspects of the standard are addressed by written policy and defined procedures. | X | | |
| Comments: | | | |
| A general informed consent is done on admission. There was no evidence of refusals noted during the chart review. | | | |
| The following corrective action is required for Compliance Indicators #4 and 6: | | | |
| Acceptable documentation includes<br>• a plan by the RHA on how this standard will be corrected, including<br>• any policy and procedure changes and staff training. | | | |

| Focused Survey Results: |
| --- |
| We reviewed revised policy and procedures and confirmed staff training had taken place. A random chart review of health records also confirmed consistency in compliance with the proper documentation of any health evaluation or treatment refusals, including evidence of instances in which the juvenile refused to sign, and a second witness was called to sign the refusal form accordingly. **The standard is now met.** |