U.S. Department of Justice
Federal Bureau of Prisons

Program Statement

OPI: HSD/OQM
NUMBER: P6013.01
DATE: 1/15/2005
SUBJECT: Health Services Quality Improvement

1. **PURPOSE AND SCOPE.** To establish an outcome based Quality Improvement(QI) system in the health care programs at Bureau institutions. Quality improvement is a tool Health Service Units use to measure effectiveness of health care delivery processes to:

- Evaluate and improve health care delivery systems and clinical outcomes,
- Identify and reduce errors, and
- Improve overall staff and patient safety.

Quality improvement activities are most effective when they are planned, systematic, and when all appropriate disciplines and staff work collaboratively to implement them.

This Program Statement establishes requirements for Quality Improvement Plans at every Bureau institution, and introduces **Plan, Do, Check, and Act (PDCA)** as the accepted quality improvement methodology. Each institution has unique issues when identifying specific areas of systemic health care quality that require oversight and improvement. This Program Statement outlines the following major components of quality improvement to be used at Bureau institutions:

a. A written Quality Improvement Plan with outcome based measures consistent with evidence based guidance provided by the Medical Director;

b. Patient Rights and Patient Service Surveys;

c. Risk and Error Management and Sentinel Events, including undesirable patterns or trends of systemic processes or outcomes;

d. Medication usage including assessing the appropriateness and effectiveness of pain management, and the safe use of medications;

e. Quality control where indicated such as radiology retakes, controls on devices such as glucometers;

f. Infection control surveillance;

g. Utilization Review;

h. Mortality Review; and

i. Primary source credential verification and clinical privileges. (Refer to Program Statement Credentialing, Privileging, and Practice Agreements)

Monitoring the processes related to delivery of health care is critical to evaluate adverse patient outcomes or identify problematic aspects of a health care delivery process. In order to improve outcomes and reduce risks, these processes will be monitored continuously, rather than waiting for the end result, or an adverse outcome, to determine how the deficiency occurred.

2. **PROGRAM OBJECTIVES.** The expected results of this program are:

a. Methods will be established for institutions to participate in an "Outcome Based" quality improvement system in which critical aspects of patient care processes and patient outcomes are measured, results are analyzed and improvements, when necessary, are made.

b. The effectiveness of identified outcomes related to specific evidence based guidance issued by the Medical Director will be measured at each institution and reported to the Office of Quality Management, Health Services Division.

c. To revise mortality review procedures to reflect a change in reporting requirements of 30 days for the Comprehensive Mortality Review process.

3. **DIRECTIVES REFERENCED**

P5553.06	Escapes/Deaths Notification (8/23/99)
P6027.01	Credentialing/Privileging/Practice Agreements for Health Care Providers (1/15/05)
P6031.01	Patient Care (1/15/05)
P6190.02	Infectious Disease Management (10/3/95)
P6360.01	Pharmacy Services (1/15/05)

4. **STANDARDS REFERENCED**

a. American Correctional Association 4th Edition Standards for Adult Correctional Institutions: 4-4344, 4-4384**(M)**, 4-4408, 4-4410, 4-4422, 4-4423, and 4-4425

b. American Correctional Association 3rd Edition Standards for Adult Local Detention Facilities: 3-ALDF-4E-03, 3-ALDF-4E-06, and 3-ALDF-4E-45

5. **QUALITY IMPROVEMENT (QI) METHODOLOGY.** In the institution Health Services Unit (HSU), a variety of professionals and support staff participate in processes that support various health care functions, which result in health care outcomes. Health care outcomes in a correctional environment can be impacted by many disciplines working together as a team. Consequently, an effective QI program should be a multi-disciplinary effort and involve representatives from other institution disciplines.

Each Health Services Administrator (HSA) will develop a written plan for QI based on the health care mission and scope of services provided at the institution. The **"PDCA" (Plan, Do, Check, Act)** method of QI is the methodology Bureau institutions are to use. The Quality Improvement Plan is a written plan, approved by the institution Health Services Governing Body (GB), and subject to Union review and/or negotiation.

The Governing Body will also assist the HSU in establishing priorities for processes or outcomes to be measured. Documented compliance with the plan must be maintained in the HSU and reviewed and renewed annually.

The elements of **PDCA** are:

- **Plan.** Planning health care delivery, and a system to evaluate its effectiveness, requires not only the involvement of institution health care staff, but also other disciplines as well, institution leadership, and community health care providers.

- **Do.** Do or deliver the planned services. While delivering services also measure those functions or processes identified as high risk, high volume, or problem prone. Health care processes are measured against the following dimensions:

(1) Doing the right thing (the efficacy and appropriateness of the care or treatment provided).

(2) Doing the right thing well (the availability, timeliness, effectiveness and continuity of services provided).

(3) The safety and efficiency with which services are provided.

- **Check.** When evaluating the results of what is done, or measuring quality, staff should check against previously measured results at their institution, or compare results against other comparable services measured at similar institutions. Staff may also elect to compare similar measures with community organizations.

  The Office of Quality Management (OQM), HSD, will provide comparative data to field institutions regarding evidence based outcome measures. Assessment is required when analysis detects an undesirable variation in outcomes, in adverse drug reactions, and all other significant health care errors, including medication errors.

- **Act.** Based on results of the Quality Improvement Program, institution staff will recommend improvement action to the institution Governing Body, i.e.; additional training, education, etc. The Governing Body will assess the QI program's effectiveness annually.

The QI Plan will include, at a minimum, details on the following:

- Patient Rights and Organizational Ethics and details on how the inmates will be provided these rights;
- Risk Management;
- Utilization Review;
- A system to identify and evaluate potential Sentinel Events;
- Medication usage including drug utilization reviews, and medication errors;
- Infection control surveillance such as the intake and annual TB screening program, and nosocomial infections; and

- Establishment of measures that focus simultaneously on processes and outcomes that:

  (1) measure outcomes associated with evidence based guidance issued by the Medical Director;

  (2) measures those processes identified by the institution as high-risk; high-volume, or problem prone processes;

  (3) measures the needs and expectations of patients and staff;

  (4) measures effectiveness of infection control activities;

  (5) measures safety and trends of medication usage; and

  (6) measures the safety of the environment of care.

Measures must clearly identify the process being reviewed and will also include both a numerator and denominator statement, which defines the group of patients and what is to be measured, or the desired outcome.

Example: Outcome measured - **Management of Diabetes**, a current HgbA1c Level of 8% or less in diabetes patients managed on oral medication or insulin.

Numerator: Diabetic patients with HgbA1c level <8%
Denominator: Total number of diabetic patients with HgbA1c level evaluated this reporting period

Example: Outcome measured - **Control of Hypertension**, a current blood pressure of 140/90, or less, on patients prescribed medication for the diagnosis of hypertension.

Numerator: Medicated patients with current BP reading <140/90
Denominator: Medicated patients evaluated this reporting period

The HSA will appoint a committee to systematically assess the QI at that institution. This committee should be inter-disciplinary and include health care staff and staff from other departments and will meet at least quarterly.

(1) If the committee includes bargaining unit employees, their membership and duties are subject to negotiation with the union.

(2) It is recommended that institutions consider assigning QI duties to a specific employee, under the Quality Improvement/Infectious Disease Coordinator Position Description which may be found on BOPDOCS.

The committee will document all quality improvement initiatives and may use the PDCA format provided (Attachment A). Discussion of QI activities, and an overall assessment of effectiveness of QI activities must be documented in GB meeting minutes (see Section 8).

Institutions should refer to, and comply with, current standards from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for Quality Improvement, applicable to the type of accredited health care program for that institution.

The Health Services Division will provide periodic reports to the field on systemic patterns and trends of outcomes based on institution participation in the national measures.

6. **PATIENTS' RIGHTS AND RESPONSIBILITIES.** Each HSU will inform all inmates of their rights and responsibilities to health care in the institution. The rights and responsibilities are to be based on the scope of services provided at the institution, but they must contain the basic rights and responsibilities as outlined in Attachment B.

The institution may add rights and responsibilities specific to each institution, such as triage/sick call procedures, call out procedures, etc.

Patient rights and responsibilities are to be discussed during the Admissions and Orientation (A&O) process and must be included in the institution's A&O book. A copy will be posted in the clinical area. Rights and Responsibilities will be translated into foreign languages spoken by a significant number of inmates at the institution (Attachment B).

7. **PATIENT SERVICE SURVEYS.** Each HSU will develop surveys to assess patient perception of the health services provided. These are to be completed at least annually and must represent a random sample of the patient population. The survey results should be used to evaluate various health care delivery processes or patient outcomes, and are to be included in the minutes of local Governing Body meetings.

8. **HEALTH SERVICES GOVERNING BODY.** To augment the authority of the Assistant Director, Health Services Division, and the authority of the Medical Director, a National Health Services Governing Body has been established, including these members:

a. Assistant Director, Health Services Division, Chair;
b. Medical Director;
c. Assistant Director, General Counsel and Review;
d. Assistant Director, Human Resource Management;
e. Assistant Director, Correctional Programs;
f. Assistant Director, Administration Division;
g. All Regional Directors;
h. All Medical Referral Center (MRC) Wardens; and
i. Wardens representing two non-MRC institutions.

The Bureau's Governing Body, which meets at least annually re-delegates the daily operation and decision-making authority, regarding institution health care programs to the institution.

At the institution level, the Warden is the representative to the National Health Services Governing Body. The institution Governing Body, at a minimum, consists of the Warden, Associate Warden, Clinical Director (CD), and HSA (or designees). The union will be a member of the institution Governing Body. When issues are discussed which may lead to discipline of staff or may prompt an investigation into staff members, or are similarly sensitive, these discussions will take place without the union present. The Warden may appoint additional members to the local Governing Body.

The local Governing Body will meet at least quarterly but meetings may occur more frequently if deemed necessary. Among the topics to be discussed at these meetings are:

- Appointments/Privileging/Practice Agreements of staff;
- Biomedical ethics;
- Quality improvement activities, including an assessment of the plan;
- Risk management issues;
- Potential or actual sentinel events; and
- Other pertinent health services issues.

9. **SENTINEL EVENTS AND ROOT CAUSE ANALYSIS.** A sentinel event is defined as an unexpected occurrence involving death, serious physical injury (loss of limb or function), psychological injury, or risk thereof, that are associated with the health care provided to a patient in a Bureau institution.

The HSA will establish a system of review for any suspected sentinel event. The system will include a review of the event and completion of a Root Cause Analysis of Suspect Sentinel Event (Attachment C) **within 45 days** of its occurrence. The Root Cause Analysis is a report that focuses on process and system failures that may have contributed to the sentinel event.

- This review is a means to evaluate health care delivery by identifying its significant strengths and weaknesses.

Action steps, based upon the review, will promote and expand strengths and correct deficiencies. The Root Cause Analysis will be forwarded to the Medical Director through the appropriate Regional Director's office.

This report will contain the following:

- Patient name and register number;
- Description of the event or adverse outcome;
- What processes were involved? If there was a process failure, why;
- What human factors were relevant to the outcome;
- Did equipment performance effect the outcome;
- Where any other environmental factors relevant to the outcome? If so, why;
- Did any other factors influence the outcome;
- Identify any risk points and potential contribution to this event;
- Determine what potential improvements would tend to decrease the likelihood of such events in the future;
- Provide details of plan to address identified opportunities for improvement;
- When and who will implement improvements; and
- How will effectiveness of improvements be evaluated.

a. **Reportable Sentinel Events.** Examples of sentinel events include:

(1) Suicide and/or homicide of a patient in a setting where the patient receives around-the-clock supervision (suicide watch or medical observation patients in non-MRC, inpatients in MRC, or the death of an inmate in correctional, behavioral health or medical restraints, in any setting);

(2) Surgery on the wrong body part or patient;

(3) Any patient death, paralysis, coma, or other major loss of function associated with a medication error, or other medical care delivery error; or

(4) A fall, or other accident involving a patient that results in death or major permanent loss of function as a direct result of injuries sustained in the fall. Patients in this category are usually in-patients or can be outpatients with identified disorders such as epilepsy, neurologic disorders, etc.

b. **Non-Reportable Sentinel Events.** The following are examples of events that present risks that should be evaluated and are considered **non-reportable** as sentinel events:

(1) Any sentinel event not related to the provision of patient care;

(2) Medication errors that **do not** result in death or major loss of function;

(3) Suicides **other** than in around-the-clock supervision settings (general population);

(4) Suicide attempts;

(5) A death that is attributed to the natural course of a patient's illness or underlying condition that has been under treatment.

Only the Medical Director has the authority to determine whether JCAHO will be notified that a sentinel event has occurred in any Bureau institution.

Institutions will only report a sentinel event to the Medical Director.

Institutions should also consider completing the Root Cause Analysis for incidents that are considered to be a near miss. A near miss is defined as a process variation which does not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

c. **Focus Review.** Should the Medical Director determine that the Sentinel Event warrants further review, an external focus review may be authorized.

- Refer to PS Credentialing/Privileging/Practice Agreements of Health Care Providers Section 9, 3., a-h.

10. **RISK MANAGEMENT, ERROR REDUCTION, AND PATIENT SAFETY PROGRAM.** Each HSU will develop a plan to identify risks, and minimize medical errors. When incidents or errors occur, the HSA will conduct a coordinated review to:

- identify causes;
- prevent repetition; and
- minimize the financial impact of any litigation.

Both concurrent and retrospective review systems must be used when conducting risk/error management.

An error is the failure of a planned action to be completed as intended, or the use of the wrong plan or treatment to achieve the intended health care outcome.

a. The objectives of the Risk Management/Error Program are to:

(1) Measure the frequency and severity of identified problems/hazards/errors;

(2) Minimize or eliminate risk factors;

(3) Decrease the frequency and severity of preventable errors that may result in adverse outcomes, or injuries to patients, staff, and visitors;

(4) Develop and implement methods to eliminate preventable dangers;

(5) Develop and implement appropriate educational and training programs; and

(6) Maintain current data related to health care errors.

b. The Health Services Division will provide information and periodic reports to institutions on risk management issues and errors that occur in the Bureau that may be pertinent to health care operations at all Bureau institutions.

11. **MORTALITY REVIEW.** To establish a multilevel system of reporting and reviewing **every** inmate death (by natural cause, suicide, homicide, or accidental). Mortality reviews constitute a means of:

- Evaluating the health care delivery system;
- Identifying its significant strengths and weaknesses; and
- Taking corrective action where necessary.

Each inmate death (except those legally authorized by execution) requires a systematic review at the institution and Central Office level. The reviews must use a death report packet consisting of standard elements including the Mortality Review form on BOPDOCS (BP-S563.044).

a. **24-hour Death Notice.** Within 24 hours of an inmate's death, or the next duty day, if the death occurs on a weekend or holiday, the CD is to send a GroupWise message to the Medical Director's attention with the following information:

- Name, age, and register number of inmate;
- Date and preliminary cause of death;
- Place of death;
- Brief clinical synopsis of events leading to death (including staff response);
- Past medical history; and
- Whether an autopsy will be performed.

If the death occurred in the community hospital, length of hospitalization or emergency care provided must be included. A 24-hour report is required to report all legally ordered executions (see Attachment D).

The 24 hour death notification also applies to inmates who die while in the custody of a contract or secure private correctional institution and those in Community Correction Centers (CCC). Submitting these 24 hour reports is the responsibility of the contract facility's management, or the appropriate Community Corrections Manager.

- The message is to be routed to BOP MED SVC and BOP HSD OQM, with a copy to the Regional HSA, and the appropriate Clinical Consultant.

- CCC deaths will also be reported to the appropriate Unit Manager at the deceased inmate's designated institution.

b. **Mortality Review Committee.** Each institution is to establish a Mortality Review Committee made-up of various members depending upon the institution's mission. For MRCs, the Mortality Review Committee must consist of:

- The CD;
- A staff physician;
- The institution Quality Improvement Coordinator;
- The HSA;
- The Director of Nursing; and
- Any other staff the CD deems appropriate.

For non-medical institutions, the Mortality Review Committee will include:

- The CD;
- The HSA;
- An MLP; and
- The appropriate Associate Warden.

Other staff may participate if deemed necessary. The CD is to serve as chairperson.

If an inmate has any mental health problems, the Psychology Department is to be included in the mortality review and appropriate mental health information must be included in the mortality review report.

Where possible, Mortality Review Committee members should not have been involved in the inmate's treatment. Deaths by legal execution do not require the Mortality Review Committee's review or completion of the Multi-Level Mortality Review Report (BP-S563), only 24-hour notification of death is required.

The Mortality Review Committee will:

(1) Review the report packet, the health record, and interview staff to obtain all the facts of the case;

(2) Analyze the complete report, identifying for individuals and systems their respective strengths and weaknesses for the clinical care immediately surrounding the death, and the quality of care for at least six months preceding the death; and

(3) Evaluate both individual and system performance immediately proximate to the death, specifically:

- Alert and response times;
- Communications;
- Transportation;
- Clinical skills (especially the use of CPR or other appropriate protocols);

- Equipment, supplies, and pharmaceuticals; and
- Documentation, especially in the health record. In discussing this factor, the MRC will clearly distinguish, if possible, lack of documentation from failure to provide care.

(4) Evaluate individual and system performance in the days or months preceding the death, specifically;

- Documentation;
- Working vs. final diagnosis;
- Appropriateness and timeliness of diagnostics and treatment regimens; and
- Complicating factors, either human or system, in the overall care that may have affected the outcome.

The MRC will document, by summary report, the discussion of these factors, as well as any others deemed appropriate. Highlighting positive aspects of the case is as important as detailing deficiencies. The report will conclude with recommendations for commendations or corrective action.

c. **Multi-Level Mortality Review Report (BP-S563).** The Mortality Review Committee will complete the Mortality Review Report in its entirety, and send it, accompanied by the original health record, to the Central Office, OQM **within 30 days.** Only a copy of the Mortality Review Report is to be sent to the appropriate Regional Director.

The Mortality Review Report will contain, at least, the following:

(1) A comprehensive clinical summary of the case, including a history, diagnosis, current treatment plan, sequence of events leading to death, and the cause of death;

(2) A summary of activities by institution staff, including who responded, how quickly, and what they did. This should also report any significant events or activities that accompanied the death, including the activities of other staff from the institution and the community;

(3) Designator and CCM's reports;

(4) Autopsy report, toxicology report, and death certificate (if pending receipt of these reports, send as soon as possible);

(5) If the inmate was admitted to a community hospital, the attending physician's report and other pertinent information. If the discharge/death summary is not available in a timely manner, the CD's narrative summary will relate any information obtained verbally from the attending community physicians and health care staff;

(6) Unless circumstances strongly indicate otherwise, staff names should not be used in the report, titles should be substituted;

(7) If Psychology Services was following the case, pertinent case records will be included when forwarding the file to the Central Office including the full Psychological Reconstruction of Suicides; and

(8) The reports, documentation, and summaries will be designated confidential. Only staff with a need to know will see the contents.

The Warden will review and sign the Mortality Review Report. Although the Warden may comment on the report, it will be forwarded as prepared by the Mortality Review Committee.

- If certain portions of the death file, such as the death certificate, are unavailable, they should be forwarded as soon as practicable to OQM with any revisions or addendums necessary to the Mortality Review Report.

d. **Quality Improvement Opportunities.** If the Mortality Review Committee finds opportunities to improve the quality of care, the plan of action for improvement will be incorporated in the institution's Quality Improvement Program. The follow-up on the quality improvement action must be reported in the Quality Improvement Committee's meeting minutes.

The appropriate Regional HSA (RHSA) and Clinical Specialty Consultant will monitor institution progress in implementing corrective measures, ensuring these measures are implemented satisfactorily.

e. **The Office of Quality Management Review.** The Medical Director is to refer the Mortality Review to the OQM for evaluation. The OQM will:

(1) Review the entire packet, comparing the MRC's report with the accompanying information. If needed, OQM will discuss the case with the institution staff and/or RHSA/Clinical Specialty Consultant.

(2) Have an external physician consultant review the Mortality Review Report and any accompanying information. The external consultant is to:

- Review all mortality records quarterly;
- Report to OQM on strengths and weaknesses in health care delivery; and
- Provide recommendations.

(3) Provide the external consultant's review findings to the Regional Directors and CEOs. If the external consultant recommends improvement action at the institution, the institution must document compliance with these recommendations, and report action taken to comply, within 90 days, to the Medical Director.

(4) Monitor the follow-up of the recommendations and the plan to improve care through the Program Review process and the appropriate RHSA and Clinical Specialty Consultant.

(5) Prepare system-wide trend analysis.

/s/
Harley G. Lappin
Director

Quality Improvement Tracking (PDCA)

Process:_____

Priority		Issues Relative to Which Functions: (check all applicable)						Status Codes	
	1 = High Risk		Assessment of Patient		Health promotion/Disease Prevention		Continuum of Care	R	Resolved
	2 = High Volume		Treatment of Patients		Infection Control		Nutritional Care	U	Unresolved
	3 = Problem Prone		Education/Patient/ Family		Management of Information		Human Resources	UR	Un-resolvable
			Leadership		Quality Improvement		Patient Rights/Ethics	RDP	Resolved to Degree Possible
			Environment of Care					RM	Resolved but Cont. to Monitor

Activity Being Considered by: (check one)			Dimensions of Quality:					
	Team	Name of Team		Efficacy		Continuity		Efficiency
	Dept.	Name of Department:		Appropriateness		Safety		Availability
				Timeliness		Effectiveness		Respect & Caring

DATE	NO.	PLAN What do you plan to do? Objectives?	DO What are you doing to meet your objectives? What actions?	CHECK How effective is the action you took?	ACT If the actions are completed and working, are you ready to make them policy?	STATUS CODE

INSTRUCTIONS

Process

Fill in Process line with description of what you are working toward improving, i.e. Medication Administration.

Priority

Is the process high risk, high volume, problem prone or any combination thereof? Check appropriate boxes.

Issues Relative to Which Function

Select functional areas of the standards that the process applies to, i.e. for Med. Admin. You would select Treatment of patient, Assessment of Patients, Management of Information.

Dimension of Quality

What are you working towards improving? Is it the timeliness of a service, effectiveness of a procedure, appropriateness of a treatment, availability of a service, etc.? This is what you are measuring.

Date

Date of updated form

PDCA.

This form starts with Plan & Do. As it is updated, add data in the Check & Act columns. Not every planned activity is progressing at same pace. Some may be at Do stage for awhile, while another may progress to the Act stage quickly.

Example: PLAN
What is your plan?
#1. Do a survey of staff on . . .
#2. Make a flow chart of process.
#3. Develop a policy/procedure on . . .
#4. Educate staff on process changes.

Example: DO
What are you doing?
For #1. Survey mailed out December 10th to all staff, due on December 20th.
For #2. Flow chart being developed by Rehab. of current process.
For #3. Pharmacy & medical staff preparing draft of policy.
For #4. Blank - U

Example: CHECK
Is what you are doing working?
For #1. Survey response 50%. Outcome is: ____
For #2. Flow chart complete & shows bottlenecks.
For #3. Policy still in draft version.
For #4. Blank - U

Example: ACT
For #1. Survey completed & evaluation completed.
For #2. Flow chart complete & process bottlenecks identified.
For #3. Policy approved.
For #4. Education of all staff completed.

Status Code Box & Column

With each update indicate status of each Plan item. Some items may be unresolvable.

Federal Bureau of Prisons
Health Care Rights and Responsibilities

While in the custody of the Federal Bureau of Prisons you have the right to receive health care in a manner that recognizes your basic human rights, and you also accept the responsibility to cooperate with your health care plans and respect the basic human rights of your health care providers.

Your Health Care Rights:	Your Responsibilities:
1. You have the **right to access** health care services based on the local procedures at your institution. Health services include medical, dental and all support services. If inmate co-pay system exists in your institution, Health Services cannot be denied due to lack (verified)of personal funds to pay for your care.	1. You have the responsibility to comply with the health care policies of your institution, and follow recommended treatment plans established for you, by health care providers. **You have the responsibility to pay an identified fee for any health care encounter initiated by yourself, excluding emergency care. You will also pay the fee for the care of any other inmate on whom you intentionally inflict bodily harm or injury.**
2. You have the right to know the name and professional status of your health care providers and to be treated with respect, consideration and dignity.	2. You have the responsibility to treat these providers as professionals and follow their instructions to maintain and improve your overall health.
3. You have the right to address any concern regarding your health care to any member of the institution staff including the physician, the Health Services Administrator, members of your Unit Team, the Associate Warden and the Warden.	3. You have the responsibility to address your concerns in the accepted format, such as the *Inmate Request to Staff Member* form, main line, or the accepted *Inmate Grievance Procedures.*

Your Health Care Rights:	Your Responsibilities:
4. You have the right to provide the Bureau of Prisons with **Advance Directives or a Living Will** that would provide the Bureau of Prisons with instructions if you are admitted as an inpatient to a hospital.	4. You have the responsibility to provide the Bureau of Prisons with accurate information to complete this agreement.
5. You have the right to be provided with information regarding your diagnosis, treatment and prognosis. **This includes the right to be informed of health care outcomes that differ significantly from the anticipated outcome.**	5. You have the responsibility to keep this information confidential.
6. You have the right to obtain copies of certain releasable portions of your health record.	6. You have the responsibility to be familiar with the current policy and abide by such to obtain these records.
7. You have the right to be examined in privacy.	7. You have the responsibility to comply with security procedures should security be required during your examination.

Your Health Care Rights:	Your Responsibilities:
8. You have the right to participate in health promotion and disease prevention programs, including those providing education regarding infectious diseases.	8. You have the responsibility to maintain your health and not to endanger yourself, or others, by participating in activity that could result in the spreading or catching an infectious disease.
9. You have the right to report complaints of pain to your health care provider, **have your pain assessed and managed in a timely and medically acceptable manner, be provided information about pain and pain management, as well as information on the limitations and side effects of pain treatments.**	9. You have the responsibility to communicate with your health care provider honestly regarding your pain and your concerns about your pain. You also have the responsibility to adhere to the prescribed treatment plan and medical restrictions. It is your responsibility to keep your provider informed of both positive and negative changes in your condition to assure timely follow up.
10. You have the right to receive prescribed medications and treatments in a timely manner, consistent with the recommendations of the prescribing health care provider.	10. You have the responsibility to be honest with your health care provider(s), to comply with prescribed treatments and follow prescription orders. You also have the responsibility not to provide any other person your medication or other prescribed item.
11. You have the right to be provided healthy and nutritious food. You have the right to instruction regarding a healthy diet.	11. You have the responsibility to eat healthy and not abuse or waste food or drink.
12. You have the right to request a routine physical examination, as defined by Bureau of Prisons' Policy. (If you are under the age of 50, once every two years; if over the age of 50, once a year and within one year of your release).	12. You have the responsibility to notify medical staff that you wish to have an examination.
13. You have the right to dental care as defined in Bureau of Prisons' Policy to include preventative services, emergency care and routine care.	13. You have the responsibility to maintain your oral hygiene and health.

Your Health Care Rights:	Your Responsibilities:
14. You have the right to a safe, clean and healthy environment, including smoke-free living areas.	14. You have the responsibility to maintain the cleanliness of personal and common areas and safety in consideration of others. You have the responsibility to follow smoking regulations.
15. You have the right to refuse medical treatment in accordance with Bureau of Prisons' Policy. Refusal of certain diagnostic tests for infectious diseases can result in administrative action against you. You have the right to be counseled regarding the possible ill-effects of refusing medical treatment.	15. You have the responsibility to notify health services regarding any ill-effects that occur as a result of your refusal. You also accept the responsibility to sign the treatment refusal form.

ROOT CAUSE ANALYSIS OF SUSPECT SENTINEL EVENT
Federal Bureau of Prisons

Complete this form when submitting a root cause analysis to address a suspected Sentinel Event. Submit this report to the Office of Quality Management, Health Services Division within 45 days of the suspected Sentinel Event. Institutions are encouraged to complete this process for "near misses" but are not required to submit those to the OQM/HSD.

Institution:_____

Date of Report:_____

Name of Patient:_____

Reg. No._____

Provide a brief description of event:_____

_____

_____

_____

_____

1. This event resulted in: (Must check one)

_____Un-anticipated death

_____Serious physical or psychological injury, such as loss of limb or function (or risk thereof).

2. Which of the following sub categories apply to this event? (Must check at least one)

_____Suicide of a patient under constant supervision in a BOP facility.

_____Death of a patient in restraints

_____Medication error resulting in death, paralysis or coma of a patient.

_____Surgery on the wrong patient, wrong side or wrong body part

_____Patient fall that results in death or major permanent loss of function.

3. Was the event directly related to the patient's illness or underlying condition? ____Yes ____No

4. Were any of the following factors a significant contributor to this event? (Check all that apply)

_____Staffing or other human factors

_____Equipment

_____Underlying systems or processes

_____Environmental factors

5. For any of the factors you selected in Item #4, provide details as to **why**:

6. Identify any risk points and their potential contributions to this event:

7. Determine what potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future:

8. Provide details of established plan to address identified opportunities for improvement:

9. Who is responsible for implementation of improvement plans?_____

10. When will improvement actions be implemented?_____

11. How will the effectiveness of improvement actions be evaluated?___

12. Have the leaders of the organization been involved in this process? _____Yes _____No

Prepared by: _____

_____ _____
Name Title

24 HOUR DEATH REPORT

DATE:
INSTITUTION:
NAME/TITLE OF STAFF COMPLETING REPORT:

INMATE NAME:
REGISTER NUMBER:
DATE OF DEATH:
DATE OF BIRTH:

PLACE OF DEATH:
□ **Institution** □ **Community Hospital** □ **Other:**
__ Gen. Pop.
__ SHU
__ Medical Unit
__ Behavioral Health Unit

TYPE OF DEATH: **DNR ORDER?** □ **Yes** □ **No**
AUTOPSY? □ **Yes** □ **No**
__ Natural Cause
__ Suicide
__ Accidental
__ Homicide
__ Legal Execution
__ Unknown

PRELIMINARY CAUSE OF DEATH:

CLINICAL SYNOPSIS OF EVENTS LEADING TO DEATH: (Please provide sufficient information including a short summary of past medical history, length of hospitalization or emergency room care, and staff response to this event).