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SAFETY, RESPECT
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LA SÉCURITÉ,
LA DIGNITÉ
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POUR TOUS

Audit of Physical Health Care Delivery to Inmates Internal Audit Branch

378-1-236

**Approved by the Audit Committee
April 3, 2008**

Canada

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EXECUTIVE SUMMARY

Correctional Service of Canada (CSC) is obligated, under the Correctional and Conditional Release Act (CCRA), to provide inmates with “essential” health care which conforms to professionally accepted standards. In addition, health care services must respect gender, cultural and linguistic differences, and be responsive to the special needs of women and aboriginal people. Adequately addressing offenders’ health needs assists them in participating in correctional programs that contribute to their successful reintegration and contributes to public health and safety.

To fulfill this responsibility, in 2007-08, CSC plans to spend \$108.3 million on physical health care. There are approximately 12,700 inmates housed within CSC’s 58 penitentiaries. About four out of five offenders admitted to a federal penitentiary have a serious substance abuse problem, and the inmate population have significantly higher rates of HIV and Hepatitis C than the general Canadian population.

In the fall of 2006, CSC’s Executive Committee approved a key organizational change, the intent of which is to improve the quality and consistency of physical health care delivery across Canada. Under the old structure, the Director General of Health Care reported to the Assistant Commissioner, Correctional Operations and Programs. As of September, 2007, health services became a separate sector at NHQ headed by the Assistant Commissioner, Health Services with four new directorates at National Headquarters and five new regional directorates. The Chief of Health Services at the institution, who manages the operation of the health care centre and used to report to the Deputy Warden at the institution, now reports to the Regional Director of Health Services.

Maximum, medium and some minimum level institutions have their own health care centres. Health care is provided by nurses along with physicians and various specialists (such as dentists and optometrists) retained on contract in the institution. Inmates may also have to go out to the community for health care services from other specialists or from public hospitals.

In its 2007-08 Corporate Risk Profile, CSC has recognized that additional measures should be taken to ensure that CSC will be able to deliver essential physical health care to offenders such as developing a Continuous Quality Improvement program that includes accreditation by the Canadian Council on Health Services Accreditation, finalizing implementation of the new governance model for health care and continuing to address infectious disease concerns.

Further, in the 2007-08 CSC Report on Plans and Priorities, CSC has committed to ensure that offenders’ health assessments are completed and essential physical health needs are addressed in accordance with professional standards. In the area of infectious disease control, CSC has committed to improving and better coordinating discharge planning activities for offenders with infectious diseases and expanding health promotion initiatives to encourage healthy behaviours by inmates.

This audit was undertaken to provide assurance that the controls in place to support the delivery of physical health care are adequate and effective. It is expected that the results of this audit should assist CSC in meeting its commitments and provide the Assistant Commissioner, Health Services

and other CSC senior executives with guidance on areas on which to focus attention for continued improvement in the quality and consistency of physical health care for inmates.

More specifically, the audit objectives were:

- to assess the adequacy of the management framework for institutional physical health services;
- to determine the extent to which CSC institutions / health care centres are complying with existing health care legislation, policies and procedures for the physical well being of their inmates;
- to determine whether the management of infectious disease practices in the institutions / health care centres is compliant with policy; and
- to determine the extent to which CSC institutions / health care centres are complying with existing health legislation and health policies and procedures for the physical well-being of inmates with specific health care needs;

Conclusions

Adequacy of the management framework – Key elements of the Management Framework are in place for the provision of physical health care for inmates in CSC institutions, but there are some important areas where improvements need to be made:

- The split between non-essential and essential health services is not clearly defined. This leaves room for interpretation by site health services personnel, as to which health services are essential and will be provided by CSC, and which are non-essential and may be provided if paid for by the offender.
- Performance information for monitoring and reporting on the quality of health care services provided by CSC is very limited which impedes CSC's ability to monitor performance and demonstrate compliance with policy.
- Continuous quality improvement programs are not yet in place for the delivery of physical health care services at the site level. The sites are waiting for national/regional direction before proceeding with implementation. This program needs to be tied to the overall accreditation process and the performance management framework to ensure the provision of appropriate health services in CSC.
- The funding formula for the delivery of health care services needs to be revisited. Salary budgets for nursing staff are based primarily on hours of operation. Factors such as the number of offenders in the institution would be more relevant to determine how many health care personnel are needed to provide a consistent level of service across the country.
- All nurses must have training in Emergency Trauma Care, CPR and Suicide Prevention. For the full time nurses at the sites we visited, national training records indicated that most CSC health care personnel are not receiving required training.

Compliance of Health Care Centres with existing health care legislation, policies and procedures - In a number of areas, CSC institutions / health care centres are complying with existing health care legislation, policies and procedures for the physical well being of their inmates. However, in other areas, although we found evidence that CSC is delivering health care services to address the continuing health care needs of offenders, assurance on overall compliance could not be provided as not all relevant information was contained in the inmates' health care files. There are

important concerns that need to be addressed:

- Health care assessments due within two and fourteen days of arrival at Regional Reception Centres are not always completed on time.
- Documentation of health care files needs to be improved in order to assess and demonstrate compliance with policy requirements.
- There are inconsistencies in the access provided to health care services. There are no national standards for Health Care Centre hours of operation. There is also no standard approach to schedule frequency or duration of visits made by health care professionals on contract at CSC institutions which affects wait times to access health care services.
- Provision of sufficient escorts to meet health care needs of offenders going out for community services is a challenge at some sites which can delay medical care received by inmates.

Management of Infectious Disease Practices - Although practices for the management of infectious diseases comply with policy in some areas, improvements are required as follows:

- Harm reduction measures including condoms, dental dams, bleach and lubricants are not readily available at many CSC institutions.
- Although infectious disease education/counselling programs are in place in most institutions we visited, support groups such as the Peer Educating Counselling Program (PEC) or the Aboriginal PEC (APEC) are not active at all sites.
- For the most part, sites have the required equipment and supplies needed to do the clean-up of blood and body fluids, but there is no related national training standard for those doing the clean-up or those supervising them.
- Most elements of infection control are taking place in accordance with policy but some concerns were raised related to the cleanliness of health care facilities.

Inmates with specific health care needs – Overall, CSC institutions / health care centres are complying with existing health legislation and health policies and procedures for the physical well-being of inmates requiring palliative care, women offenders and aboriginal inmates.

Recommendations have been made in the report to address these areas of improvement. Senior management has reviewed, and agrees with, the findings contained in the report. The Management Action Plan which addresses the recommendations is included in Appendix D.

1.0 INTRODUCTION

There are approximately 12,700 inmates (of which 3.9% are women and 19.5 % are Aboriginal) housed within CSC's 58 penitentiaries. About four out of five offenders admitted to a federal penitentiary have a serious substance abuse problem. Most offenders are generally in poorer health than the average Canadian, having 7 to 10 times higher rate of HIV than the general Canadian population and approximately a 30 times higher rate of Hepatitis C¹.

For physical health care, Correctional Service of Canada is obligated, under the Correctional and Conditional Release Act, to provide inmates with "essential" health care which conforms to professionally accepted standards. The legislation also stipulates that CSC must respect gender, cultural and linguistic differences and be responsive to the special needs of women and aboriginal people.

To fulfill their responsibility to provide access to health services, in 2007-08, CSC plans to spend a total of \$108.3 million. Out of this total, \$8.5 million is allocated for the NHQ Health Sector and \$99.8 million is allocated to the 5 regions for delivery of physical health care in their facilities (see Appendix C for details).

In the fall of 2006, CSC's Executive Committee approved a key organizational change, the intent of which is to improve the quality and consistency of physical health care delivery across Canada. Under the old structure, the Director General of Health Care reported to the Assistant Commissioner, Correctional Operations and Programs. As of September, 2007, Health Services became a separate sector at NHQ headed by the Assistant Commissioner, Health Services. The new Health Services governance structure was implemented to increase the focus on health services at the national level, with four new directorates at National Headquarters and five new regional directorates (see Organization Charts following). To further enhance the national decision making process, a new Executive Subcommittee on Health Services has also been created.

Each institution at the maximum and medium level has a health care centre. In some minimum level institutions, there are self-contained health care facilities, but others have more limited services available on-site because they share their health services with a medium security facility situated beside them. The Chief of Health Services at the institution is usually a registered nurse and is responsible for managing the operation of the health care centre. They used to report directly to the Deputy Warden of Correctional Operations but, under the new structure, they now report to the Regional Director of Health Services. This reduces the direct control of health care operations by the Deputy Wardens at the site level, and requires a more consultative approach to ensure operational requirements of the institution are met by the health care operations.

Nurses provide most health care services at the primary-care level within the institutions. Secondary care is provided on site by physicians and various specialists (such as dentists and optometrists) retained on contract, who visit the institution on a regular schedule. Supplemental care is provided by health care specialists, and public hospitals in nearby communities and CSC regional hospitals. Both staff and contractors are regulated by their independent licensing or accrediting bodies.

¹ CSC Report on Plans and Priorities - 2007-08

Over the last few years, the provision of physical health care services has been the subject of criticism by the Office of the Correctional Investigator. In his last two annual reports, the Correctional Investigator has raised concerns with CSC delivery of health care services; more specifically in the areas of accreditation of CSC health care facilities and the prevention of transmission of infectious diseases. Inmates can submit complaints directly to the Office of the Correctional Investigator and in 2006-07, complaints related to physical health care were the most frequent of all categories, at about 12% of the total. Within the health care, 50% of the complaints related to access to health care, 40% concerned decisions made and 10% were related to dental care services.

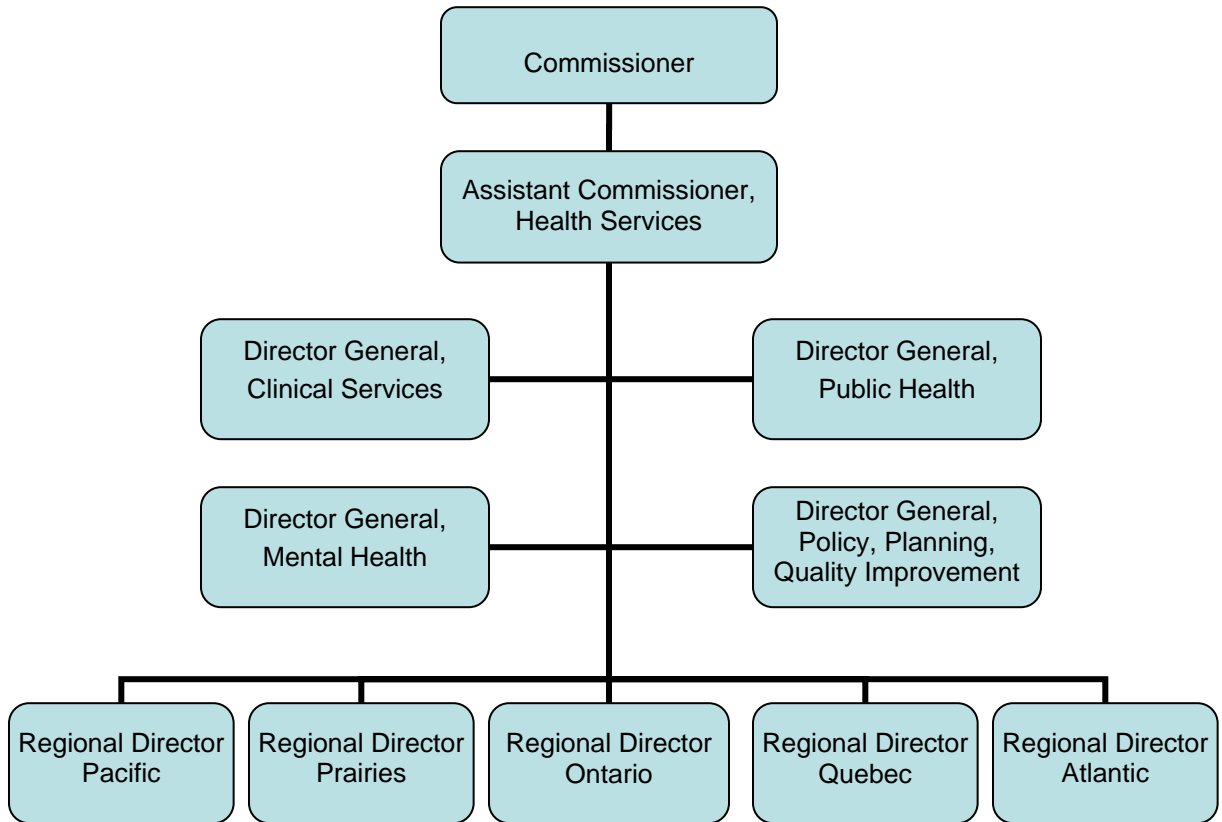
CSC also monitors complaints made by inmates in all areas including health services. Complaints made directly to CSC related to physical health care continue to be among the highest area of concern for inmates. For the most recent ten month period for which data was available (April 2007 to January 2008), there were 514 complaints made to CSC staff related to physical health care concerns. All but 37 of these were resolved at the institutional level and less than 7% of the complaints related to physical health care are upheld at all levels of the process.

In its 2007-08 Corporate Risk Profile, CSC has recognized that additional measures should be taken to ensure that CSC will be able to deliver essential physical health care to offenders such as developing a Continuous Quality Improvement program that includes accreditation by the Canadian Council on Health Services Accreditation, finalizing implementation of the new governance model for health care and continuing to address infectious disease concerns.

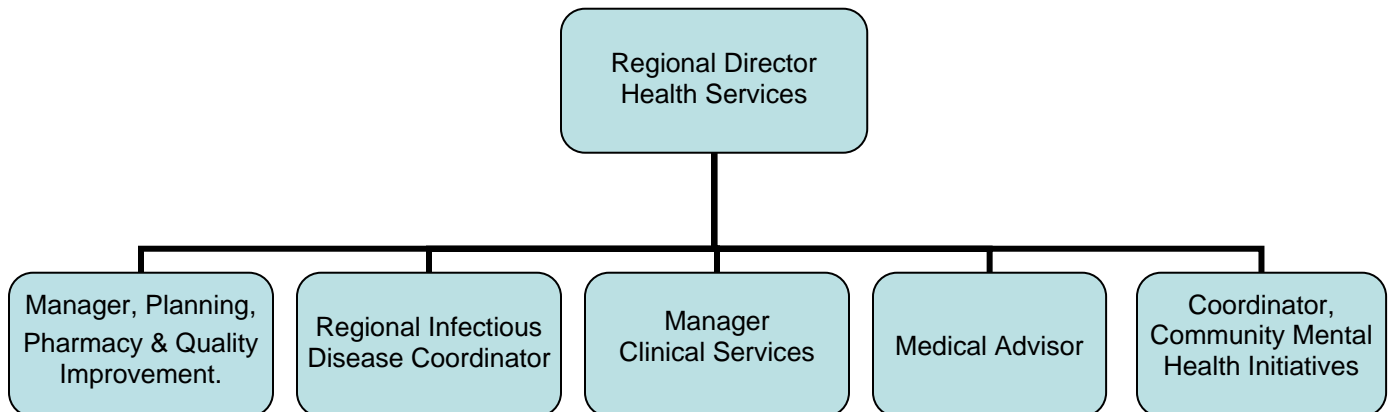
Further, in the 2007-08 CSC Report on Plans and Priorities, CSC has committed to ensure that offenders' health assessments are completed and essential physical health needs are addressed in accordance with professional standards. Adequately addressing offenders' health needs assists them in participating in correctional programs that contribute to their successful reintegration and contributes to public health and safety. In the area of infectious disease control, CSC will be focusing on improving and better coordinating discharge planning activities for offenders with infectious diseases and expanding health promotion initiatives to encourage healthy behaviours by inmates.

This audit was undertaken to provide assurance that that the controls in place to support the delivery of physical health care are adequate and effective. It is expected that the results of this audit should assist CSC in meeting its commitments and provide the Assistant Commissioner, Health Services and other CSC senior executives with guidance on areas on which to focus attention for continued improvement in the quality and consistency of physical health care for inmates.

National Health Services Organization Chart



Regional Health Services Organization Chart



2.0 AUDIT OBJECTIVES AND SCOPE

2.1 Audit Objectives

The objectives of the audit were:

- to assess the adequacy of the management framework for institutional physical health services;
- to determine the extent to which CSC institutions / health care centres are complying with existing health care legislation, policies and procedures for the physical well-being of their inmates;
- to determine whether the management of infectious disease practices in the institutions / health care centres is compliant with policy; and
- to determine the extent to which CSC institutions / health care centres are complying with existing health legislation and health policies and procedures for the physical well being of inmates with specific health care needs.

The criteria used for the audit can be found in Appendix A.

2.2 Audit Scope

The audit was national in scope and the audit team interviewed health care staff at the local, regional and national levels. From September to November, 2007, site visits were made to institutions across all regions and at all security levels – minimum, medium, maximum – as well as the Special Handling Unit (SHU), Regional Reception Centres and Regional Hospitals, two women’s institutions and two healing lodges (one for men and one for women). See Appendix B for the list of institutions visited.

For the purpose of file reviews, unless specified otherwise above, the period of coverage for this audit was from April 1, 2006 to September 30, 2007.

This audit covered physical health care provided to inmates. The audit excluded mental health services (including psychological services) and the issuing of prescription drugs because these areas are expected to be covered under separate audits in the next two years. The audit also excluded the issue surrounding inmates’ access to health care services in their official language of choice, as the Office of the Commissioner of Official Languages published an audit report in July 2007, addressing this topic.

3.0 APPROACH AND METHODOLOGY

At the institutions we visited, we interviewed Chiefs of Health Services, Nurses, Deputy Wardens and/or Wardens as available, and inmate committee representatives. Interviews were also conducted with OPI's at regional headquarters and at NHQ.

The audit team consisted of members of the Internal Audit Branch, augmented by representatives from each region with significant knowledge and experience with provision of physical health care services in CSC facilities. At each of the institutions, these health care professionals reviewed a sample of 15 randomly pre-selected inmate medical files to verify compliance with policies related to ongoing health care, for a total of 202 files reviewed nationally.

In order to determine if the preparation for transfer / release was appropriate, we also requested for review, 5 randomly selected files for inmates recently transferred into, or soon to be transferred out of the institution, and 5 files of inmates soon to be released from the institution to the community, for a total of 170 files reviewed nationally.

In 4 of 5 regions (except the Prairies) inmates are admitted to CSC at a central Regional Reception Centre (RRC). As part of the admission process, they are required to receive an immediate evaluation and a more extensive evaluation to determine their health care needs. We visited 3 of these RRC's and two men's facilities in Prairie Region and one Women's facility and requested for review 15 inmate medical files at each, to assess compliance with policies for offenders entering CSC, for a total of 95 files.

Health care files for all offenders currently or recently requiring palliative care at the institutions we visited (9 files in total), were reviewed to determine adherence to the CSC Palliative Care Guidelines.

Table 1 – Sample Size of Health Care Files Reviewed

Type of File Reviewed	# of Files Reviewed
Ongoing health care	202
Inmates transferred to another institution	93
Inmates released to the community	77
Inmates being admitted to CSC	95
Inmates receiving palliative care	9

Other documents we reviewed included: Standing/Post Orders related to health care; training records and monitoring tools. We conducted walk-arounds in the health care units and the institutions to verify compliance with policy requirements.

We reviewed all nurses' central training records for each institution the audit team visited (165 nurses in total), to ensure compliance with "National Training Standard for CSC 2007-08".

Finally, the audit team debriefed the Regional Deputy Commissioners on relevant findings. In addition, a debriefing was held at NHQ with the Assistant Commissioner, Health Services.

4.0 AUDIT FINDINGS AND RECOMMENDATIONS

4.1 MANAGEMENT FRAMEWORK

To support its legislative obligations, CSC policy governing the delivery of physical health care to inmates is contained in a series of Commissioner's Directives (CD's). The following policies and guidelines related to the provision of health care services to inmates were covered by our audit:

- **CD 800 - Health Services** – As the main policy instrument for physical health care, this CD includes requirements for essential health care, inmate access to services, licensing of professionals, health education and promotion programs, reception of offenders, handling of medical emergencies, outside consultation and terminal or chronic illness.
- **CD 821 - Management of Infectious Diseases** – This policy covers orientation for new admissions, harm reduction measures, education programs / counselling services, measures for the handling and clean-up of blood and body fluids and collection of data on inmates' infectious diseases.
- **CSC Palliative Care Guidelines** - These guidelines deal with CSC's approach to offenders living with a terminal illness.

In addition, there are requirements for the involvement of health care staff in other case management policies including:

- **CD 710-2 Transfers** – Determination of the requirement for an inmate to be transferred to another institution or to the regional treatment facility must include input from the health care staff and relevant information must be forwarded to the receiving institution.
- **CD 712-4 Release Process** – Prior to release the offender must be provided with relevant documentation including health care coverage, social insurance number and birth certificate as well as a short term supply of any necessary medication. Referrals to available community resources may also be necessary to ease the transition to community.

There is also a Health Care Manual which summarizes all of these policy requirements for the provision of health care services at CSC institutions. Completing the policy framework for health services are the National Emergency Medical Directives which guide nursing personnel in the treatment of emergency medical conditions, and locally developed Standing Orders and Post Orders to cover local variances and requirements.

4.1.1 Policy Framework

We expected that CSC policies and procedures would be up to date, compliant with legislation and sufficient to ensure the physical health needs of inmates are being addressed in a consistent manner across the country.

CSC has policies in place for the delivery of health care services that are generally up to date and continue to be revised as needed; however the distinction between what constitutes essential services (those required under the CCRA) and non-essential / other health services is not clearly defined.

In our discussions with health care professionals at the facilities we visited, no major concerns were raised about the current policy framework for the provision of CSC health care services. These health care policies are reviewed and revised as required, for a number of reasons including: to provide a response to findings of CSC internal investigations or audits of outside organizations such as the Office of the Privacy Commissioner; or to ensure that consistent approaches are used to provide physical health care services to inmates.

For physical health care, the Correctional and Conditional Release Act requires that, among other things:

- the Service shall provide every inmate with essential health care;
- the provision of health care shall conform to professionally accepted standards; and
- health care means medical care, dental care and mental health care, and it shall be provided by registered health care professionals.

CD-800 - Health Services specifies (under Essential Health Services) that inmates shall have access to screening, referral and treatment services. With respect to physical health care, essential services are defined to include:

- emergency health care (i.e., delay of the service will endanger the life of the inmate);
- urgent health care (i.e., the condition is likely to deteriorate to an emergency or affect the inmate's ability to carry on the activities of daily living);
- dental care for acute dental conditions where the inmate is experiencing swelling, pain or trauma; preventive treatment (i.e., necessary fillings, extractions, etc.) subject to the motivation displayed by the inmate to take an active part in the process; and removable dental prostheses as recommended by the institutional dentist. All other dental care will be initiated and funded by the inmate.

In addition to the three areas listed as essential services for physical health care, CD-800 specifies that inmates shall also have reasonable access to other health services (i.e., conditions not outlined above) which may be provided in keeping with community practice. The provision of these services will be subject to considerations such as the length of time prior to release and operational requirements. The audit found that this reference in the directive related to “other health services” is vague and open to interpretation.

With the exception of Pacific Region, it is left up to the local health care professionals, usually the physician on contract, in consultation with the Chief of Health Services, to determine which services are essential and will be provided by CSC, and which are non-essential and may be provided if paid for by the offender. The contract health care professionals usually also provide health care services in the community and, as a result may be aware of the standards that are used there for those on social assistance programs. However, this subjective decision-making can lead to inconsistent levels of health care provided from site to site. Moreover, there is no accountability within CSC for the determination of health care services to be provided in accordance with the CCRA.

According to CD 800, all inmate-requested services deemed non-essential by the institution's physician will be at the inmate's complete expense including consultation fees and, at the discretion of Institutional Head, any associated escort costs. Health Services shall be responsible for the coordination of arrangements for all inmate-requested services. We were informed by the health care personnel we interviewed that when inmates request health care services that are deemed to be non-essential by CSC staff, they will usually be provided access to such services if:

- the physician or other health care professional will authorize it;
- institutional security will permit it;
- the inmate will cover all associated expenses including escorts, overtime etc.; and
- the request can be met by the health care staff with a reasonable amount of effort to schedule and arrange the services or obtain the product requested.

Good Practice

Pacific Regional Health Services Branch issues Regional Health Service Orders that specify which medical and dental procedures are essential and are therefore funded by CSC, and how to process requests made by inmates for a non-essential service.

4.1.2 Local Procedures and Directives

We expected that medical policies, procedures and/or directives, where needed, would be in place in CSC facilities to ensure the national policies and procedures are being effectively implemented.

Institutions have developed local directives and procedures, as needed, to supplement national policies to ensure that they are being effectively implemented.

At the national level, there are Emergency Medical Directives to guide and facilitate the management of emergency medical conditions by nursing personnel at CSC institutions. They define an acceptable, standardized approach to each specified patient health-related problem. They are subject to consistency and compliance with provincial laws and regulations, as well as provincial medical and nursing regulatory body policies and regulations. Institutions we visited had ready access to the national directives either through the Infonet or in hard copy.

CSC policy requires that procedures for health care emergencies shall be in place in all institutions and that in the absence of a clinician, Health Care Orders shall be in place to outline the course of action to be taken by health service staff in both routine and emergency situations.

To ensure that policies, procedures and/or directives are being effectively implemented, institutions also have local Standing Orders, Post Orders, Institutional Operating Procedures or Medical / Physicians' Standing Orders / Standing Health Services Clinical Orders to enhance the direction provided by national directives. Standing Orders are approved by the Institutional Head and the most common subjects are Administration of Methadone and Prevention of Suicide and Self-Inflicted Injuries. A few sites visited had Post Orders established, with some of them providing details on the roles and responsibilities of the health care professionals and the Correctional Staff posted in the Health Care Centres, and others related to distribution of medications.

Physicians' Standing Orders or Standing Health Services Clinical Orders have also been developed at some sites to provide specific medical guidelines for the treatment of various conditions. The Pacific region has standardized these directives regionally as their Regional Health Service Orders,

referred to above. In addition to clarifying essential and non-essential services, there are regional orders dealing with a variety of health-related topics including Palliative Care, Suicide Prevention, Infectious Disease, Doctor's Standing Orders, Emergency Protocols, Pharmacy and Therapeutics.

4.1.3 Monitoring and Reporting Mechanisms

We expected that monitoring and reporting mechanisms would be in place at NHQ, RHQ and the institutions to ensure compliance with policy.

Performance information on the provision of health care services by CSC is very limited. This impedes CSC's ability to monitor and report on performance and demonstrate compliance with policy.

All health-related information for offenders is currently kept in paper-based offender health care files. Very little information is currently put on the Offender Management System, in order to maintain confidentiality of health care information. This makes analysis of regional or national results difficult. The availability of performance information is expected to improve when the new initiative to automate offender health care information, the Health Information Management Module (HIMM), is installed. The projected implementation date for this system is 2010. This system will be supportive of the CSC Health Services clinical activities and programs by providing a means to track, monitor, and share offenders' health information from CSC admission through release back to the community. The module is expected to accommodate all CSC health services providers across 58 sites and will have the capacity to share information with the Offender Management System (OMS) on a "need-to-know" basis.

At the national level, the Management Control Framework relies on self-reported information submitted from site management to assess compliance with a number of performance measures. Under the former structure, the Deputy Warden was responsible for submitting reports on Health Services, usually with input from the Chiefs of Health Services, on whether:

- access to essential health services is available from registered or licensed professionals 24 hours per day;
- there is 24 hour on-site availability of staff with current certification in basic first aid and CPR;
- a process is in place to allow inmates to request health services in confidence; and
- appropriate health-related procedures are followed prior to an inmate's transfer.

Of the sites we visited, only one institution reported non-compliance with these requirements, as of the last report available on November 30, 2006.

There are also more specific Management Control Framework measures for Management of Infectious Diseases related to the following areas:

- availability of harm reduction measures, including bleach distribution;
- training for staff and inmates, including the Peer Education and Counselling Program;
- provision of protective clothing and equipment and training; and
- pre-release planning and transfer of inmates.

Of the sites we visited, only one institution reported non-compliance with these requirements, as of the last report submitted on June 30, 2007. This information is not consistent with some of the

findings from this audit, such as the availability of harm reduction measures – covered later in this report. Therefore, we have concerns with the reliability of such information to monitor the services being provided.

There are no systematic national or regional reviews of health care. However, regional reviews of health care services have been completed on an ad hoc basis. These cover a variety of subjects, including:

- accuracy and completeness of information entered on medical files;
- arrangements with local hospitals to provide services to CSC;
- security concerns in the health care facility;
- administration and control of medication and prescription drugs;
- management of biomedical hazardous substances; and
- emergency equipment availability.

Some of the Chiefs of Health Services we interviewed informed us they review health care files in their units to ensure the files are complete and accurate and give feedback to staff on any problems identified, however it is done on an ad hoc basis. NHQ is developing guidelines that outline which official CSC forms are to be filed in each section of the health services file. This could be used as a benchmark in the future for any reviews of health care charts.

Overall, at this time, CSC has very little performance information on the provision of health care services. This has an impact on its ability to monitor and demonstrate compliance with policy. The Health Services Sector has recognized this gap and has indicated that it is developing a performance management framework for the delivery of health services with a view to generate performance information manually on key indicators by the end of 2008-09, with more extensive reporting once the Health Information Management Module system is in place.

4.1.4 Continuous Quality Improvement/ Accreditation Programs

We expected that Continuous Quality Improvement Programs would be in place at the site level, as part of CSC's commitment to providing quality health services.

Continuous Quality Improvement/Accreditation Programs at the site level are not yet in place pending the implementation of the revised accreditation process.

Although we found some local initiatives of an ad hoc nature, continuous quality improvement programs are not generally in place for the delivery of physical health care services at the site level. The sites are waiting for national/regional direction before proceeding with implementation. There is recognition that this program needs to be tied to the overall performance management framework, including the accreditation of CSC facilities, to ensure the provision of appropriate health services in CSC.

In 2004, CSC secured the assistance of the Canadian Council on Health Services Accreditation to assess the level of compliance with independent standards on health service delivery. The purpose of accreditation is to determine how well CSC health care facilities perform, based on community standards of health services delivery, and to identify areas of improvement to achieve these community standards.

During 2005/06, out of 54 sites to be accredited, 29 sites had an accreditation survey. Some of these resulted in non-accreditation and corrective actions were being examined; others were "accredited with conditions". The rest of the sites had an "education" survey, which helps the institutions learn about the accreditation process and prepare them for the actual accreditation survey at a later date.

The Canadian Council on Health Services Accreditation conducted these site visits for accreditation using standards developed for community health care facilities. The accreditation process was re-examined and it was decided to adjust the process so it would be more appropriate for the correctional setting. In recent discussions with the Health Sector, we were informed that the standards will be piloted by the end of March, 2008 and an advance survey will be undertaken in the fall of 2008, to determine if any changes are required before proceeding with the process. The next three-year cycle of the accreditation process will then resume in May, 2009 with these revised standards.

Given CSC's commitment, we expected that some progress would have been made by the sites in implementing continuous quality improvement. Continuous quality improvement and accreditation programs are means for the CSC to demonstrate that it meets the CCRA requirement for the provision of health care that conforms to professionally accepted standards. Until such programs are implemented, it may be difficult for CSC to monitor and ensure compliance with legislative requirements.

4.1.5 Roles and Responsibilities

We expected that roles and responsibilities for health care services have been defined, they are understood and are being followed at NHQ, RHQ and the institutions.

Revised roles and responsibilities for Health Services staff are being implemented and are understood and are being followed by staff at all levels.

Responsibilities for provision of health care at the local level by the nursing staff have not changed, but the reporting structure for the Chief of Health Services has. The chiefs we interviewed are aware of the new structure and their new reporting relationships through RHQ, rather than the former reporting through the Deputy Warden. In most cases, both the Chiefs of Health Services and the Deputy Warden feel that, through consultation, they can still deliver an appropriate level of health services and meet the operational needs of the institution, even if the Deputy Warden no longer has line authority over the Chief of Health Services. The level of cooperation between the operational side of the institution and the health care providers and management was reported to be very good. At the regional and national level, many of the new positions are still being staffed, so to is too early to assess these new structures.

4.1.6 Staffing Levels and Resource Allocations

We expected that staffing levels and resources allocation within health care would be in accordance with the approved organizational plan.

Health Care Centres are generally fully staffed and resources are allocated and spent according to plan, however, the funding formula used to establish budgets needs to be revisited.

Most Health Care Centres we visited are managing to stay fully staffed, although the current shortage of nurses in the community is making this a challenge. The Chiefs of Health Services we interviewed reported that the long staffing process (often taking a year or more) to bring qualified nurses into indeterminate positions in CSC makes this even more difficult. It is primarily at the Chief of Health Services level where personnel are in the position on an acting basis.

In order to establish their funding requirements for the upcoming fiscal year, the Chiefs of Health Services at each site estimate their full operational funding needs for contracted services, supplies and other costs and submit it to RHQ for inclusion in the national health care budget. Salary budgets for nursing staff are set by indeterminate staffing formula, which were developed in 1999, based primarily on hours of operation (i.e. 24 hour, 16 hour or 8 hour operations) and associated shift schedules. Factors such as the number of offenders in the institution or other health services demand-related information would be more relevant to determine how many health care personnel are needed to provide a consistent level of service across the country.

There are also a few nationally funded initiatives such as Methadone, HIV AIDS, and Hepatitis C, for which sites receive funding, based on a national formula, as well as use. They can request additional funding from these programs if, for example, the numbers of users increase.

Information contained in Appendix C show that there is a wide regional variation in the budget per inmate for physical health care. It ranges from \$6,149 in Ontario to \$9,253 in the Atlantic, a variance of 50%. Although regional differences may be justified, it is difficult to account for such variances. Further, as we will discuss later in the report (in section 4.2.2) the current funding formula has an impact on CSC's ability to provide consistent health care services across the country.

NHQ is currently reviewing the factors that should be included to determine the nursing resources that an institution or hospital should have. This is due to be completed in 2008 and, along with a current NHQ review of nursing work descriptions, should help rationalize the levels of staffing in the CSC health care system.

4.1.7 Licensing of Health Care Professionals

We expected that health care professionals would be registered, licensed or certified in accordance with their respective professional requirements.

CSC ensures that Health care professionals are licensed in accordance with their respective professional requirements on an annual basis.

CD 800 requires health services to be provided by health care professionals who are registered or licensed in Canada, preferably in the province of practice. The national Health Services Manual also specifies that the Service shall hire physicians who carry a current certificate from the provincial College of Physicians and Surgeons but it does not specify who is to ensure this requirement is being met.

The standard contract for physician services used by the institutions we visited contains a requirement that the medical service provider shall comply with all laws regulations and rules applicable to the performance of the work specified in the contract. The contractor (i.e. the health

care service provider) must obtain all permits and hold all certificates and licenses required for the performance of the work. Evidence of compliance is to be furnished by the contractor to CSC at such times as CSC may reasonably request.

Most of the Chiefs of Health Services we interviewed do not check the license status of physicians on contract. However, staff in Contract Services or Health Services at Regional Headquarters check the license status annually at the time of contract renewal, or have directed health care staff to start doing this on an annual basis and will be monitoring that it is being done. Almost all contracts for health care services have a term of either one year or one year plus a number of years, with the option to renew annually, at the discretion of CSC. In addition, Chiefs of Health Services we interviewed also rely on the licensing bodies or the health care professionals to notify them if they lose their license to practice during the year.

The Health Services Manual further states that nurses who are providing direct care to inmates shall be currently registered in the province of practice and that the Chief Health Services shall establish a list of all nursing staff and verify annually their registration status. Nursing staff submit their certification each year to CSC in order to get reimbursed for their fees. The Chiefs of Health Services use this process to annually verify that the registration of nursing staff remains current.

4.1.8 Training

We expected that training is being provided and taken as required for all CSC personnel involved in delivery of physical health care services.

In most cases, the National Training Standards are not met by CSC health care personnel.

In the National Training Standards, all nurses must have training in Emergency Trauma Care, CPR and Suicide Prevention/Response. The Emergency Trauma Care and CPR training includes two courses: International Trauma Life Support and CPR Level C. For 165 full-time nurses from the sites we visited, we examined central training records in the CSC PeopleSoft database, to determine their training status.

The CPR Level C course is directed towards trauma-related emergency situations and is consistent with community standards for Health Professionals and it must be completed annually. As of August 2007, 55% of the nurses in our sample had completed the CPR training, according to central training records.

International Trauma Life Support trains nurses to care for critically injured patients and it is required by all nursing staff. After the initial training, a refresher course is needed every three years. As of August 2007, only 27% of the nurses met this requirement. Nine institutions of the 16 we visited, did not have any nurses who had completed this training. In fact, 70% of the nurses with ITLS training were from only four institutions.

Suicide Prevention/Response training must be completed by all institutional staff who have regular interaction with inmates. The initial training in Suicide Prevention can be met through several avenues: Correctional Training Program, New Employee Orientation Program or Suicide Prevention for those who do not partake in the first two training programs. This training should be completed within four months of an employee's start date. This training must be updated every two

years with the Suicide Prevention Refresher course which is done through e-learning. Only thirteen percent of the nurses in our sample met this requirement.

Conclusions and Recommendations

Key elements of the Management Framework are in place for the provision of physical health care for inmates in CSC institutions, but there are some important areas where improvements need to be made.

- The CCRA requires that CSC shall provide every inmate with essential health care; however, CSC defines essential services in general terms. This leaves room for interpretation by site health services personnel as to which health services are essential and will be provided by CSC, and which are non-essential and may be provided if paid for by the offender. This can lead to inconsistency in the provision of health care services from site to site.
- Performance information for monitoring and reporting on the quality of health care services provided by CSC is very limited which impedes CSC's ability to monitor performance and demonstrate compliance with policy. The Health Services Sector needs to develop and implement a performance management framework for the delivery of health services
- Continuous quality improvement programs are not yet in place for the delivery of physical health care services at the site level. The sites are waiting for national/regional direction before proceeding with implementation. This program needs to be tied to the overall performance management framework and accreditation process, to ensure the provision of appropriate health services in CSC.
- Salary budgets for nursing staff are set by staffing formulae, which are based primarily on hours of operation. Factors such as the number of offenders in the institution would be more relevant to determine how many health care personnel are needed to provide a consistent level of service across the country. This funding formula used to establish budgets needs to be revisited.
- In the National Training Standards published in April 2007, all nurses must have training in Emergency Trauma Care, CPR and Suicide Prevention. For the full-time nurses at the sites we visited, national training records indicated that most CSC health care personnel are not receiving required training.

Recommendation #1

The Assistant Commissioner, Health Services should clarify the distinction between essential and non-essential/other health care services.

Recommendation #2

The Assistant Commissioner, Health Services should develop and implement a performance management framework related to the delivery of health care services.

Recommendation #3

The Assistant Commissioner, Health Services should implement a Continuous Quality Improvement program and the Accreditation process.

Recommendation #4

The Assistant Commissioner, Health Services in collaboration with Assistant Commissioner Corporate Services should update the resourcing formulae for CSC Health Care Centres.

Recommendation #5

The Assistant Commissioner, Health Services should ensure that CSC health care staff meet the requirements of the National Training Standards related to their duties in CSC facilities.

4.2 COMPLIANCE OF HEALTH CARE CENTRES WITH EXISTING HEALTH CARE LEGISLATION, POLICIES AND PROCEDURES.

Provision of ongoing health care services to offenders begins at initial intake where medical evaluations have to be made within specified time frames (2 days and 14 days) to identify any health-related concerns offenders have upon entering the CSC system. They are given the opportunity to be tested for a number of significant medical conditions. If these tests prove to be positive, they are offered counselling and treatment, they have access to health care specialists in the institution and in the community, they are provided with required medication by CSC, they are monitored on an ongoing basis to determine their progress, and finally, when they are going to be released into the community, they are put in contact with community resources to ensure their care continues. This continues with ongoing day-to-day health care, response to emergency situations, transfers between facilities, escorted absences to receive treatment in the community and eventual discharge into the community.

Correctional officers are required to escort inmates for health care appointments in the community, and, in higher security level institutions, sometimes even within the institution. Institutions typically have a limited number of correctional staff available for these escort duties. A scheduled appointment in the community may be cancelled when the escort officers are pulled away to meet operational requirements or if the number of escorts required is greater than the number of staff available. These delays can have a negative impact on providing timely health care for inmates. In addition, escorts needed for unplanned trips can incur overtime spending which may be difficult to accommodate when resources are limited.

Any lack of communication and cooperation between health care and operational staff can increase the risk that some elements of inmate health care will be inadequately handled.

4.2.1 Intake / Reception

We expected that the requirement related to the 2-day and the 14-day health care assessments at Intake would be met.

Health care assessments at Regional Reception Centres are not always completed on time and in some cases, there was no evidence on file to demonstrate that the required service was provided.

The first health care assessment, which is to be completed within two days of arriving at the unit, addresses any immediate health-related concerns such as communicable conditions; acute medical, mental or dental conditions; conditions requiring continuing treatment; and activity limitations. The second assessment is to be completed within the first 14 days and is more comprehensive in nature. The 14-day assessment requires a review of the inmate’s health status, immunization reviews and delivery, screening for tuberculosis, counselling and screening regarding HIV, relevant health education and referrals to other health care professionals.

There is a specific CSC form (#1244) which must be used when the 2-day and 14-day assessments have been completed and which details the specific information to be collected for each interview.

To determine whether or not the 2-day and 14-day assessments were being completed as required, we reviewed inmate health care files in three men’s Regional Receptions Centres (RRC) in Atlantic, Quebec and Pacific regions, at Sask Pen and Riverbend institutions in the Prairies and at Edmonton Institution for women offenders. The audit determined whether or not the information contained in the files indicated that the 2 and 14-day requirements were met, that the appropriate form was completed and that referrals were made when required. The results of the file review are presented in Table 2 and indicate that the 2-day assessment is being completed on time more often than the 14-day assessment. These initial evaluations are critical to ensuring that inmates receive appropriate health care while incarcerated.

Another requirement identified in CD800 in the 14-day evaluation, is for the provision of health education and promotion programs to meet the identified health needs of individual inmates and specific inmate groups. This was noted as having been done in 60% of the files we reviewed.

Table 2 – Results of File Review at CSC Intake

	2-Day Assessment	14-Day Assessment
Completed on time	84%	64%
Appropriate Form filled in	91%	77%
Evidence of referrals made when required	62%	76%
Evidence of health education/ promotion provided	N/A	60%

4.2.2 Emergency Health Care

We expected that inmates’ emergency health care needs would be met by medical and non medical staff in accordance with policy.

Emergency Health Services are provided in compliance with policies

CD 800 requires that access by inmates to health services be available on a 24-hour basis. Access can be provided through on-site coverage, on an on-call basis, through other CSC institutions, or through other community services. Emergency health care during hours when health care staff are not on site usually involves transporting the inmate to a community facility for care. In some institutions, when health care staff are not on site after hours, correctional staff will contact medical personnel or the nursing staff for advice on how to handle the emergency. At some sites, nursing or contract health care professionals are on call for this purpose. At other sites, correctional staff

decide on their own whether or not to call an ambulance or to transport the inmate themselves to a local hospital. All sites we visited advised us that correctional staff are very responsible in sending out inmates who require emergency health services in the community. Inmate Committee representatives also stated that they believe that inmates needing emergency health care are receiving appropriate treatment.

CD 800 requires that non-health services staff arriving on the scene of a possible medical emergency must immediately call for assistance, secure the area and initiate CPR/first aid without delay where physically feasible.

The policy also specifies that, when 24-hour nursing coverage is not provided, on-site staff with current certification in basic first aid and cardiopulmonary resuscitation (CPR) training will be available on site. A list of staff maintaining this certification shall be routinely accessible throughout the institution. Some institutions maintain a list of persons trained in CPR others maintain a list of correctional officer refresher training due dates and notify them when their recertification is approaching. Either approach ensures there are always personnel trained in CPR available to provide emergency response capability.

CSC policy requires that the Institutional Head must ensure there are quarterly on-site simulations of medical emergencies that will allow staff to practice and remain current in skills. Of the 18 sites we visited, 16 had conducted four in the last year and the other two institutions had two simulations conducted in that time frame.

4.2.3 Continuing Health Care

We expected that after leaving intake, inmates' continuing (non-emergency) health care needs would be identified and addressed in accordance with policy.

A process is in place to allow inmate to submit in confidence a request for health services.

In terms of identifying inmates health concerns, CD 800 requires that a process be in place to allow inmates the opportunity to submit in confidence a request for health care services, indicating the reason for the request and that these requests be relayed to a health care professional without delay. The sites we visited all have a process in place to receive inmate requests for health care services, either through a separate request box near inmate cells or at the health care centre or through a drop in clinic open to all inmates. These boxes are emptied at least once a day by the health service professionals. Nurses visit inmates in segregation at least once a day and get their requests directly.

Assurance cannot be provided on the delivery of continuing health care in accordance with policy

As noted previously, CSC has not clearly defined what constitutes "essential services" for physical health care. This makes assessment of compliance with the CCRA difficult to achieve. Further, as we noted in Section 4.1.3, there is very limited performance information available on the delivery of health care services, another factor which makes it difficult to assess compliance. Finally, not all relevant information is always contained in the health care file.

Information kept in Health Care files varies from institution to institution.

There are CSC forms that must be completed at certain times such as at intake, where a standard form is completed which records allergies, drug sensitivities, current treatment / drug regimes and current health problems including infectious diseases.

As a standard of practice set out by licensing / regulatory bodies, registered health professionals must ensure that all significant interactions with patients are documented. The type of interaction dictates which form is used i.e. if it was an x-ray, the radiography form would be used, or if it is a consultation, the Consultation and Referral form is used. If it was a patient visit, then a Progress Note would be written.

Beyond this however, it is not specified what must be documented for areas such as preparing an inmate for release to the community, which as noted above, makes it difficult to monitor if all necessary steps have been taken to ensure a smooth transition. It also makes monitoring level of service measures, such as time to receive medical attention for requests to see the doctor, very difficult as well. The health care professionals completing the file review for this audit found a wide variation in the information included in the health care files. The Assistant Commissioner Health Services is currently completing guidelines for documentation and maintenance of inmate health care records, as a guide for nursing staff on the use and management of the forms that make up an inmate's health care records. This should help to improve consistency in the filing of health care related information.

There are inconsistencies in the level of access to health care services provided.

During our site visits and interviews, we found some evidence that CSC is delivering health care services to address the continuing health care needs of offenders; however, we noted that the services are not provided consistently across the country.

There are no national standard for hours of operation for health care centres at CSC institutions and they are set locally to accommodate the operational requirements of the facility, the availability of contract professionals, as well as the needs of health care staff. This leads to a variety of hours of operation across the system and inconsistent provision of health care services to inmates in CSC institutions. For example, at three of the medium security institutions we visited, hours when nurses are available on site varied from 12 to 16 hours per day on weekdays and 8 to 16 hours per day on weekends.

Waiting times to access the services within the institution for non-urgent care also vary.

Frequency and duration of visits made by health care professionals on contract are established locally by the Chiefs of Health Services, based on their knowledge of expected demand, the availability of the professionals and funding.

The main indicator of the level of service provided by these contract professionals is the wait times for inmates to see them. However, the waiting times are difficult to establish for any particular health care service because the health care files are not structured to provide this kind of information. It is often not possible to link individual requests for health care services to a particular consultation and thereby establish the time required to access the system.

The three main health care services provided at almost all institutions are the general practitioner physician, the dentist and the optometrist. We obtained information from the Chiefs of Health Services we interviewed on the frequency of contract professional visits and the estimated waiting times for inmates to obtain these services. At all sites we visited, they informed us that if an inmate has an urgent need to access these services, they are seen the next time the service provider comes to the institution. If it is an emergency, they will be taken out to the community for immediate treatment. The frequency of physicians' visits varies from once a week to every day and their waiting lists vary from a week to a month for non-urgent care. Wait times for dentists' services are more problematic with waiting lists for regular check-ups ranging from one to six months and annual check-ups and routine cleanings are not available at all sites. Optometrists typically visit every few weeks and are generally able to satisfy all requests for care in every visit they make.

Inmate Committee members expressed some concerns about the level of health care provided at the CSC facilities we visited.

At the sites we visited, we met with representatives of the local inmate committees to get feedback on their concerns related to the provision of physical health care services. One of the more common concerns expressed was that when inmates submit a request for health services, they are not always informed that their request has been received and that they are, in fact, on the list to be seen by health services. This relates to non-emergency health care requests. More urgent needs are generally attended to quickly. Health care staff informed us they do not always have time to notify inmates that they are on the waiting list for consultation.

CD 800 requires that inmate requests for routine health services shall be screened by a nurse or other health care professional and referred to a clinician as appropriate. This helps to optimize the utilization of scarce specialist resources. However, the inmates we interviewed feel that, in the community, if they want to see a doctor they do not have to be "cleared" by a nurse first.

Finally, inmate committee representatives expressed concern with long waiting times to receive medical attention for requests submitted to health care centres. Chiefs of Health Services we interviewed informed us that for services obtained in the community, CSC staff normally contact the service provider and the offender is placed on the community waiting list with all other users. As long as the visit is not postponed because an escort is not available, inmates have waiting times for health care services that are comparable to the general public. For services delivered within the institution, it relates back to the issue of funding for contracted services impacting on service availability, especially for non-urgent requests. At some institutions we visited, the Chief of Health Services told us that the resulting resource levels mean that the service provider only has sufficient time to deal with urgent care needs and those with less urgent needs are frequently faced with longer wait times.

Health Care staff we interviewed have concerns with the health care facilities.

To be able to deliver proper health care, staff require reasonable facilities, appropriate equipment and sufficient medical supplies. At each facility we visited, we asked the Chiefs of Health Services and nurses whether they had any overall concerns with the health care facility, the equipment provided or the medical supplies available. For the facilities, 75% had concerns (covered in more detail in Section 4.3.4 of the report); for equipment, about half of the staff had concerns; and for medical supplies, only 30% had concerns. Again, the issue of funding availability was noted as a

contributing factor for the concerns expressed.

4.2.4 Escorts for Outside Medical Appointments

We expected that there would be sufficient resources to ensure that whenever inmates have to be escorted to receive medical care, correctional officers would be available to provide this service.

Provision of sufficient escorts to meet health care needs of offenders going out for community services is a challenge at some sites which can delay medical care received by inmates.

As part of our audit, we interviewed 15 Deputy Wardens to determine if there were any issues with the availability of escorts when inmates need to go to outside medical appointments. Almost half of them answered that it is an issue. In particular they cited a high number of escorts required on a regular basis, compared to the availability of correctional personnel to do the escorts.

The audit team also interviewed 20 Chiefs of Health Services about whether there are difficulties, such as cancellations or delays, with correctional officers bringing inmates to outside medical appointments caused by escorts not being available. Thirty percent said it is an ongoing problem and an additional thirty percent said it is an occasional problem.

The main constraint on providing escorts for external medical appointments is the overtime incurred for the correctional staff used for these escorts, especially when the requirement arises with short notice. At some institutions the number of escorts for medical appointments to the outside community for non-emergency needs is limited to one escort team per day. At other sites, there is more flexibility in the ability to access outside appointments. Escorts for hospital stays are usually more difficult to delay because they are typically related to more serious health care needs.

According to information provided by Correctional Operations and Programs Sector at NHQ, medical Escorted Temporary Absences (ETA) represent the largest portion of ETA overtime, and are a recurring subject of discussions between Institutional Management and Chiefs of Health Services. With the aging inmate population, there has been an increase in the general health services required, including medical ETAs. However, escort positions are still funded according to the 1999-2000 standards of 2, 3 or 4 positions per site. With the Revised Deployment Standards, escort positions are expected to increase to a minimum of 4 per site (by April, 2009). This should enhance the institutions' ability to provide escort services required for medical care.

4.2.5 Discharge and Transfer Planning

We expected that health care planning for discharge and transfer of inmates is in accordance with policy.

Compliance related to health care planning for discharge and transfer of inmates was difficult to assess due to a lack of information on many of the files reviewed.

According to CD800 on Health Care, prior to transfer the inmate's health service file shall be reviewed to identify any health problems in order to ensure continuity of care and fitness for program placement at the receiving institution, and to ensure that no medical complications are likely to arise during the transfer. This requires advance notification to the health care staff when an

inmate is being transferred or released to enable them to prepare the inmate and his records for transfer. There is a Health Services Transfer Summary that must be completed to ensure the receiving health care staff are aware of current medication, major medical problems and items requiring follow-up.

In addition, prior to transfer to another institution, the sending institution is responsible for all health-related care until the inmate reaches the receiving institution. The health care file is supposed to travel with the inmate to the receiving institution. CD 800 requires that following an inter or intra-regional transfer every inmate shall be given a nursing assessment and a referral to an appropriate clinician, if necessary. Most health care staff told us they review the health care file of incoming transferred inmates to ensure they are familiar with any immediate health care needs the inmate might have.

We interviewed 23 nurses and 20 Chiefs of Health Services and asked if they have reasonable notice prior to the release and transfer of inmates in general. About half feel they get reasonable notice, one quarter said it is an occasional problem and one quarter feel they do not. The health care professionals we interviewed told us they do complete the planning and preparation of inmates for transfer or release regardless but timely notification makes their task easier.

Based on a sample of 80 inmates who transferred into the institution we visited within a few weeks of our visit, we observed the following:

- The required administrative summary form (377-1), which includes information on current treatment and medication, major medical problems, items requiring follow-up including vaccinations and blood work, was included 95% of the time;
- Documented discussions between the sending and receiving institutions pertaining to the health care needs of the inmate being transferred were included in only 35% of the health care files;
- It was only indicated on about half of the files that the inmate arrived with his/her health care file; and
- The health care files were all reviewed by the receiving institution's health care staff upon arrival or within a few days of arrival.

The national directive on the release process for inmates going out to the community requires that prior to effecting the release of an offender CSC staff must identify and confirm any health care needs (including methadone) and ensure that the offender is provided with adequate medication (e.g. two-week supply) and health care coverage from the province of release. Referrals to available community resources may be necessary to ease the transition to community living for offenders with special needs, for example, those prescribed methadone.

Based on a sample of 77 inmates who were due to be released within a few weeks of our visit we noted the following from the information available in patient health care files:

- There was evidence of comprehensive pre-release planning about half the time;
- Indication that consultation took place with the community was only entered in about 30% of the files;
- It was almost never indicated whether an inmate had health care coverage in the province of release, but this is usually arranged by the Institutional Parole Officer; and

- There was insufficient information on file to determine whether or not inmates in our sample were going out to the community with the required temporary supply of their medication.

4.2.6 Sharing of Health Care Information

We expected that health care information would be shared in accordance with policy to protect confidentiality.

Concerns were expressed by health care staff about the confidentiality and sharing of health care information.

CD 800 states that a process shall be in place to allow inmates the opportunity to submit in confidence a request for health care services, indicating the reason for the request, and that an inmate's request for health services attention shall be relayed to a health care professional without delay.

We surveyed the health care facilities we visited to assess whether; a closed office is available in the health care centre to allow for private consultations; and non-medical activities are taking place within the health care centre, which could compromise the ability to maintain confidentiality of information being exchanged. We found that although the majority of the health care centres had enough space to conduct interviews privately and had only medical activities occurring in the centre, lack of space was a concern at most sites.

Health care information is locked away, as required, in all sites that do not have staff on site 24-7. Health care staff reported they only share health care-related information with non health care staff when absolutely required and only as much as is necessary. There were some concerns raised by health care staff with sharing of health care information related to:

- correctional staff being in the health care facility and being able to overhear discussions or consultations between health care staff and inmates;
- correctional staff having access to the health care files in off hours when health care staff are not around, in case of emergency;
- inmates being called over the loudspeaker system to report to see particular health care staff who have very specific responsibilities or specialties such as Hepatitis C or HIV; and
- inmates going out to external appointments in groups where it might be assumed they all have similar health concerns.

Conclusions and Recommendations

In a number of areas, CSC institutions / health care centres are complying with existing health care legislation, policies and procedures for the physical well being of their inmates. However, in other areas, although we found evidence that CSC is delivering health care services to address the continuing health care needs of offenders, assurance on overall compliance could not be provided as not all relevant information was contained in the inmates' health care files. There are important concerns that need to be addressed:

- Each offender arriving at the Regional Reception Centres in CSC must be evaluated within two days of arrival to identify any immediate health-related concerns; a second more comprehensive assessment is due within the first 14 days. Of the files we reviewed, the 2-

day assessments were completed within the required timeframe 84% of the time, and the 14-day deadline was met only 64% of the time. These initial evaluations are critical to ensuring that inmates receive appropriate health care while incarcerated.

- Information kept in Health Care files varies from institution to institution. Beyond the standard forms used to record pertinent information at intake units and documentation of significant interactions with patients, CSC does not specify what must be documented for areas such as preparing an inmate for release to the community. This makes monitoring level of service measures, such as time to receive medical attention for requests to see the doctor, very difficult as well as assessment of compliance.
- There are inconsistencies in the access provided to health care services. There are no national standards for Health Care Centre hours of operation. There is also no standard approach to schedule frequency or duration of visits made by health care professionals on contract at CSC institutions which affects wait times to access health care services.
- Inmates regularly require health care services in the community and they must be escorted by correctional staff. This can cause overtime charges whenever the number of escorts required exceeds the number of officers available. Because of this, provision of sufficient escorts to meet health care needs of offenders going out for community services is a challenge at some sites which can delay medical care received by inmates.
- Concerns were also raised by health care staff about confidentiality and sharing of health care information.

Recommendation #6

The Assistant Commissioner, Health Services should ensure processes are in place to achieve compliance with the requirements for health care examinations of offenders at the Regional Reception Centres.

Recommendation #7

The Assistant Commissioner, Health Services should provide direction on the information that must be documented in inmate health care files.

Recommendation #8

The Assistant Commissioner, Health Services should establish service standards for the level of access to health care services to be provided at CSC institutions.

Recommendation #9

The Assistant Commissioner, Health Services in collaboration with the Assistant Commissioner, Correctional Operations and Programs should review the availability of escorts required for the provision of healthcare services and take additional measures, as needed, to ensure that inmates have timely access to required health care services in the community.

Recommendation #10

The Assistant Commissioner, Health Services should assess if additional measures are required to ensure the confidentiality of inmate health care information.

4.3 Practices for the Management of Infectious Diseases

4.3.1 Harm Reduction Measures

We expected that harm reduction measures would be available for inmates within the institutions in accordance with policy.

Harm reduction measures are not readily available for inmates at many CSC institutions

Infectious diseases are addressed in CD 821, which indicates that “Approved harm reduction items shall be readily and discreetly accessible to inmates in CSC operational units so that no inmate is required to make a request to a staff member for any item”. The harm reduction items include condoms, dental dams, bleach and lubricants. Few institutions met these requirements. In fact, nationally, institutions were in compliance only about half the time.

The means by which harm reduction measures are available to offenders within institutions also varies widely. In some institutions, offenders maintain these supplies as their institutional “job”, or offenders in the Peer Education and Counselling (PEC) program provide them. In others, it is the Supervisor, Institutional Services who is responsible for ensuring there is a means for dispensing bleach or giving out condoms, lubricants or dental dams. In some cases, offenders have to ask for these supplies, which is contrary to the policy.

Where harm reduction items are available, it is also important to have instructional material available, especially in the case of the proper use of bleach to clean syringes. In the institutions we visited, this information was available only 57% of the time.

4.3.2 Education / Counselling Programs

We expected that infectious disease education/counselling programs are in place in accordance with policy.

Infectious disease education/counselling programs are in place in most institutions however, inmate support groups are not active at all sites.

CSC policy requires that Health Education and Promotion programs shall be provided to meet the identified needs of individual offenders and specific offender groups. Infectious disease education/counselling programs are in place in most institutions we visited and are being managed by the Infectious Disease Nurse (IDN) who is funded from the national budget for Infectious Disease Programs. However, support groups such as the Peer Education and Counselling Program (PEC) or the Aboriginal PEC (APEC), where warranted, are not active at all sites. Some sites are having difficulty keeping trained counsellors available to provide this service because funding for the training is not always available and there are not always inmates interested in being trained and providing this service.

4.3.3 Cleanup of Blood and Bodily Fluids

We expected that measures would be in place for the handling and clean-up of blood and body fluid in accordance with policy.

Concerns were expressed with the availability of training for the clean-up of blood and body fluids.

According to the Protocol on Managing Exposure to Blood and/or Bodily Fluids, the Operational Unit Head is responsible for ensuring that:

- arrangements have been made with a nearby hospital/clinic to deal with Post-exposure Protocol;
- appropriate post-exposure medication is available for the treatment of staff and offenders.

All sites we visited have made arrangements with a nearby hospital to deal with post-exposure protocol or have received such services in the past and have appropriate post-exposure medication available for the treatment of staff and inmates.

According to CSC policy, the Institutional Head or his/her delegate is responsible for determining who will be involved in the cleaning up of blood and/or other body fluids within the institution, and it can be specifically-trained staff or specifically-trained inmates who are under the supervision of specifically-trained staff or outside contractors. Inmates and staff involved in the handling and clean-up of blood and body fluids are required to be trained in the use of, and provided with, protective clothing and equipment. The equipment required includes face shields, gloves, gowns, eye protection and a spill clean-up kit. However, there is currently no national standard for training related to clean-up of blood or other bodily fluids.

At most institutions we visited, the clean-up of blood and bodily fluids is the responsibility of the staff of the Supervisor, Institutional Services and for the others it is done under contract. We interviewed their staff and they informed us that the clean-up is done either by the staff or by inmates who are supervised by the staff or by contractors. For the most part, sites have the required equipment and supplies needed to do the clean-up. Because there is no related national training standard, the one area that is not consistently addressed is the training provided to those doing the clean-up and those supervising them. Staff responsible for the clean-up expressed concern to us that there is no direction available for what training should be provided to the personnel doing the clean-up, or to those supervising them. Some sites have developed their own training packages or obtained them from contractors, which could affect the effectiveness of the cleaning provided.

4.3.4 Infection Control

We expected that elements of infection control are in place in accordance with policy.

Most elements of infection control are taking place in accordance with policy but some concerns were raised related to the cleanliness of health care facilities.

Some of the main elements for controlling infectious disease are included in the CSC Infection Control Manual (2006). It states that housekeeping is an extremely important part of preventing the spread of infections; all horizontal and frequently touched surfaces should be cleaned daily and when soiled. It also stated that hand hygiene is the simplest, most effective measure for preventing health-care related infections and it includes hand washing and the use of an alcohol-based, antiseptic hand sanitizer. Finally, it requires that used sharp items such as needles, be disposed of in designated puncture resistant containers located in the area where the items were used. We were also informed by a Regional Infectious Disease Coordinator that the need for professional housekeeping in the Health Centres has been discussed at a number of national forums and that increasingly, in infection prevention and control forums, there is an emphasis on environmental controls including housekeeping.

During our walk-around examination of the health care facilities, we assessed factors such as:

- overall appearance and cleanliness of the facility;
- availability of suitable facilities for hand washing and dispensers of hand sanitizing products; and
- sharps disposal system availability.

We found that the size and condition of health care facilities varied widely from site to site based on the age of the institution and the history of the health care centre. The audit team considered thirty-two percent of the health care centres observed to be unclean and/or cluttered. Two of the centres we visited used a contractor to do the cleaning and another used a contractor to supervise the cleaners. The remainder used inmate cleaners. All Chiefs of Health Services were concerned with the level of cleaning provided by inmate cleaners who are not trained to clean a medical care facility, may not always be motivated to perform at an acceptable level, and who are replaced frequently, as they leave the institution or change jobs. In some cases the nursing staff advised us that they did the cleaning, or re-cleaned certain areas, because they were not satisfied with the level of cleanliness provided by inmate cleaners.

All health care facilities had suitable facilities for hand washing with soap dispensers, paper towels and waste disposal nearby. Most centres have alcohol based hand sanitizers located in them but some had not yet been installed and not all are accessible for inmates to use. All facilities we visited have a sharps disposal system.

4.3.5 Release/Transfer Planning

We expected that release/transfer planning for inmates with infectious disease is taking place in accordance with policy.

Compliance related to health care planning for discharge and transfer of inmates with infectious diseases was difficult to assess due to a lack of information on many of the files reviewed.

Inmates with infectious diseases were randomly included in the sample of files reviewed to determine the compliance with the overall requirements for the preparation of inmates for discharge and transfer (Section 4.2.5). Beyond these general requirements however, CD 821 (Management of Infectious Diseases) states that the Chief, Health Services is responsible for ensuring the provision of quality clinical care and treatment to inmates living with infectious diseases, including continuity of care when transferred to another institution and pre-release planning for their return to the community.

Under pre-release planning, CD 821 specifies that inmates who require ongoing medical care for the treatment of an infectious disease shall be:

- referred to the full range of community treatment resources prior to their release;
- given a summary of their related health care information for the benefit of their health care providers in the community;
- provided with information on groups which offer education and support services in the community in which they will be residing; and
- encouraged to establish contacts with education or support groups in the community

These duties are handled for the most part by the Infectious Disease Nurse, as one of the main responsibilities of that portfolio. They work in conjunction with the Institutional Parole Officer as part of pre-release planning. As noted earlier (Section 4.2.5), information related to pre-release preparation is not systematically entered on the health care file. Therefore we interviewed the Infectious Disease Nurses at the institutions we visited, to determine what is done to prepare inmates with infectious diseases for release into the community. For the most part, at the institutions we visited, the Infectious Disease Nurses told us they do complete these four elements of pre-release planning for the inmates in their institution and no concerns were expressed by them on their ability to meet these requirements.

Conclusions and Recommendations

Although practices for the management of infectious diseases comply with policy in some areas, improvements are required as follows:

- Harm reduction materials such as condoms, dental dams, bleach and lubricant are required to be readily and discreetly accessible to inmates in CSC operational units. Nationally institutions were in compliance only about half the time.
- Although infectious disease education/counselling programs are in place in most institutions we visited, support groups such as the Peer Educating Counselling Program (PEC) or the Aboriginal PEC (APEC) are not active at all sites.
- For the most part, sites have the required equipment and supplies needed to do the clean-up of blood and body fluids, but there is no related national training standard for those doing the clean-up or those supervising them which could affect the effectiveness of the cleaning provided.
- Most elements of infection control are taking place in accordance with policy but some concerns were raised related to the cleanliness of health care facilities. Proper cleaning services are not being provided at most health care facilities, where untrained inmate cleaners are being used to clean these facilities.

Recommendation #11

The Regional Deputy Commissioners in collaboration with the Assistant Commissioner, Health Services should ensure that required harm reduction measures are made available to inmates as required by CSC policy.

Recommendation #12

The Assistant Commissioner, Health Services in collaboration with the Regional Deputy Commissioners should continue to improve the availability of health care education/counseling programs at all sites.

Recommendation #13

The Assistant Commissioner, Human Resource Management in collaboration with the Regional Deputy Commissioners, should assess the need to establish a national training program for personnel involved in the clean-up of blood and body fluids.

Recommendation #14

The Regional Deputy Commissioners, in collaboration with the Assistant Commissioner Correctional Operations and Programs and the Assistant Commissioner, Health Services should take measures to improve the cleanliness of the health care facilities where needed.

4.4 Inmates with specific health care needs

The CCRA states that the principles that shall guide the Service are that correctional policies, programs and practices respect gender, ethnic, cultural and linguistic differences and be responsive to the special needs of women and aboriginal peoples, as well as to the needs of other groups of offenders with special requirements.

4.4.1 Palliative Care Inmates

We expected that the specific physical health care needs for inmates requiring palliative care would be addressed in accordance with policy.

Physical health care needs for inmates requiring palliative care are being addressed in accordance with policy.

The CCRA allows under its provisions for exceptional cases that parole may be granted at any time to an offender who is terminally ill, as long as they do not present an undue risk to society. The National Parole Board decides whether release to the community is acceptable. Generally, the Institutional Parole Officer is responsible for the application for early parole to the National Parole Board, with appropriate input from health services at the site. We interviewed Chiefs of Health Care at the sites we visited and they informed us that this application is being made for inmates requiring palliative care, in cases for which the parole officer believes the risk is acceptable and the CHS's are being consulted in this process.

CSC has created the Palliative Care Guidelines (2002) which state that the goals of palliative care in CSC are to provide patient-centred care comparable to what is offered in the community. Where release to the community is not feasible, CSC will strive to provide compassionate, patient-centred palliative care. Within CSC, a range of professionals and staff are generally involved in each patient's care. The composition of a multidisciplinary team may vary depending on the needs of the patient and family. In addition, consultants may be called on a case-by-case basis.

Two of the key elements identified by the Palliative Care Guidelines to ensure all elements of palliative care are being addressed, are completion of: 1) the Multidisciplinary Palliative Care Team - Care Checklist; and 2) the Care Plan. The checklist contains key events that need to take place such as relevant CSC forms have been completed and key contacts have been identified and notified. The Care Plan provides more detailed information on the contact persons for the inmate and any required follow-up actions.

The Palliative Care Guidelines also recommend that the patient should be allowed to remain at the parent institution or in the community setting as long as he/she desires, if adequate care can be provided, and that the patient should be transferred to the Regional Hospital or community facility when care can no longer be provided at the parent institution.

There are not many inmates requiring palliative care at any given time so there were only nine files to review for palliative care patients at the facilities we visited. For these files, almost all had evidence that a multidisciplinary team was in place and in 67% of the cases, the CSC Multidisciplinary Palliative Care Team – Care Checklist form was used. In almost all the cases, there was an appropriate and documented Palliative Care Plan in place. In most of the files it was noted that transfer to a regional hospital had been considered and the regional hospital had been contacted. Some regions have a regional palliative care team which supports the sites in dealing with the care issues for patients with palliative diagnosis. Others provide counselling to the institutions and training for health care staff.

4.4.2 Women Inmates

We expected that specific physical health care needs for women offenders would be identified and addressed in accordance with policy.

The Institutional Mother-Child Program is being provided for women inmates in accordance with policy

As part of the CCRA requirement for correctional policies, programs and practices to be responsive to the special needs of women, CSC has created the Policy for the Institutional Mother-Child Program which allows for full-time or part-time residency of a child with his/her mother in the institution. It states that all routine health care for the child shall normally be provided by community health care agencies outside of the institution, unless alternate arrangements are made. Staff are to provide assistance to the child in medical emergencies. Accommodation is also to be provided for pre- and post-natal care for pregnant inmates; however, arrangements are to be made for infant births at community hospitals. The Chiefs of Health Care Services at the women's facilities we visited informed us that there are not many participants in this program, but they can be accommodated using physicians on contract in the institution in combination with community health services.

4.4.3 Aboriginal Inmates

We expected that the specific physical health care needs for aboriginal inmates would be addressed in accordance with policy.

Provision of access to elder services for aboriginal inmates are being addressed

In addition to the CCRA requirement cited above for CSC services to be responsive to the special needs of aboriginal peoples, it states that the Service shall take all reasonable steps to make available the services of an aboriginal spiritual leader or elder to aboriginal inmates. It is through the elder that aboriginal inmates have access to aboriginally-based physical health care services and approaches.

At the two women's facilities and the two healing lodges we visited, aboriginal inmates have access to the services of an elder who is located on site. When required, access to the services of an elder at facilities with lower aboriginal inmate populations (for both men and women) is provided through the assistance of CSC personnel in the institution or at regional headquarters who are responsible for provision of aboriginal services.

Regional Aboriginal Health Program Coordinators have been established in the Prairie and Pacific Regions where aboriginal inmate populations are higher than other regions. This should help to promote the availability of aboriginally based physical health care alternatives.

Conclusion

Overall, CSC institutions / health care centres are complying with existing health legislation and policies for the physical well-being for inmates requiring palliative care, women offenders and aboriginal inmates.

Appendix A – Objectives and Criteria

Objective	Criteria
<p>1. To assess the adequacy of the management framework for institutional physical health services.</p>	1.1. CSC policies and procedures are up to date, compliant with legislation and sufficient to ensure the physical health needs of inmates are being addressed.
	1.2. Medical policies, procedures and/or directives are in place in CSC facilities to ensure the national policies and procedures are being effectively implemented.
	1.3 Monitoring and reporting mechanisms are in place at NHQ, RHQ and the institutions to ensure compliance with policy.
	1.4 Continuous Quality Improvement Programs are in place for the delivery of physical health care services.
	1.5 Roles and responsibilities for health care services have been defined, they are understood and are being followed at NHQ, RHQ and the institutions.
	1.6. Staffing levels and resources allocations within health care are in accordance with the approved organizational plan.
	1.7 Health professionals working in health care are registered, licensed or certified in accordance with their respective professional requirements.
	1.8 Training is being provided and taken as required for all CSC personnel involved in delivery of physical health care services.
<p>2. To determine the extent to which CSC institutions / health care centres are complying with existing health care legislation, policies and procedures for the physical well-being of their inmates.</p>	2.1 At intake, inmates’ health care needs are identified and addressed in accordance with policy.
	2.2 Inmates’ emergency health care needs are being met by medical and non medical staff in accordance with policy.
	2.3 After leaving intake, inmates’ continuing health care needs are identified and addressed in accordance with policy.
	2.4 Escorts for medical appointments are available as required.
	2.5 Health care planning for discharge and transfer of inmates is in accordance with policy.
	2.6 Health care information is documented, organized, stored and shared in accordance with policy.

Appendix A – Objectives and Criteria

3. To determine whether the management of infectious disease practices in the institutions / health care centres is compliant with policy.	3.1 Harm reduction measures are available within the institutions in accordance with policy.
	3.2 Infectious disease education/counselling programs are in place in accordance with policy.
	3.3 Measures are in place for the handling and clean-up of blood and body fluid in accordance with policy.
	3.4 Infection control is taking place in accordance with policy.
	3.5 Release/transfer planning for inmates with infectious diseases is taking place in accordance with policy.
4. To determine the extent to which CSC institutions / health care centres are complying with existing health legislation and health policies and procedures for the physical well being of inmates with specific health care needs.	4.1 Specific physical health care needs for inmates requiring palliative care are addressed in accordance with policy.
	4.2. Specific physical health care needs for women offenders are identified and addressed in accordance with policy.
	4.3 Specific physical health care needs for aboriginal inmates are addressed in accordance with policy.

Appendix B – Institutions / Facilities Visited

Location of Site Visits

Atlantic Region

- Regional Headquarters
- Atlantic Institution – Maximum Security
- Dorchester Institution – Medium Security and Hospital
- Springhill Institution – Regional Reception Centre

Quebec Region

- Regional Headquarters
- Special Handling Unit – High-maximum security
- Regional Reception Centre – Multi-level security
- Regional Hospital – Multi-level security
- Archambault Institution – Medium Security
- Federal Training Centre – Minimum Security

Ontario Region

- Regional Headquarters
- Kingston Penitentiary – Maximum Security / Hospital
- Warkworth Institution – Medium Security
- Pittsburgh Institution – Minimum Security

Prairie Region

- Regional Headquarters
- Saskatchewan Penitentiary – Medium Security
- Regional Psychiatric Centre – Multi-level Security
- Riverbend Institution – Minimum Security
- Edmonton Institution for Women – Multi-level Security
- Pê Sâkâstêw – Men’s Healing Lodge
- Okimaw Ohci – Women’s Healing Lodge

Pacific Region

- Regional Headquarters
- Pacific Institution/Regional Reception Centre – Multi-level security
- Mountain Institution – Medium security
- Ferndale institution – Minimum Security

Appendix C – Physical Health Services Funding

Table 1 - CSC Physical Health Care Budget – 2007-08

CSC – Physical Health Care							
	Revised Budget – 2007-08						
	NHQ	Atlantic	Quebec	Ontario	Prairies	Pacific	Total
800 - HEALTH POLICY, QUALITY IMPROVEMENT, AND ACCREDITATION							
240 - Operating	\$825,352	\$194,347	\$192,622	\$257,398	\$415,476	\$852,641	\$2,737,836
210 - Salaries	\$2,256,384	\$712,451	\$499,090	\$1,212,173	\$1,419,491	\$1,465,892	\$7,565,481
SUB TOTAL	\$3,081,736	\$906,798	\$691,712	\$1,469,571	\$1,834,967	\$2,318,533	\$10,303,317
820 - CLINICAL SERVICES							
240 - Operating	\$1,344,069	\$7,065,450	\$10,058,558	\$12,257,129	\$10,307,943	\$7,458,695	\$48,491,844
210 - Salaries	\$1,679,261	\$3,619,489	\$7,946,942	\$7,598,506	\$6,529,088	\$6,185,092	\$33,558,378
SUB TOTAL	\$3,023,330	\$10,684,939	\$18,005,500	\$19,855,635	\$16,837,031	\$13,643,787	\$82,050,222
860 - PUBLIC HEALTH							
240 - Operating	\$1,592,853	\$983,346	\$3,443,448	\$808,229	\$1,549,237	\$1,481,793	\$9,858,906
210 - Salaries	\$776,598	\$619,834	\$1,077,521	\$1,188,655	\$1,251,862	\$1,126,417	\$6,040,887
SUB TOTAL	\$2,369,451	\$1,603,180	\$4,520,969	\$1,996,884	\$2,801,099	\$2,608,210	\$15,899,793
TOTAL ALLOCATION	\$8,474,517	\$13,194,917	\$23,218,181	\$23,322,090	\$21,473,097	\$18,570,530	\$108,253,332
Number of Inmates	N/A	1,426	3,398	3,793	3,477	2,071	N/A
Average Physical Health Care Budget (\$ per Inmate)	N/A	\$9,253	\$6,833	\$6,149	\$6,176	\$8,967	N/A

Appendix D – Management Action Plan

Recommendation	Action Summary	OPI	Planned Completion Date
1. The Assistant Commissioner, Health Services should clarify the distinction between essential and non-essential/other health care services.	<p>Building on the good practice in Pacific Region, Health Services will:</p> <ul style="list-style-type: none"> • Define key essential health services and non-essential health services for physical health services; and • Clarify for inmates how to request non-essential health services not covered by CSC. 	ACHS	<p>March 2009</p> <p>March 2009</p>
2. The Assistant Commissioner, Health Services should develop and implement a performance management framework related to the delivery of health care services.	<p>Health Services will:</p> <ul style="list-style-type: none"> • Develop a comprehensive performance measurement framework, including health objectives, outputs and outcomes. The complete performance measurement framework will be implemented when the CSC electronic health record is implemented. • Identify snapshot health data elements which can be used to inform decision-making in the short-term and begin to establish benchmarks for health services' delivery in the longer-term. • Collect identified data elements. • Analyze collected data for FY 08-09. 	ACHS	<p>March 2009</p> <p>May 2008</p> <p>Ongoing</p> <p>September 2009</p>
3. The Assistant Commissioner, Health Services should implement a Continuous Quality Improvement program and the Accreditation process.	<p>Health Services will implement, as a priority, a Continuous Quality Improvement program and accreditation process. Below are the key milestones:</p> <ul style="list-style-type: none"> • Develop a national work plan that identifies key deliverables at the national, regional and site level; • Implement a communication strategy; • Conduct the primer survey; and • Begin to conduct the accreditation surveys. 	ACHS	<p>May 2008</p> <p>May 2008</p> <p>Nov 2008</p> <p>May 2009</p>

Appendix D – Management Action Plan

Recommendation	Action Summary	OPI	Planned Completion Date
<p>4. The Assistant Commissioner, Health Services in collaboration with Assistant Commissioner Corporate Services should update the resourcing formulae for CSC Health Care Centres.</p>	<p>Health Services, in collaboration with Corporate Services, will update the resourcing formulae for health care units and hospitals. Below are the key milestones:</p> <ul style="list-style-type: none"> • Collect and analyze workload assessment data for nurses; and • Develop revised resourcing formulae based on the workload assessment 	<p>ACHS / ACCS</p>	<p>March 2009 September 2009</p>
<p>5. The Assistant Commissioner, Health Services should ensure that CSC health care staff meet the requirements of the National Training Standards related to their duties in CSC facilities</p>	<p>CSC just recently received new, on-going funding to address the training needs of nurses.</p> <p>Within the context of the nursing training initiative, emphasis will be placed on meeting the mandatory National Training Standards for nurses. More specifically, full-time nurses will receive, in FY 08-09, the identified mandatory training.</p> <p>Compliance will be monitored and corrective measures implemented as necessary.</p>	<p>ACHS</p>	<p>March 2009</p>
<p>6. The Assistant Commissioner, Health Services should ensure processes are in place to achieve compliance with the requirements for health care examinations of offenders at the Regional Reception Centres.</p>	<p>Since the audit was finalized, CSC has amended its policy for initial inmate health assessments; it is now to be completed within 24 hours of admission.</p> <p>The Assistant Commissioner Health Services will reinforce the importance of completing the initial health care examination and the 14 day assessment to all RDs/Chiefs of Health Care Units for Regional Reception Centres.</p> <p>Establish a mechanism to document refusals by inmates.</p> <p>Compliance will be monitored and corrective measures implemented as necessary.</p>	<p>ACHS</p>	<p>April 2008 September 2008</p>

Appendix D – Management Action Plan

Recommendation	Action Summary	OPI	Planned Completion Date
<p>7. The Assistant Commissioner, Health Services should provide direction on the information that must be documented in inmate health care files.</p>	<p>Work in this area is ongoing. Health care documentation guidelines have been drafted and are currently out for consultation.</p> <p>Guidelines will be implemented this spring.</p> <p>Additional data/information needed for improved health care delivery decision-making, including methods for data collection, will be identified in response to recommendation 2.</p>	<p>ACHS</p>	<p>April 2008</p>
<p>8. The Assistant Commissioner, Health Services should establish service standards for the level of access to health care services to be provided at CSC institutions.</p>	<p>In order to better standardize levels of access to health care services, more information is needed on workload and wait times. Health Services will:</p> <ul style="list-style-type: none"> • Collect data on current wait times in key areas; • Complete the workload assessment identified in response to recommendation number 4; and • Implement service standards for the level of access to health care services in all Health Care Units. 	<p>ACHS</p>	<p>December 2008</p> <p>March 2009</p> <p>TBD following finalized resourcing indicators in response to recommendation number 4.</p>

Appendix D – Management Action Plan

Recommendation	Action Summary	OPI	Planned Completion Date
<p>9. The Assistant Commissioner, Health Services in collaboration with the Assistant Commissioner, Correctional Operations and Programs should review the availability of escorts required for the provision of healthcare services and take additional measures, as needed, to ensure that inmates have timely access to required health care services in the community.</p>	<p>The Assistant Commissioner Health Services, together with the Assistant Commissioner Correctional Operations and Programs and the Deputy Commissioner for Women will review the availability of escorts for the provision of healthcare services and implement corrective measures as needed.</p> <p>The aim of this review will be to eliminate, wherever possible, the cancellation or delay of medical appointments due to the lack of available escorts and to minimize the use of overtime for both security and health care staff.</p> <p>More specifically, Health Services, in collaboration with Correctional Operations and Programs and the Women Offender Sector, will:</p> <ul style="list-style-type: none"> • Collect data on cancelled/delayed medical appointments and reasons; • Analyze data; • Make recommendations as required 	<p>ACHS / ACCOP /DCW</p>	<p>December 2008</p> <p>March 2009</p> <p>September 2009</p>
<p>10. The Assistant Commissioner, Health Services should assess if additional measures are required to ensure the confidentiality of inmate health care information.</p>	<p>The Assistant Commissioner Health Services will review existing confidentiality policies and practices.</p> <p>Additional measures will be implemented if required.</p>	<p>ACHS</p>	<p>October 2008</p>

Appendix D – Management Action Plan

Recommendation	Action Summary	OPI	Planned Completion Date
<p>11. The Regional Deputy Commissioners in collaboration with the Assistant Commissioner, Health Services should ensure that required harm reduction measures are made available to inmates as required by CSC policy.</p>	<p>The Regional Deputy Commissioners will remind all sites, in writing, of the requirement to ensure harm reduction materials, such as condoms, dental dams, bleach and lubricants are readily and discreetly accessible to inmates.</p> <p>Compliance will be monitored and corrective measures implemented as necessary.</p>	<p>RDCs / ACHS</p>	<p>May 2008</p>
<p>12. The Assistant Commissioner, Health Services in collaboration with the Regional Deputy Commissioners should continue to improve the availability of health care education/ counselling programs at all sites.</p>	<p>Harm Reduction in CSC is actively under review and the results of the review will inform and reference its position within the overall context of public health in the Service.</p> <p>One of the elements targeted in this review is identifying measures that CSC can implement in order to improve the availability of health care education and counselling programs at all sites.</p>	<p>ACHS / RDCs</p>	<p>December 2008</p>
<p>13. The Assistant Commissioner, Human Resource Management in collaboration with the Regional Deputy Commissioners, should assess the need to establish a national training program for personnel involved in the clean-up of blood and body fluids.</p>	<p>The Assistant Commissioner, Human Resource Management, in collaboration with Regional Deputy Commissioners, will implement a national training program for personnel involved in the clean-up of blood and bodily fluids.</p>	<p>ACHRM / RDCs</p>	<p>April 2008</p>

Appendix D – Management Action Plan

Recommendation	Action Summary	OPI	Planned Completion Date
<p>14. The Regional Deputy Commissioners, in collaboration with the Assistant Commissioner Correctional Operations and Programs and the Assistant Commissioner, Health Services should take measures to improve the cleanliness of the health care facilities where needed.</p>	<p>Regional Deputy Commissioners, in collaboration with the Assistant Commissioner, Corporate Services and the Assistant Commissioner, Health Services, will:</p> <ul style="list-style-type: none"> • Identify standards for the cleaning of health care facilities; and • Implement identified corrective measures. 	<p>RDCs / AC CS / ACHS</p>	<p style="text-align: center;">October 2008</p> <p style="text-align: center;">TBD</p>