Los Angeles County
Correctional Health Services

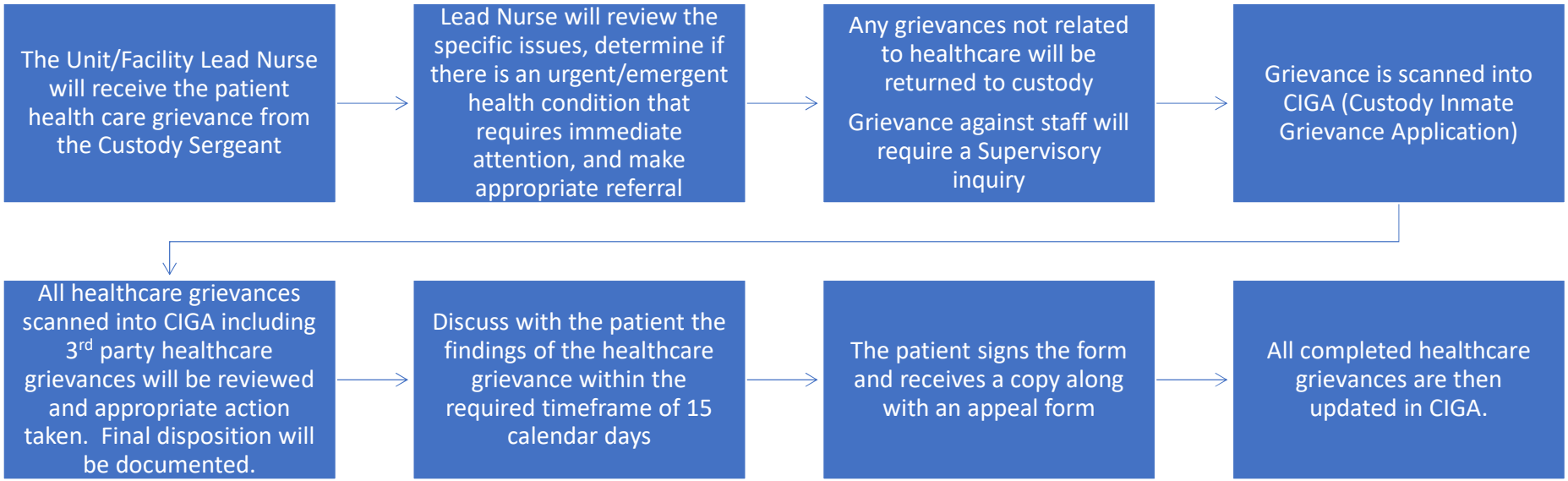
Patient Grievances

Ed Matzen, Chief Nursing Officer II

PATIENT HEALTHCARE GRIEVANCE

A patient's expressed effort to grieve and/or appeal any decision, action, condition or omission by the Department or its staff, that the patient can demonstrate as having a material adverse effect on his or her health, safety or welfare.

CHS HEALTHCARE GRIEVANCE WORKFLOW



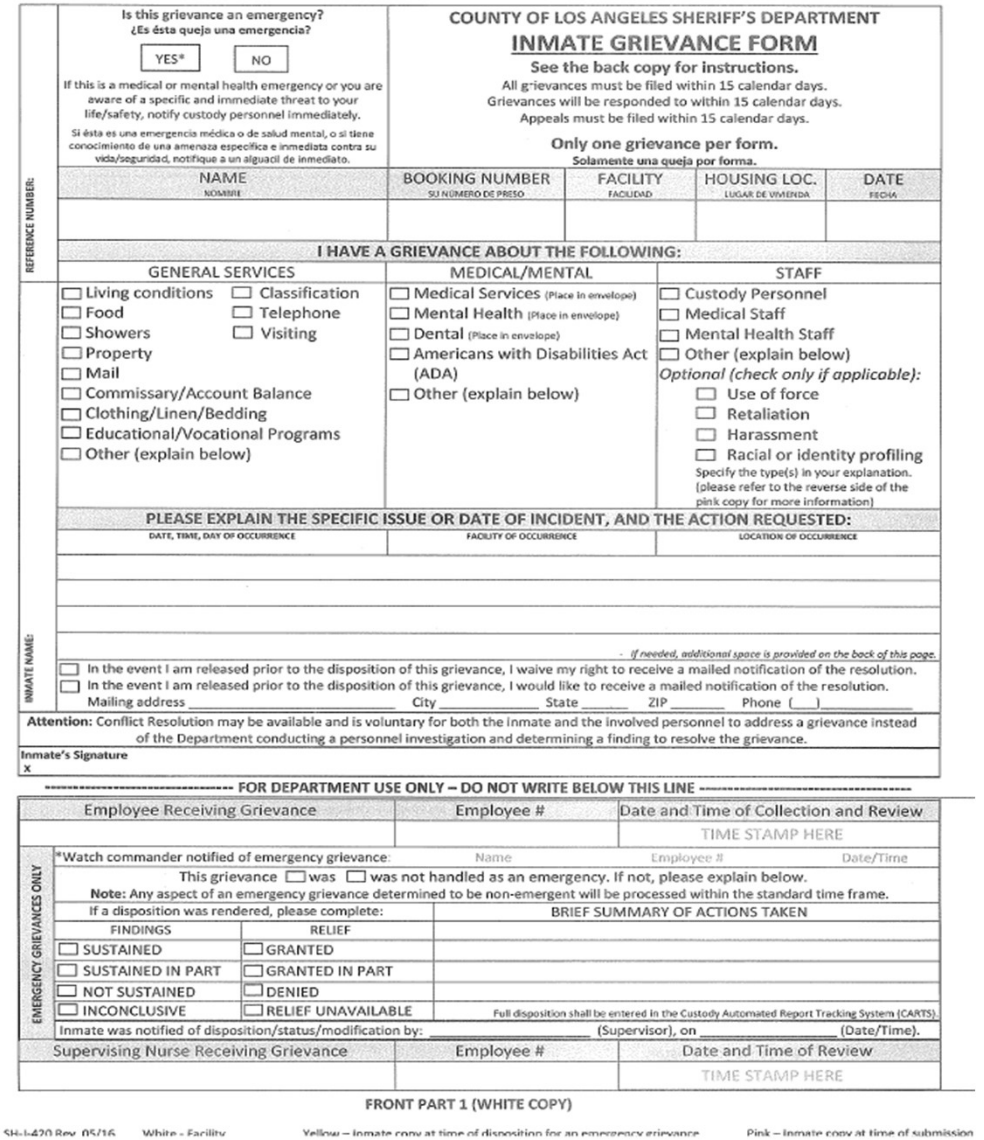
APPEALS PROCESS

Patients are given the appeal form upon receipt of the disposition.

If patient is not satisfied with the disposition, appeal form may be completed and submitted within 15 calendar days of receiving the written disposition.

Management will conduct a review and render a disposition within 15 calendar days.

INMATE GRIEVANCE FORM (SAMPLE)



Is this grievance an emergency?
¿Es ésta queja una emergencia?

YES* NO

If this is a medical or mental health emergency or you are aware of a specific and immediate threat to your life/safety, notify custody personnel immediately.

Si ésta es una emergencia médica o de salud mental, o si tiene conocimiento de una amenaza especifica e inmediata contra su vida/seguridad, notifique a un alguacil de inmediato.

COUNTY OF LOS ANGELES SHERIFF'S DEPARTMENT

INMATE GRIEVANCE FORM

See the back copy for instructions.

All grievances must be filed within 15 calendar days.
Grievances will be responded to within 15 calendar days.
Appeals must be filed within 15 calendar days.

Only one grievance per form.
Solamente una queja por forma.

REFERENCE NUMBER:

NAME (NOMBRE)	BOOKING NUMBER (SU NÚMERO DE PRESO)	FACILITY (FACILIDAD)	HOUSING LOC. (LUGAR DE VIVIENDA)	DATE (FECHA)

I HAVE A GRIEVANCE ABOUT THE FOLLOWING:

INMATE NAME:

GENERAL SERVICES	MEDICAL/MENTAL	STAFF
☐ Living conditions ☐ Classification	☐ Medical Services (Place in envelope)	☐ Custody Personnel
☐ Food ☐ Telephone	☐ Mental Health (Place in envelope)	☐ Medical Staff
☐ Showers ☐ Visiting	☐ Dental (Place in envelope)	☐ Mental Health Staff
☐ Property	☐ Americans with Disabilities Act (ADA)	☐ Other (explain below)
☐ Mail	☐ Other (explain below)	*Optional (check only if applicable):*
☐ Commissary/Account Balance		☐ Use of force
☐ Clothing/Linen/Bedding		☐ Retaliation
☐ Educational/Vocational Programs		☐ Harassment
☐ Other (explain below)		☐ Racial or identity profiling
		Specify the type(s) in your explanation. (please refer to the reverse side of the pink copy for more information)

PLEASE EXPLAIN THE SPECIFIC ISSUE OR DATE OF INCIDENT, AND THE ACTION REQUESTED:

DATE, TIME, DAY OF OCCURRENCE	FACILITY OF OCCURRENCE	LOCATION OF OCCURRENCE

If needed, additional space is provided on the back of this page.

☐ In the event I am released prior to the disposition of this grievance, I waive my right to receive a mailed notification of the resolution.
☐ In the event I am released prior to the disposition of this grievance, I would like to receive a mailed notification of the resolution.
Mailing address _____ City _____ State _____ ZIP _____ Phone (___)_____

Attention: Conflict Resolution may be available and is voluntary for both the inmate and the involved personnel to address a grievance instead of the Department conducting a personnel investigation and determining a finding to resolve the grievance.

Inmate's Signature
X

---------- FOR DEPARTMENT USE ONLY – DO NOT WRITE BELOW THIS LINE ----------

Employee Receiving Grievance	Employee #	Date and Time of Collection and Review
		TIME STAMP HERE

EMERGENCY GRIEVANCES ONLY

*Watch commander notified of emergency grievance: Name Employee # Date/Time

This grievance ☐ was ☐ was not handled as an emergency. If not, please explain below.

Note: Any aspect of an emergency grievance determined to be non-emergent will be processed within the standard time frame.

If a disposition was rendered, please complete:		BRIEF SUMMARY OF ACTIONS TAKEN
FINDINGS	RELIEF	
☐ SUSTAINED	☐ GRANTED	
☐ SUSTAINED IN PART	☐ GRANTED IN PART	
☐ NOT SUSTAINED	☐ DENIED	
☐ INCONCLUSIVE	☐ RELIEF UNAVAILABLE	Full disposition shall be entered in the Custody Automated Report Tracking System (CARTS).

Inmate was notified of disposition/status/modification by: _____ (Supervisor), on _____ (Date/Time).

Supervising Nurse Receiving Grievance	Employee #	Date and Time of Review
		TIME STAMP HERE

FRONT PART 1 (WHITE COPY)

SH-I-420 Rev. 05/16 White - Facility Yellow – Inmate copy at time of disposition for an emergency grievance Pink – Inmate copy at time of submission

COMMON HEALTHCARE GRIEVANCES RECEIVED

Provision of medications, treatments, medical supplies, or equipment

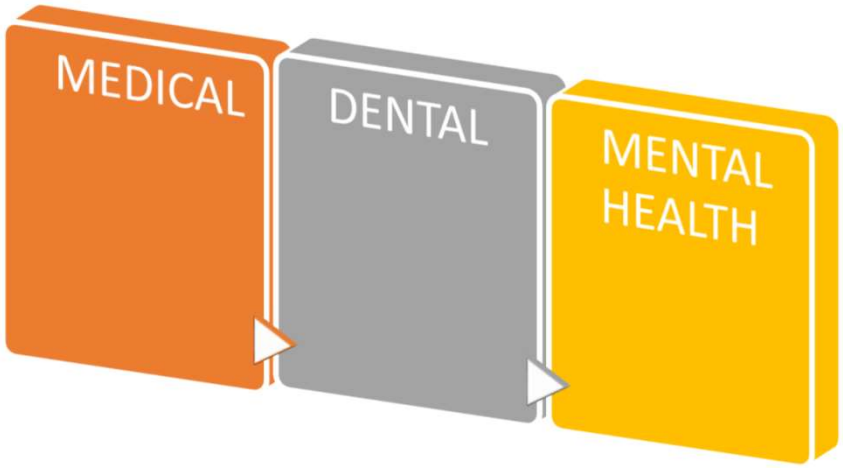
Health care appointments including specialty care appointments / services

HEALTH SERVICE REQUESTS

A Health Service Request (HSR) is the formal written process used by our patients to request non-emergency medical, dental, or mental health care within the Los Angeles County Jail.

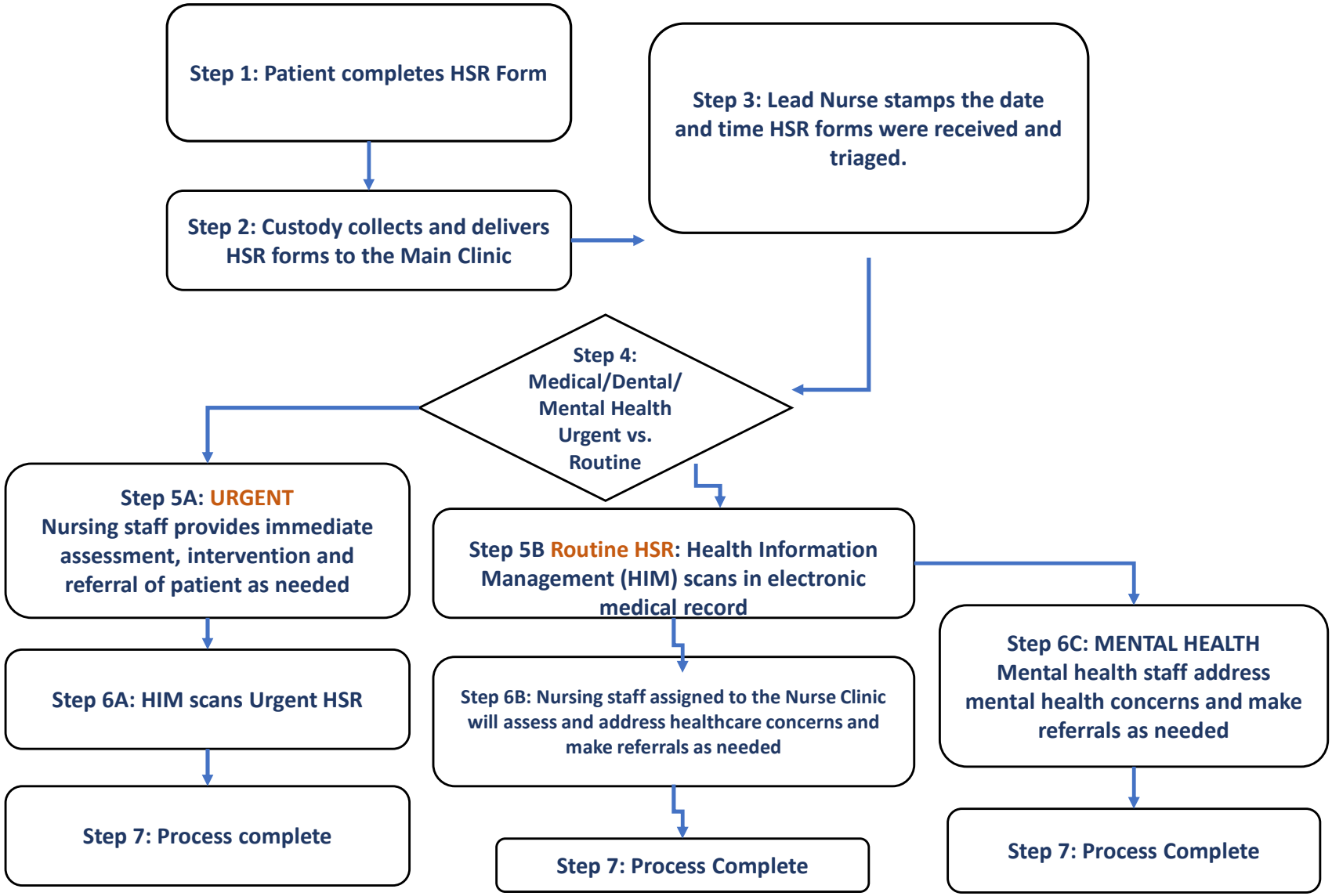
HSRs allow patients to seek health care services, request follow-up care, report symptoms or seek evaluation. HSR forms are available in all custody housing areas. HSR forms are triaged by nursing staff and prioritized based on healthcare need to ensure timely and appropriate care.

CHS Health Service Request Workflow

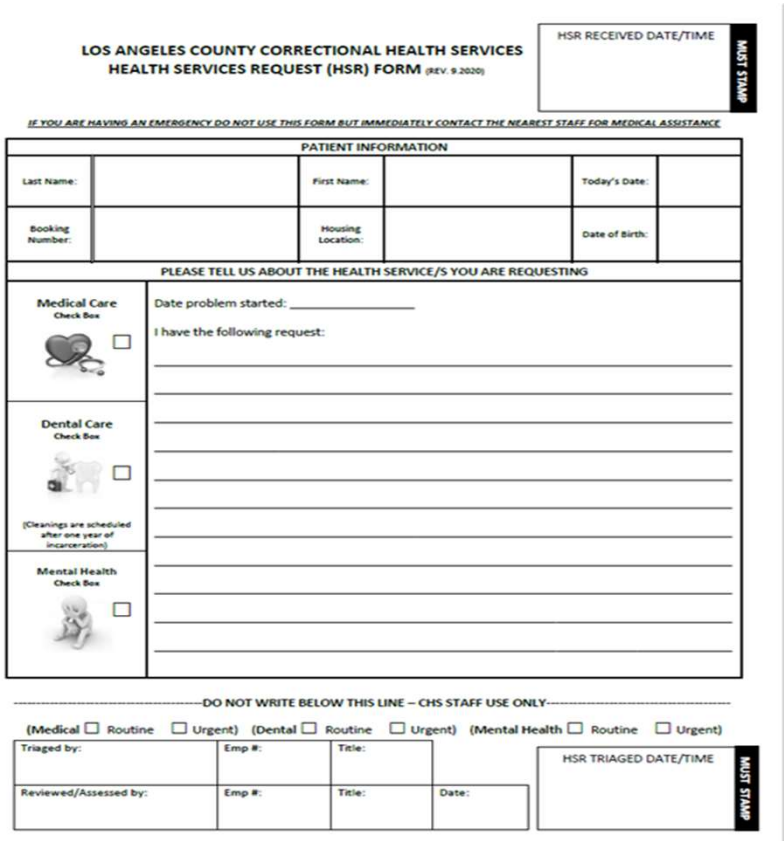


URGENT

ROUTINE


Step 1: Patient completes HSR Form
Step 2: Custody collects and delivers HSR forms to the Main Clinic
Step 3: Lead Nurse stamps the date and time HSR forms were received and triaged.
Step 4: Medical/Dental/ Mental Health Urgent vs. Routine
Step 5A: URGENT Nursing staff provides immediate assessment, intervention and referral of patient as needed
Step 6A: HIM scans Urgent HSR
Step 7: Process complete
Step 5B Routine HSR: Health Information Management (HIM) scans in electronic medical record
Step 6B: Nursing staff assigned to the Nurse Clinic will assess and address healthcare concerns and make referrals as needed
Step 7: Process Complete
Step 6C: MENTAL HEALTH Mental health staff address mental health concerns and make referrals as needed
Step 7: Process Complete

CORRECTIONAL HEALTH SERVICES
HEALTH SERVICE REQUEST FORM
(ENGLISH AND SPANISH VERSIONS)



LOS ANGELES COUNTY CORRECTIONAL HEALTH SERVICES
HEALTH SERVICES REQUEST (HSR) FORM (REV. 9.2020)

HSR RECEIVED DATE/TIME — MUST STAMP

IF YOU ARE HAVING AN EMERGENCY DO NOT USE THIS FORM BUT IMMEDIATELY CONTACT THE NEAREST STAFF FOR MEDICAL ASSISTANCE

PATIENT INFORMATION

Last Name:		First Name:		Today's Date:	
Booking Number:		Housing Location:		Date of Birth:	

PLEASE TELL US ABOUT THE HEALTH SERVICE/S YOU ARE REQUESTING

Medical Care Check Box ☐

Date problem started: _____

I have the following request:

Dental Care Check Box ☐

(Cleanings are scheduled after one year of incarceration)

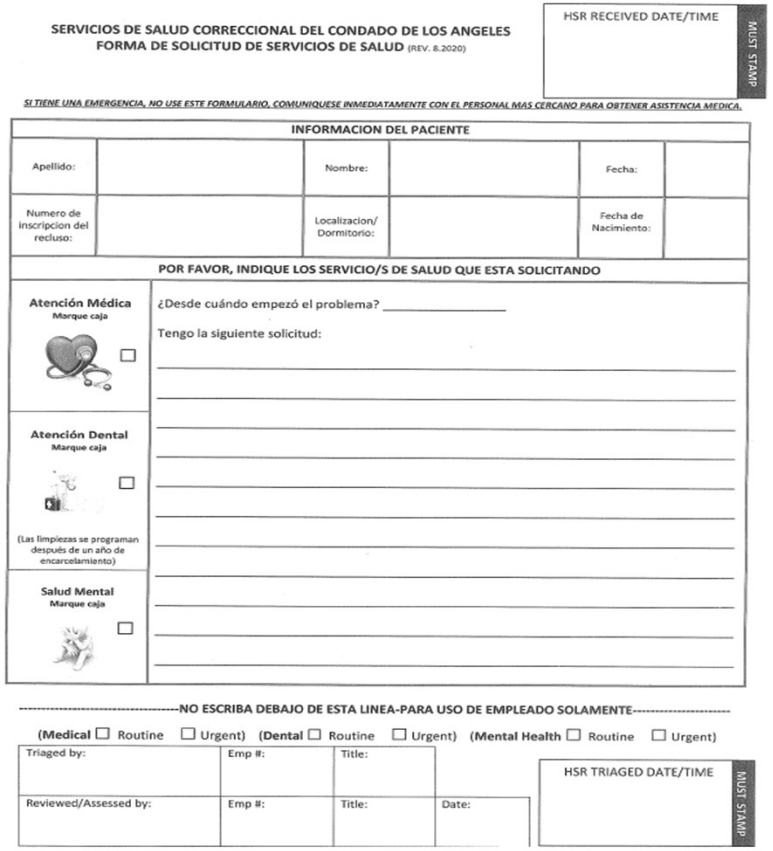
Mental Health Check Box ☐

----------DO NOT WRITE BELOW THIS LINE – CHS STAFF USE ONLY----------

(Medical ☐ Routine ☐ Urgent) (Dental ☐ Routine ☐ Urgent) (Mental Health ☐ Routine ☐ Urgent)

Triaged by:	Emp #:	Title:	
Reviewed/Assessed by:	Emp #:	Title:	Date:

HSR TRIAGED DATE/TIME — MUST STAMP



SERVICIOS DE SALUD CORRECCIONAL DEL CONDADO DE LOS ANGELES
FORMA DE SOLICITUD DE SERVICIOS DE SALUD (REV. 8.2020)

HSR RECEIVED DATE/TIME — MUST STAMP

SI TIENE UNA EMERGENCIA, NO USE ESTE FORMULARIO. COMUNIQUESE INMEDIATAMENTE CON EL PERSONAL MAS CERCANO PARA OBTENER ASISTENCIA MEDICA.

INFORMACION DEL PACIENTE

Apellido:		Nombre:		Fecha:	
Numero de inscripcion del recluso:		Localizacion/ Dormitorio:		Fecha de Nacimiento:	

POR FAVOR, INDIQUE LOS SERVICIO/S DE SALUD QUE ESTA SOLICITANDO

Atención Médica Marque caja ☐

¿Desde cuándo empezó el problema? _____

Tengo la siguiente solicitud:

Atención Dental Marque caja ☐

(Las limpiezas se programan después de un año de encarcelamiento)

Salud Mental Marque caja ☐

----------NO ESCRIBA DEBAJO DE ESTA LINEA-PARA USO DE EMPLEADO SOLAMENTE----------

(Medical ☐ Routine ☐ Urgent) (Dental ☐ Routine ☐ Urgent) (Mental Health ☐ Routine ☐ Urgent)

Triaged by:	Emp #:	Title:	
Reviewed/Assessed by:	Emp #:	Title:	Date:

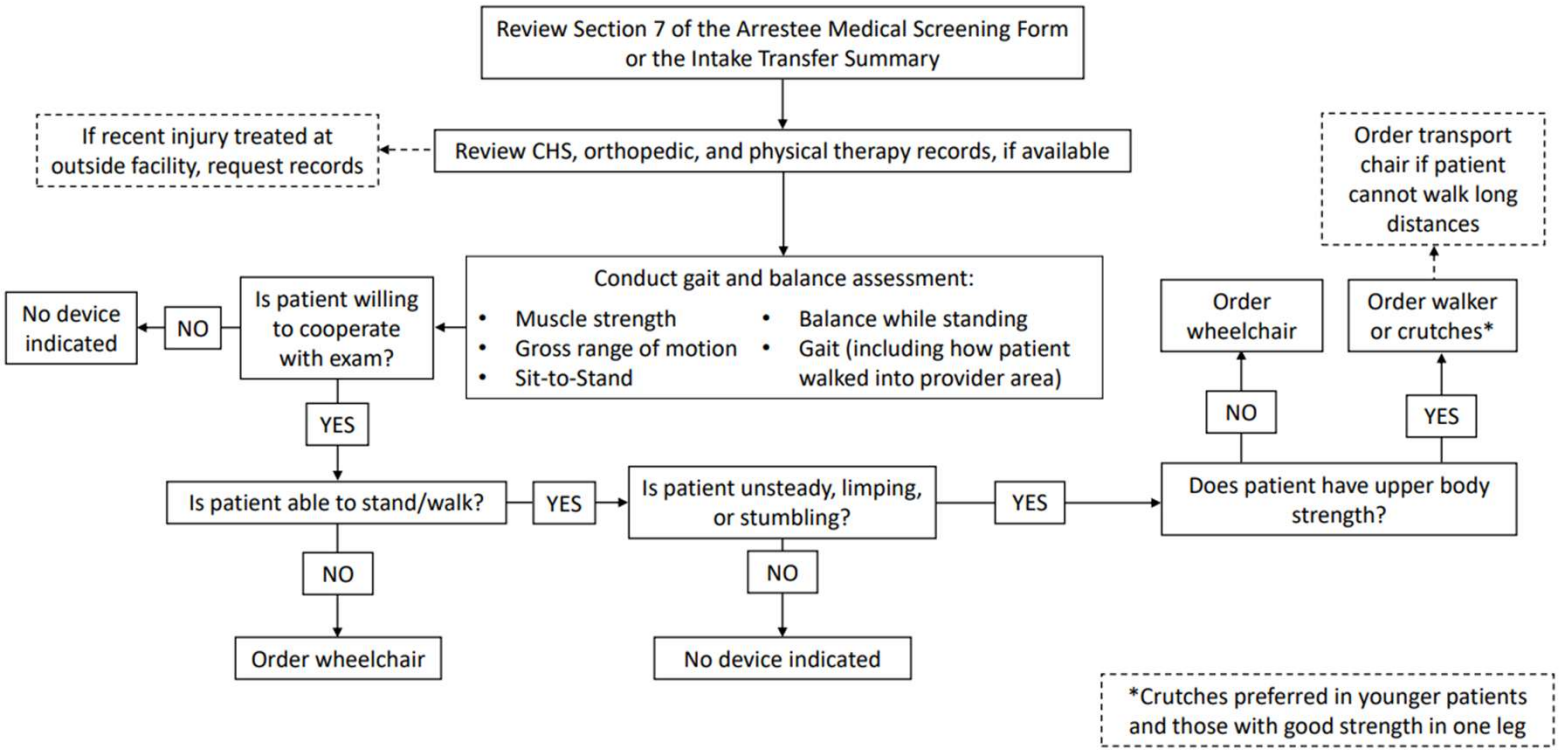
HSR TRIAGED DATE/TIME — MUST STAMP

OBSTACLES TO ACCESSING CARE

- HSR form availability and access
- Access to writing tools
- Timeliness of HSR form collection each shift and triage
- Access to patients including availability of custody escorts
- Facility/security lockdowns, disturbances, etc.
- Inmate movement and transfers
- Personnel resources to perform patient care delivery through all steps

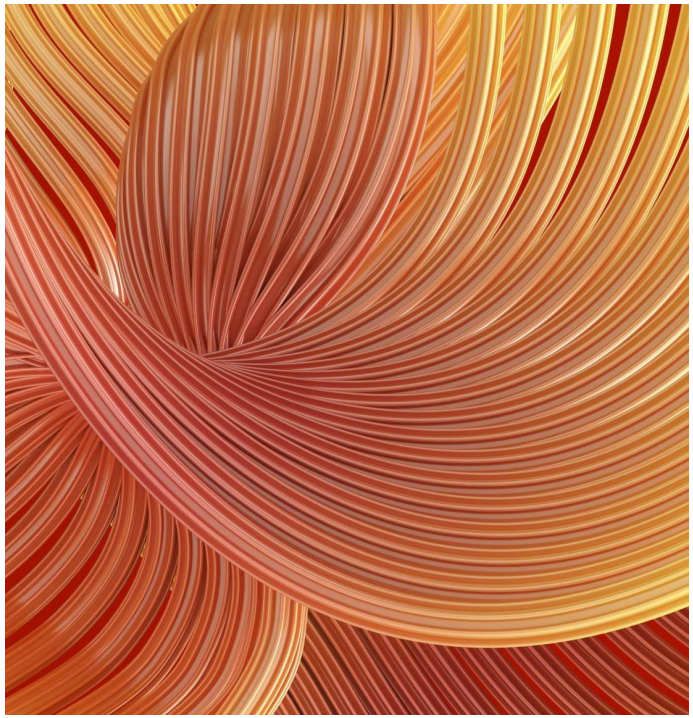
ACCESS TO MEDICAL AND ASSISTIVE DEVICES

CHS AMBULATORY DEVICE GUIDELINES – INITIAL EVALUATION



OBSTACLES TO ACCESSING MEDICAL AND ASSISTIVE DEVICES

Mental Health Level of Care (P3-P4 will need Mental Health clearance to ensure patient safety)
Procurement of actual durable medical equipment
Replacement of broken or damaged assistive device
Patient misuse of medical appliance or assistive device
Communication of review and renewal of medical orders



Thank you!

Any questions?