

CORRECTIONAL MEDICAL AUTHORITY (CMA)

PHYSICAL & MENTAL HEALTH SURVEY

OF

BAY CORRECTIONAL FACILITY

in

Panama City, Florida

September 21-23, 1999

INSTITUTIONAL STATISTICS PROVIDED CMA ON September 8, 1999				
Population	Custody	Type	Maximum Capacity	Current Occupied Beds
Adult	Minimum through Medium	Male	750	696

MEDICAL GRADES				
I	II	III	IV	Impaired
348	168	175	5	0

"S" GRADES				
I	II	III	IV	V
677	19	0	0	0

Physical Health Executive Summary

All conclusions were based on a sample review of medical records; interviews with inmates, health care providers and security staff; and a physical inspection of the institution.

Bay Correctional Facility (BCF) is an institution for minimum/medium custody adult males operated by Corrections Corporation of America, through a contract with the Florida Correctional Privatization Commission. The institution reported a capacity of 750 beds. Their inmate census at time of survey was 696, an increase of 11 since the first survey in 1996. The institution was initially constructed in 1995.

At the 1996 survey strengths were noted in clinical management in three of the chronic illness clinics. There were no Level I citations, five Level II citations and one italicized issue reported. There were delays observed in access to dental care also inadequate assessments and clinical management were reported in episodic care and two chronic illness clinics. Also, administrative deficiencies were identified in the lack of an infirmary facility and any policies addressing alternative care. Staff training on the use of the automatic external defibrillator was lacking as well. The italicized issue concerned emergency care events that were not recorded on required emergency care forms.

On August 7, 1997, CMA staff returned to the facility to assess progress made in the institution's corrective action plans. Four of the five citations were found corrected. The remaining uncorrected citation was the absence of an infirmary facility. Partial correction had been taken in the incorporation of required emergency care forms into their emergency care processes.

This survey revealed one Level I citation regarding the clinical management in one mortality record review and one emergency care record. There were four Level II citations and five Additional Issues. The Level II citations were comprised of one area of concern regarding clinical management/documentation and three administrative issues.

Physical Health Strengths

1. The recreational program was a strength at the institution, providing a wide array of indoor sports and incentive programs to the inmates.
2. The licensed dental hygienist was able to assume some of the duties reserved for dentists in other institutions. This contributed to a very efficient dental clinic operation.
3. The use of automatic external defibrillators (AEDs) was addressed in both mock code drills and in CPR training classes. The protocol for cardiac arrest events included the use of an AED.
4. Clinical management was appropriate in each of the reviewed sick call, hypertension, diabetes and seizure clinic records.

Physical Health Citations - Level I

Clinical Management/Documentation

1. Inadequate assessments and clinical management were identified in one of three mortality records and in one emergency care record:
 - a. One of three mortality records reviewed revealed inadequate assessments and clinical management that spanned a nine-day period preceding the inmate's death.
 - b. One emergency care record reviewed detailed deficiencies in assessment, clinical management and indicated follow-up care.

Physical Health Citations - Level II

2. One HIV/immunodeficiency clinic record lacked evidence of an indicated chest x-ray and three records lacked evidence of the provision of influenza vaccines or signed refusals during the previous year.

Administrative

3. The pharmacy lacked some emergency medications and policies and procedures regarding dispensing, distribution and accounting of pharmaceuticals, as well as policies and procedures regarding maintaining pharmacy records and secure storage of controlled substances.
4. In the absence of an infirmary, the alternative care policy that designated use of a medical observation room excluded conditions requiring close observations short of hospital level care.
5. Three health care provider staff lacked the proper level of cardiopulmonary resuscitation training certification.

Physical Health Additional Issues Noted

6. Two emergency care records lacked indications of the time of transfer for outside hospital care. A third record lacked information regarding the time of arrival of emergency medical service personnel.
7. Three COPD/asthma clinic records lacked a recording of the last asthma attack.

8. One TB/INH prophylaxis clinic record lacked a detailed intake history.
9. First aid kits lacked cardiopulmonary microshields and had out-of-date eyewash.
10. Critiques of mock code drills and disaster drills were cursory and lacked sufficient detail to adequately review staff responses.

Mental Health Executive Summary

All conclusions were based on a sample review of medical records; interviews with inmates, health care providers and security staff; and a physical inspection of the institution.

This was the second CMA mental health survey of Bay Correctional Institution. The initial survey was conducted December 3-5, 1996. As in 1996, BAYCI was operated by a private vendor, Corrections Corporation of America, under contract with Florida's Privatization Commission to provide complete management and operational services for the facility. The mental health program continued to serve a relatively healthy population of minimum to medium custody adult males, the majority of whom were psychological grade S1s. The pre-survey questionnaire indicated that the mental health caseload consisted of 19 S2 inmates (the caseload was 22 in 1996). As in 1996, the institution had a maximum capacity of 750 inmates (696 beds were occupied).

As in 1996, the institution did not have an infirmary or certified isolation management rooms. Inmates on suicide observation status were managed in the segregation cell area of the institution. However, in contrast to 1996 survey findings, these cells were reserved for suicide observation patients only and confinement inmates were not housed in this area. Furthermore, constant observation of the patient is strictly maintained in all circumstances. The institution is advised to reevaluate the housing and management of suicidal/self-injurious inmates in light of any increases in inmate custody levels, length of sentence, or mental health patient acuity levels.

Overall, the mental health program demonstrated a number of strengths. In particular, there was evidence of good communication between departments that helped facilitate the delivery of mental health services. The institutional environment was positive with a strong

emphasis on vocational rehabilitation and substance abuse treatment programs. The mental health staff consisted of experienced and well-trained professionals with competent clerical support.

The institution received one Level I Citation regarding the documentation of suicide observation status and one Level II Citation regarding the completeness of institutional operating procedures.

Mental Health Strengths

1. There was a strong institutional emphasis on vocational rehabilitation and substance abuse treatment that enhanced the welfare and morale of the inmates.
2. Inmate and staff interview data and surveyor observations indicated good communication between departments, and with inmates, that enhanced the delivery of mental health services.
3. The psychological specialists and physician came in on weekends as needed to respond to mental health emergencies.
4. The institution was in the process of developing an institutional operating procedure for the management of sexual assaults of inmates by other inmates.

Mental Health Citations - Level I

Clinical Management/Documentation

5. Suicide observation procedures were inconsistently documented in four of the five applicable cases reviewed (HSB 15.05.09; Minimum Standard).

- a. In two cases the physician's order for suicide observation status was not documented.
- b. In one case key documentation was lacking or not completed in a timely manner including physician's orders, daily physician reviews of the inmate, and the physician's clinical justification for removal of a mattress from the inmate.
- c. In one case the discharge summary was not documented upon termination of the inmate's suicide observation status.

Mental Health Citations - Level II

Administrative

- 6. The institutional operating procedures were incomplete (Minimum Standard):
 - a. Four-point restraints were not implemented at this institution. Less restrictive restraint procedures were available to the staff, but were not addressed in an institutional operating procedure. This issue was raised in 1996.
 - b. The use of emergency treatment orders was not addressed in an institutional operating procedure. This issue was raised in 1996.

Mental Health Additional Issues Noted

There are no Additional Issues Noted