CORRECTIONAL MEDICAL AUTHORITY (CMA)

PHYSICAL & MENTAL HEALTH SURVEY

OF

BROWARD CORRECTIONAL INSTITUTION

in

Ft. Lauderdale, Florida

December 14 – 16, 1999

INSTITUTIONAL STATISTICS PROVIDED CMA ON December 3, 1999				
Population	**Custody**	**Type**	**Maximum Capacity**	**Current Occupied Beds**
Adult	Maximum	Female	532	649

MEDICAL GRADES				
I	**II**	**III**	**IV**	**Impaired**
242	61	299	17	7

"S" GRADES				
I	**II**	**III**	**IV**	**Impaired**
146	66	382	26	3

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Physical Health Executive Summary

Broward Correctional Institution is a maximum custody Department of Corrections institution for adult females with a capacity for 532 offenders. At the time of the survey, 649 offenders were in residence. Physical health services have been provided at the institution through contract services with Prison Health Services (PHS) since April 1999.

The most commonly identified area of concern identified during the survey was in respect to the completion and accurate documentation of assessments, treatments, and follow up care (including referrals for a higher level of evaluation/care). These concerns were noted in a majority of the episodic and chronic illness clinic records reviewed, and therefore were identified as the area in most need of correction. Other, less critical issues identified during the survey included some environmental concerns (lack of hot water, inoperable showers, etc.), incomplete training records, poorly documented institutional logs, etc.

Overall, the deficiencies, concerns, and issues noted during the survey resulted in the issuance of 11 citations -- one Level I clinical management, nine Level II clinical management, and one Level II administrative. Also, eight "additional issues" (less critical issues or concerns) were identified.

Physical Health Citations - Level I

Clinical Management/Documentation

1. Concerns regarding assessments, treatments and indicated follow-up care were noted in two of the 10 (20%) mortality records reviewed. Also, two of the 10 records reviewed lacked required death certificates.

2. Two of six (33%) sick call records and five of six (83%) emergency care records reviewed contained assessment and/or treatment deficiencies.

Physical Health Citations - Level II

Clinical Management/Documentation

3. Three of eight (38%) asthma clinic records reviewed lacked information necessary for complete assessments and/or the development of continuity of care plans.

4. Concerns noted in each of the four (100%) diabetes clinic records reviewed included incomplete documentation of assessments, treatments, continuity of care plans, and/or inconsistently documented health education.

5. Concerns noted in five of the six (83%) hypertension clinic records reviewed included inadequate documentation of assessments and treatments, and/or inconsistently documented health education.

6. Concerns noted in four of six (66%) immunodeficiency clinic records reviewed included incomplete baseline laboratory studies and inconsistently documented health education.

7. Concerns noted in three of four (75%) seizure clinic records reviewed included incomplete documentation of initial histories and treatment plans, and/or inconsistently documented health education.

8. Assessment and/or treatment concerns were noted in one of four (25%) TB/INH clinic records reviewed.

9. Assessment concerns noted in four of six (66%) records selected for comprehensive review included incomplete laboratory studies, inconsistently documented initial histories, and inconsistently documented health education.

10. Administrative and/or documentation concerns were noted in each of the five (100%) infirmary records reviewed.

Physical Health Additional Issues Noted

11. An inventory of over-the-counter medications maintained in dormitories D and P revealed count logs did not match the actual number of medications on hand.

12. The first aid kit in dormitory P (confinement) did not contain blunt-tipped scissors, nor were scissors listed on the list of contents.

13. Two downstairs showers in dormitory P were inoperable; water leakage was noted; and, a hole was present where the shower faucets connected to the wall.

14. The institution was unable to provide a summary report indicating the date correctional officers received CPR training or dates when renewals were due.

15. Health Service Bulletins (HSBs) maintained by the institution lacked evidence of annual review and/or were missing recent updates.

16. The English and Spanish version offender handbooks were contradictory regarding co-pay costs.

17. The surgical/outside consultation log was inconsistently maintained.

18. Institutional response to offender requests/informal grievances reflected slow response times.

Mental Health Executive Summary

All conclusions were based on a sample review of medical records; interviews with offenders, health care providers and security staff; and a physical inspection of the institution. This was the third CMA mental health survey of Broward Correctional Institution (BROCI).

The institution houses offenders of all psychological grades, and provides inpatient and outpatient services. Constructed in 1977, it is a maximum custody female institution with a capacity of 532 beds. Of the 649 offenders housed at the institution at the time of the survey, approximately 382 (59%) were S3s; 66 (10%) were S2s; 146 (23%) were S1 offenders and 29 (5%) were S4 and S5s. BROCI, located in Region III, is one of two institutions in the state offering inpatient mental health services to female offenders.

Mental Health Management, a subcontractor to Prison Health Services, currently provides Broward's mental health services. Several issues were identified which impact patient care. These included the ongoing perception by offenders that offenders must "cut" themselves to obtain services; service plans that do not serve their intended purpose; and crisis and transitional care programs that are not as effective as they should be. Several areas of record documentation were cited for incompleteness as well. In total the mental health program at Broward Correctional Institution received one Level I citation and 12 Level II citations.

Mental Health Strengths

1. No deficiencies were identified in the reception records reviewed.

Mental Health Citations - Level I

Clinical Management/Documentation

1. Individualized service plans were not developed with function in mind; they were not individualized; they did not always incorporate important events and they often did not reflect the level of programming or contact indicated in the record.

Mental Health Citations - Level II

Access

2. Offenders indicated during interviews that the fastest and most effective way to obtain mental health services was to injure themselves, otherwise receiving services could take a very long time. This was also reflected in the request log which showed that in the last three months 8% of the requests had gone unanswered.

Clinical Management/Documentation

3. The required group treatment sessions were not taking place.

4. In both outpatient and inpatient records biopsychosocial assessments (BPSA) were late and/or incomplete.

5. In seven of 11 records (64%) the timing of psychiatric contacts was unpredictable and did not follow the guidelines specified. Psychiatric evaluations omitted medical or psychotropic histories, and offered only limited description of the offender's problem or ability to change.

6. Informed consents were absent from three of the four inpatient records (75%) reviewed.

7. In three of 11 records (27%) substance abuse problems were not referred, nor was the problem, once diagnosed, addressed in the service plan.

8. In the TCU the goal of returning the offender to general population on a permanent basis was obscured by approaches which did not emphasize coping skill development, trial visits and other more aggressive transitional methods.

9. In three of four suicide observation records (75%) reviewed, required documentation was missing: observation sheets, signed treatment refusal, and a complete nursing assessment.

Administrative

10. Inpatient records were disorderly, and the sequential history of treatment was difficult to determine.

11. The crisis stabilization unit (CSU) had a standard procedure to remove clothing and provide only a paper gown for these female offenders. Underpants were not provided to these offenders even during their menstrual cycle.

12. Offenders and staff reported that confinement evaluations were most often conducted at cell front instead of calling the offender out. This was considered a breach of privacy and confidentiality by both.

13. Psychological specialists related that “CCs” (corrective counseling) were issued by security for offenders who failed to show up for their appointments and for offenders who were not compliant with medications.