



CORRECTIONAL MEDICAL AUTHORITY

PHYSICAL & MENTAL HEALTH SURVEY

of

LAKE CORRECTIONAL INSTITUTION

in

Clermont, Florida

on

August 10 – 13, 2010

CMA Physical Health Team Leader:

Priscilla Wood, BS

CMA Mental Health Team Leader:

Jane Holmes-Cain, LCSW

Physical Health Team Members:

Phillip Barkley, MD
Mark Heifferman, DDS
Thomas Garrett, DDS
Wendy Suckow, PA
Pat Meeker, RN
Sue Brown, RN

Mental Health Team Members:

Erik Gooch, DO
Ronald Girona, PhD
Sean Jennings, PsyD
Heather Allman, LCSW
Andrew Daire, LMHC, PhD
Mandy Petroski-Moore, LCSW
Kathy Louvaris, ARNP
Rizan Yozgat, ARNP
Kaye Harris, RN

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DEMOGRAPHICS

The institution provided the following information in the Pre-survey Questionnaire.

INSTITUTIONAL INFORMATION			
Population	Type	Custody Level	Medical Level
1143	Male	Close	4

Institutional Potential/Actual Workload

Main Unit Capacity	1093	Current Main Unit Census	1143
Annex Capacity	N/A	Current Annex Census	N/A
Satellite Unit(s) Capacity	N/A	Current Satellite(s) Census	N/A
Total Capacity	1093	Total Current Census	1143

Inmates Assigned to Medical/Mental Health Grades

<i>Medical Grade</i>	1	2	3	4	5	<i>Impaired</i>
	555	339	243	5	N/A	13

<i>Mental Health Grade (S-Grade)</i>	<u><i>Mental Health Outpatient</i></u>			<u><i>MH Inpatient</i></u>			<i>Impaired</i>
	1	2	3	4	5	6	
	286	66	645	86	17	41	5

Inmates Assigned to Special Housing Status

<i>Confinement/Close Management</i>	DC	AC	PM	CM3	CM2	CM1
	83	83	0	N/A	N/A	N/A

OVERVIEW

Lake Correctional Institution (LAKCI) houses male inmates of minimum, medium and close custody levels. The facility grades are Medical 1, 2, 3 and 4 and psychology (S) grades 1, 2, 3, 4, 5 and 6. The scope of health services provided includes comprehensive medical, dental, mental health and pharmaceutical services. Specific services include: health education, preventative care, chronic illness clinics, emergency care, and observation/infirmarary care as required for medical and mental health. Inpatient mental health is also provided at LAKCI.

The Correctional Medical Authority (CMA) conducted a thorough review of the medical, mental health and dental systems at LAKCI August 10 – 13, 2010. Record reviews evaluating the provision and documentation of care were also conducted. Additionally, a review of administrative processes and a tour of the physical plant were conducted. Overall survey findings revealed several areas of concern to be addressed through the process outlined in s. 945.6031 (3), (4) F.S.

“Within 60 calendar days following a survey, the authority shall submit a report to the Secretary of Corrections indicating deficiencies found at the institution.

(4) Within 30 calendar days after the receipt of a survey report from the authority, the Department of Corrections shall file a written corrective action plan with the authority, indicating the actions which will be taken to address deficiencies determined by the authority to exist at an institution. Each plan shall set forth an estimate of the time and resources needed to correct identified deficiencies.

In addition, as a result of one finding considered by the survey team to be very serious and requiring immediate attention by the department, an emergency notification, in accordance with s. 945.6031 (3), F.S., was transmitted to the Secretary on August 13, 2010.

“Deficiencies found by the authority to be life-threatening or otherwise serious shall be immediately reported to the Secretary of Corrections. The Department of Corrections shall take immediate action to correct life-threatening or otherwise serious deficiencies identified by the authority and within 3 calendar days file a written corrective action plan with the authority indicating the actions that will be taken to address the deficiencies.”

The emergency notification informed the Secretary of the following:

Emergency Finding 1:

This issue concerns problems with seven cases reviewed for the use of psychiatric restraints including:

- two cases where documentation did not indicate the inmate's behavior warranted restraints
- two cases where orders do not specify the criteria for release

- three cases where documentation indicated the inmates are not observed at the required intervals
- three cases where documentation indicated the inmates were not offered food and fluids
- four cases where documentation indicated inmates were not offered a urinal per policy
- four cases where respiration checks were not documented
- four cases where documentation indicated limbs were not exercised
- six cases where documentation indicated restraints were not removed after 30 minutes of calm behavior.

These restraint episodes occurred on 6/23/10, 7/5/10, 7/13/10, 7/16/10, 7/17/10, 7/17/10, and 7/18/10.

On August 18, 2010, the CMA was provided a copy of the department's corrective action plan (CAP) dated August 13, 2010, addressing the emergency finding (EF) (Attachment 1). Once the department is in receipt of this full survey report, the CMA looks forward to receiving a detailed CAP for all findings. Refer to page 8 of this report for a detailed discussion of the emergency finding (MH-1).

Exit Conference and Final Report

At the conclusion of the survey, the survey team conducted an exit conference with institutional personnel to discuss preliminary survey results. The findings and final conclusions presented in this report are a result of further analysis of the information collected during the survey. The suggested corrective action(s) included in this report should not be construed as the only action required to demonstrate correction, but should be viewed as a guide for developing a corrective action plan. Where recommended corrective actions suggest in-service training, a copy of the curriculum and attendance roster should be included in the corrective action plan files. Additionally, evidence of appropriate monthly monitoring should be included in the files for each finding. Unless otherwise specified, this monitoring should be conducted by an institutional clinician/peer and must be documented by a monthly compilation of the following:

- 1) The inmate names and DC numbers corresponding to the charts (medical records) reviewed;
- 2) The criteria/finding being reviewed;
- 3) An indication of whether the criteria/finding was met for each chart reviewed;
- 4) The percentage of charts reviewed each month complying with the criteria;
- 5) Back-up documentation consisting of copies of the relevant sections reviewed from the sampled charts.

PHYSICAL HEALTH FINDINGS

ADMINISTRATIVE PROCESSES REVIEW

No findings were reported regarding administrative processes, infection control, and quality management.

INSTITUTIONAL TOUR

The tour of the facilities revealed no issues; the surveyor noted that the kitchen, grounds, and dorms were clean and in order.

EPISODIC CARE REVIEW

There were no findings in emergency or sick call records.

DENTAL REVIEW

There were no dental findings. However, the dental surveyors noted that more inmates could be seen in the dental clinic if another dental assistant was available.

CLINICAL SYSTEM REVIEW

There were findings in two chronic illness clinic record reviews, as noted in the table below.

OTHER RECORD REVIEW

There were no significant findings in the consultations, medication administration and health record/OBIS reviews. There were issues regarding periodic screening evaluations and intra-system transfers as noted in the table below.

ENDOCRINE CLINIC RECORD REVIEW	
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Finding(s)	Suggested Corrective Action(s)
<p>PH-1: In 5 of 14 Endocrine Clinic records reviewed, microalbuminuria testing was not documented as required.</p>	<p>Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column.</p> <p>Create a monitoring tool and conduct monthly monitoring of no less than ten records to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

IMMUNITY CLINIC RECORD REVIEW	
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Finding(s)	Suggested Corrective Action(s)
<p>PH-2: In 4 of 11 Immunity Clinic records reviewed, there was no documentation hepatitis B vaccine was offered to inmates with no evidence of past hepatitis B infection.</p>	<p>Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column.</p> <p>Create a monitoring tool and conduct monthly monitoring of no less than ten records to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

INTRASYSTEM TRANSFER RECORD REVIEW	
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Finding(s)	Suggested Corrective Action(s)
<p>PH-3: In 2 of 9 records, discrepancies were found including:</p> <p>(a) The DC4-760A “Health Information Transfer/Arrival Summary” was not completed by the receiving institution, as required.</p>	<p>Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column.</p> <p>Create a monitoring tool and conduct monthly monitoring of no less than ten records to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction.</p>

**INTRASYSTEM TRANSFER
RECORD REVIEW**

Finding(s)	Suggested Corrective Action(s)
(b) The DC4-760A or progress note did not document that vital signs were taken as required.	Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.

MEDICATION ADMINISTRATION

Finding(s)	Suggested Corrective Action(s)
PH-4: In 5 of 15 records, medication orders were not signed, dated and/or timed by clinicians as required.	Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column.
PH-5: In 4 of 15 records, there was no evidence the medication administration record (MAR) was reviewed for lapses in medication administration.	<p>Create a monitoring tool and conduct monthly monitoring of no less than ten records to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

PREVENTIVE CARE

Finding(s)	Suggested Corrective Action(s)
PH- 6: In 7 of 14 records reviewed the most recent periodic screening encounter was either not completed timely or was missing.	<p>Provide in-service training to staff regarding the issue(s) identified in the Finding(s) column.</p> <p>Create a monitoring tool and conduct monthly monitoring of no less than ten records to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

CONCLUSION

Medical records at Lake CI were very well organized, data entry efforts were timely and accurate, and administrative documents were appropriately maintained. Review of the inmate housing and food service areas revealed no negative findings. Staff appeared to be knowledgeable about procedures; all areas on the compound were clean and neat. Interviews with inmates, nursing staff, and security staff were consistently positive.

The institutional staff provided good clinical management and monitoring of inmates. It was also evident that security staff works very well with medical staff to ensure inmates receive the care they need. Overall the clinic staff, including medical and administrative, demonstrated their dedication to providing the required physical health care to the inmate population.

MENTAL HEALTH FINDINGS

Lake Correctional Institution provides outpatient and inpatient mental health services. The following are the mental health grades used by the department to classify inmate mental health needs at LAKCI:

- S1 - Inmate requires routine care (sick call or emergency).
- S2 - Inmate requires ongoing services of outpatient psychology (intermittent or continuous).
- S3 - Inmate requires ongoing services of outpatient psychiatry (case management, group and/or individual counseling, as well as psychiatric care).
- S4 - Inmate requires a structured residential setting in a Transitional Care Unit (TCU).
- S5 - Inmate requires crisis intervention in a Crisis Stabilization Unit (CSU).
- S6 – Inmate requires acute hospital care in a Mental Health Treatment Facility (MHTF). The majority of inmates are placed in MHTF via court order. In addition, a separate court order must be obtained to involuntarily medicate inmates who pose a danger to self or others and are refusing psychotropic medication.

CLINICAL RECORDS REVIEW

Psychiatric Restraints	
Finding(s)	Suggested Corrective Action(s)
<p>MH-1: A comprehensive review of 7 restraint episodes revealed the following deficiencies: [EF-1]</p> <p>(a) Two episodes did not contain adequate documentation that the behavior warranted restraints. (see discussion)</p> <p>(b) Four episodes did not contain appropriate documentation of the restraint episode. (see discussion)</p> <p>(c) Two episodes did not contain the criteria for release in the physician’s orders. (see discussion)</p> <p>(d) Six records did not contain evidence that the inmate was released from restraints after 30 minutes of calm behavior. (see discussion)</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issue in the Finding(s) column.</p> <p>Monitor all restraint episodes weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

Discussion MH-1(a): In one case, the documentation indicated restraints were authorized because the inmate refused to come out of his cell. In the second case, documentation indicated the inmate was placed in restraints for grabbing an officer's arm; however no further aggression was noted. In addition there was no documentation that less restrictive means of behavioral control were attempted prior to the application of restraints.

Discussion MH-1(b): In three of the cases, the DC4-650A "Restraint Observation Checklist" was not present in the chart. This form provides a record of documentation of the requirements for monitoring an inmate who has been placed in psychiatric restraints. These requirements include 15 minute observations and circulation and respiration checks. It is also a requirement that fluids and a urinal are offered every two hours, food is offered at mealtimes and limbs are exercised every two hours. All of this information is documented on the DC4-650A. Because these forms were missing, surveyors were unable to determine if these requirements had been met. In the remaining case, the form was present and the 15 minute observations were documented; however, the other requirements were not consistently addressed. Further, in one of these cases, an order was written to place the inmate in restraints at 0700. The inmate was not placed in restraints until 0910. According to the documentation, the delay occurred because security failed to respond. The inmate self-injured during this time.

Discussion MH-1(c): The behavioral criteria the inmate needed to display in order to be released from restraints were not noted in the physician's orders.

Discussion MH-1(d): In two of the six cases, the inmate remained in restraints for two hours or more after documentation indicated he was exhibiting calm behavior. It was also noted in the review of an inpatient record documenting the use of an Emergency Treatment Order (ETO) that security removed an inmate from restraints two hours after the order to discharge was written. Security staff is responsible for physically removing the inmate from restraints and returning him to his cell.

Self-Harm Observation Status (SHOS)	
Finding(s)	Suggested Corrective Action(s)
MH-2: In 5 of 6 records reviewed, observation checklists were missing or incomplete. (see discussion)	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issue in the Finding(s) column.</p> <p>Monitor a minimum of ten records weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

Discussion MH-2: Inmates in SHOS require observation at the frequency ordered by the physician; either every 15 minutes or continuous (one-to-one). The observed behavior is documented on observation checklists. Since these forms could not be located by staff, surveyors were unable to determine if the inmates were being monitored as required.

Outpatient Psychotropic Medication Practices	
Finding(s)	Suggested Corrective Action(s)
<p>MH-3: A comprehensive review of 15 outpatient records revealed the following deficiencies:</p> <p>(a) In 5 records, physician's orders were not timed, dated and/or signed.</p> <p>(b) In 5 records, progress notes did not contain a rationale for medication changes. (see discussion)</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues in the Finding(s) column.</p> <p>Monitor a minimum of ten records weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

Discussion MH-3(b): In one record, the medication increase was not addressed. In the remaining three records, there was no documentation regarding the addition or discontinuation of prescribed medication.

Inpatient Psychotropic Medication Practices	
Finding(s)	Suggested Corrective Action(s)
<p>MH-4: A comprehensive review of 20 inpatient records revealed the following deficiencies:</p> <p>(a) In 7 of 15 applicable records, initial lab tests were not completed as required.</p> <p>(b) In 5 of 16 applicable records, follow-up lab tests were not completed as required.</p> <p>(c) In 3 of 20 records reviewed for inpatient psychotropic medication practices and 6 of 22 records reviewed for Inpatient Services, follow-up psychiatric contacts were not completed in the required timeframe. (see discussion)</p> <p>(d) In 6 of 15 applicable records, medication consents were not signed for each class of medication prescribed.</p> <p>(e) In 4 of 20 applicable records, the medications ordered were not appropriate for the documented symptoms and/or diagnosis. (see discussion)</p> <p>(f) In 3 of 5 applicable records, the physical exam was not completed within 72 hours of admission to the CSU.</p> <p>(g) In 2 of 10 applicable records, there was no documented rationale for the use of an Emergency Treatment Order. (ETO). (see discussion)</p> <p>(h) In 6 of 10 applicable records, the physician's order was not specified as an ETO.</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues in the Finding(s) column.</p> <p>Monitor a minimum of ten records weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

Discussion MH-4(c): This finding was also noted in six of 22 Inpatient Services record reviews. Since inpatient contacts are not entered in the Offender Based Information System (OBIS), a schedule is not generated indicating which inmates need to be seen for follow-up. Staff report that a system for tracking these appointments is being implemented.

Discussion MH-4(e): In two cases, medications for depression were prescribed for symptoms of psychosis. No rationale for the use of these medications was noted in the record. In one case, an elderly inmate with a history of falls, memory problems and alcohol abuse was prescribed Benadryl, a sedating medication, in the morning. In the remaining case, the medications typically prescribed for depression and psychosis were not consistent with a diagnosis of Impulse Control Disorder.

Discussion MH-4(g): In one case the ETO was administered after the inmate's behavior was documented as calm and he had been released from restraints. In the other case the behavior was noted at 1425. The ETO was given at 1950 without further documentation.

Outpatient Mental Health Services	
Finding(s)	Suggested Corrective Action(s)
<p>MH-5: A comprehensive review of 21 outpatient records (S3 =11, S2 =10) revealed the following deficiencies:</p> <p>(a) Four records did not contain the inmate's signature on the ISP.</p> <p>(b) Eleven records did not contain adequate documentation of issues addressed in counseling. (see discussion)</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issue in the Finding(s) column.</p> <p>Monitor a minimum of ten records weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

Discussion MH-5(b): The counseling topics addressed do not vary from month to month and are often vague. For example "ISP goals" or "ISP problems" are listed as therapy topics.

Inpatient Mental Health Services

Finding(s)	Suggested Corrective Action(s)
<p>MH-6: A comprehensive review of 23 inpatient records revealed the following deficiencies:</p> <p>(a) In 13 of 22 applicable records, there was no documentation that an explanation for admission and orientation to the unit was provided within the required timeframe.</p> <p>(b) All records did not contain documentation that required hours of planned scheduled activities were being provided. (see discussion)</p> <p>(c) Twelve records did not contain weekly notes documenting inmate participation in groups. (see discussion)</p> <p>(d) Nine records did not contain evidence that Individualized Service Plans (ISP) were reviewed as required.</p> <p>(e) In 2 of 9 applicable records, psychological testing was not administered although it was clinically indicated. (see discussion)</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issue in the Finding(s) column.</p> <p>Monitor a minimum of ten records weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

Discussion MH-6(b): *In each record reviewed, documentation prior to July 12, 2010 reflected that the required number of planned scheduled services was not occurring. Staff has recently implemented a tracking system to ensure that activities are offered as required. The system also addresses the amount of time each inmate participates in the activity or indicates a refusal. Documentation after July 12, 2010 indicated that activities are being offered as required. However since compliance is only noted for the past few weeks, this issue is a finding.*

Discussion MH-6(c): *The circumstances surrounding this finding are similar to MH-6(b). Group notes were not consistently present in the record prior to July 12, 2010. Although the notes are now present, the content is often vague. For instance, the inmate's participation is often described as "said good things". The Inpatient Sr. Mental Health Clinician is aware of this issue and is providing training and support to the Human Services Counselors.*

Discussion MH-6(e): In the first case documentation indicated psychological testing was needed to rule out dementia but it could not be completed due to the unavailability of credentialed staff. In the second case psychological testing was indicated to address the diagnosis “Dementia NOS/Rule Out Cognitive Disorder NOS”. This issue was also noted during a review of inpatient psychotropic medication. The surveyor noted psychological testing was ordered on 4/13/10 yet there was no documentation this had been completed. According to staff, there are no materials for psychological testing other than the basic instruments used in the reception centers. In addition there is no one credentialed to perform complex neuropsychological testing. Surveyors recommended that this option be explored since such a large severely mentally ill population is served at this institution.

Access to Mental Health Services	
Finding(s)	Suggested Corrective Action(s)
<p>MH-7: In 13 of 25 records, there was no evidence that inmate requests were answered. (see discussion)</p> <p>MH-8: In 3 of 5 records reviewed, evaluation of the psychological emergency is inadequate. (see discussion)</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issue in the Finding(s) column.</p> <p>Monitor a minimum of ten records weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

Discussion MH-7: The request form or an incidental note addressing the request could not be located.

Discussion MH-8: The form used to address the psychological emergency does not promote thorough documentation. It allows little room for narrative beyond the initial complaint and there is no space for an adequate risk assessment. Staff generally gives one word responses to the mental status exam portion and inmate responses were not consistently adequately documented. Surveyors were unable to determine from the documentation provided if the interventions or the dispositions were appropriate.

Special Housing

Finding(s)	Suggested Corrective Action(s)
<p>MH-9: Six of 13 records reviewed contained mental status exams that were inadequate. (see discussion)</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issue in the Finding(s) column.</p> <p>Monitor a minimum of ten records weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

Discussion MH-9: *In each of the six cases, the inmate refused to be seen for the mental status exam. In each record the narrative was exactly the same for each encounter. Notes regarding collateral contacts and observations regarding the inmate's surroundings should be individualized. While it is typical for inmates in confinement to refuse to come out of their cells for evaluation, surveyors noted there seemed to be a high volume of refusals. Staff report that they have changed the times they attempt to see inmates from morning to afternoon. This seems to have decreased the number of refusals in the past few weeks.*

Use of Force

Finding(s)	Suggested Corrective Action(s)
<p>MH-10: Two of 4 records reviewed did not contain a written referral to mental health. (see discussion)</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issue in the Finding(s) column.</p>

Discussion MH-10: *In one case the inmate was seen by mental health but the encounter occurred prior to the use of force incident. In the other case the inmate was seen by mental health as required, however there was no written referral in the record.*

ADMINISTRATIVE SYSTEMS REVIEW

Administrative Issues	
Finding(s)	Suggested Corrective Action(s)
<p>MH-11: Inpatient medical records were disorganized, with pages often misfiled or missing altogether.</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues in the Finding(s) column.</p> <p>Monitor a minimum of ten records weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p>
<p>MH-12: The program description including a description of the level system is not posted in the inpatient units.</p>	<p>Provide evidence in the closure file that the issue described has been corrected. This may be in the form of documentation, acquired training materials, etc.</p> <p>Ensure the program description is posted in the inpatient units.</p>

CONCLUSION

The mental health staff at LAKCI serves a complex and difficult population. Outpatient services are provided to over 800 inmates. Outpatient staff consists of one psychiatrist, one Sr. Mental Health Clinician and nine Mental Health Specialists. Inpatient services are provided in a 74 bed Transitional Care Unit (TCU), a 25 bed Crisis Stabilization Unit (CSU) and a 55 bed Mental Health Treatment Facility (MHTF). In addition there are 26 multi-purpose cells that can be used as either CSU or TCU beds. Many of the Department's most severely mentally ill male inmates are served in the inpatient units at LAKCI. Inmates who present a danger to themselves or others and can not be managed in a lesser restrictive setting are court-ordered to the MHTF. Frequently these inmates refuse treatment necessitating a court-order for involuntary medication. Inpatient staff consists of five psychiatrists, two Sr. Mental Health Clinicians, eight Mental Health Specialists, one mental health provider who conducts groups and three Human Services Counselors. The Psychological Services Director is responsible for the supervision of both the inpatient and outpatient departments.

As noted in the report, an emergency notification regarding the use of psychiatric restraints was issued following the survey. It is standard practice in community as well as correctional settings for psychiatric restraints to be utilized only as a last resort; when all other less restrictive means of controlling behavior have been determined to be ineffective. Because of the possibility of serious negative medical and psychological consequences, a person in restraints must be monitored closely to ensure safety. There have been numerous cases in correctional and community settings where a person has suffered severe trauma or even death due to the improper use of restraints. A previously settled federal case regarding inmate health care in the Michigan Department of Corrections was reopened due to the death of an inmate in psychiatric restraints.

The Department has a very good policy in place to manage the use of psychiatric restraints, and the leadership has demonstrated a high level of commitment to providing required staff training in this area. Given this, the CMA expects the lapse in application of restraint policy identified at LAKCI to be corrected quickly and effectively including a review of why the lapse occurred and prevention of further occurrences. Accordingly, Secretary McNeil submitted a comprehensive Corrective Action Plan (CAP) addressing the emergency findings which had already begun implementation (see attachment 1). The CAP document outlines a plan for addressing the identified concerns including:

- Retraining relevant clinical staff in the use of psychiatric restraints including continuing and timely training for temporary agency staff.
- Providing a summary in memorandum form posted in the nursing stations of the steps required following a clinician's order for restraints.
- Making readily available documentation packets including all required forms for documenting an episode of restraints.
- Review of each episode of restraint on the next business day by the institution leadership team.
- Regular and logged drills for all clinical and security staff in their particular roles in placement of restraints.
- The availability of a certified isolation room maintained with pre-placed restraints to expedite the process of placing an inmate in restraints.

Staff training and monitoring of future restraint events will ensure that inmates who require psychiatric restraints will receive safe and appropriate care.

In June 2010, Secretary McNeil visited the inpatient units at Lake CI. He determined that inmates were not receiving the planned scheduled services necessary for treatment of severe mental illness including time out of their cells. Surveyors also noted that prior to July 12, 2010, inmates were not receiving these services as required. Mental health staff reported difficulties accessing inmates due to a lack of available security staff; this was also documented in the records. Both security and mental health staff interviews revealed that since Secretary McNeil's visit, these issues are improving and that many positive changes have been implemented. Surveyors noted improvement in the documentation of services after July 12, 2010.

Overall there appeared to be a lack of documentation of rationales for clinical decision making. Surveyors were unable to determine if psychological emergencies and inmate requests were consistently appropriately addressed. Medication changes and diagnoses were not consistently justified in the record. Outpatient progress notes did not always adequately address the issues focused on in therapy. As noted above, the rationale for and subsequent monitoring of psychiatric restraint episodes were not adequately documented. In addition monitoring of inmates in Self-Harm Observation Status was not adequately documented.

The inpatient medical records were also characterized by disorganization. Despite the survey team being comprised of experienced surveyors who are familiar with the Department's medical records, they had difficulty finding appropriate documentation in the medical records needed to carry out the survey protocols. Reviewers were informed prior to the survey that staff was in the process of thinning records. There did not appear to be a standardized method for thinning as the order of many of the records was inconsistent. For example forms such as refusals and consents, risk assessments and AIMS were located in different sections in many of the charts. Records were not labeled by volume making it difficult to determine the charting sequence. Many of the thinned records were not in chart format and were held together by a rubber band. Documents that should have remained in the active volume of the record were found in thinned volumes. Although staff assigned to provide assistance to surveyors was attentive and helpful, they often took several hours to locate the requested items or were unable to find them at all during the course of the survey.

As evidenced by the improvement seen in documentation over the last few weeks, it appears the Department is striving to put systems in place to address the issues noted by Secretary McNeil. Those issues as well as the issues identified in this report will require consistent monitoring and evaluation to ensure they are corrected. Depending on the results of the corrective action plan produced in response to this report, the CMA may re-survey LAKCI in the coming fiscal year.

SURVEY PROCESS

The goals of every survey performed by the CMA are:

- (1) to determine if the physical, dental and mental health care provided to inmates in all state public and privately operated correctional institutions is consistent with state and federal law, conforms to standards developed by the CMA, is consistent with the standards of care generally accepted in the professional health care community at large;
- (2) to promote ongoing improvement in the correctional system of health services; and,
- (3) to assist the Department of Corrections in identifying mechanisms to provide cost effective health care to inmates.

To achieve these goals, specific criteria designed to evaluate inmate care and treatment in terms of effectiveness and fulfillment of statutory responsibility are measured. They include determining:

- If inmates have adequate access to medical and dental health screening and evaluation and to ongoing preventative and primary health care.
- If inmates receive adequate and appropriate mental health screening, evaluation and classification.
- If inmates receive complete and timely orientation on how to access physical, dental and mental health services.
- If inmates have adequate access to medical and dental treatment that results in the remission of symptoms or in improved functioning.
- If inmates receive adequate mental health treatment that results in or is consistent with the remission of symptoms, improved functioning relative to their current environment and reintegration into the general prison population as appropriate.
- If inmates receive and benefit from safe and effective medication, laboratory, radiology, and dental practices and have access to timely and appropriate referral and consultation services.
- If psychotropic medication practices are safe and effective.
- If inmates are free from the inappropriate use of restrictive control procedures.
- If sufficient documentation exists to provide a clear picture of the inmate's care and treatment.
- If there are sufficient numbers of qualified staff to provide adequate treatment.

To meet these objectives, the CMA contracts with a variety of licensed community and public health care practitioners, such as physicians, psychiatrists, dentists, nurses, psychologists and social workers. The survey process includes a review of the physical, dental and mental health systems; specifically, the existence and application of written policies and procedures, staff credentials, staff training, confinement practices, and a myriad of additional administrative issues. Individual case reviews are also conducted. The cases selected for review are representative of inmates who are receiving mental and/or physical health services (or who are eligible to receive such services).

Conclusions drawn by members of the survey team are based on several methods of evidence collection:

- ◆ Physical evidence – direct observation by members of the survey team (tours and observation of evaluation/treatment encounters)
- ◆ Testimonial evidence – obtained through staff and inmate interviews (and substantiated through investigation)
- ◆ Documentary evidence – obtained through reviews of medical/dental records, /treatment plans, schedules, logs, administrative reports, physician orders, service medication administration reports, meeting minutes, training records, etc)
- ◆ Analytical evidence – developed by comparative and deductive analysis from several pieces of evidence gathered by the surveyor

Administrative (system) reviews generally measure whether the institution has policies in place to guide and direct responsible institutional personnel in the performance of their duties and if those policies are being followed. Clinical reviews of selected inmate medical, dental and mental health records measure if the care provided to inmates meets the statutorily mandated standard. Encounters of an episodic nature, such as sick call, an emergency, an infirmary admission, restraints or a suicide episode, as well as encounters related to a long-term chronic illness or on-going mental health treatment are also reviewed. Efforts are also made to confirm that administrative documentation, i.e., logs, consultation requests, medication administration reports, etc. coincides with clinical documentation.

Findings identified as a result of the survey may arise from a single event or from a trend of similar events. They may also involve past or present events that either had or may have the potential of compromising inmate health care. All findings identified in the body of the report under the physical or mental health sections require corrective action by institutional staff. Findings identified in the department section require corrective action by central office security or program area staff.

Attachment 1



FLORIDA DEPARTMENT of CORRECTIONS

Governor
CHARLIE CRIST

Secretary
WALTER A. McNEIL

An Equal Opportunity Employer

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<http://www.dc.state.fl.us>

DEFICIENCIES IN USE OF PSYCHIATRIC RESTRAINTS - CORRECTIVE ACTION PLAN

Re-training of relevant clinical and security staff, on the use of psychiatric restraints will be performed by the RMHC on August 17, 2010. This training will include inter alia indication for their use, management and care of the inmates in restraints and how to properly document the processes from when order to apply restraints is given to when restraints are permanently removed. This training will be on a continuing basis to ensure temporary agency nurses and new hires are provided this training within a week of hire.

A memorandum that summarizes the chronological steps to be taken following a clinician's order to apply restraints will be posted in the nursing stations by August 24, 2010. This memorandum will reflect relevant Procedures/HSBs. All relevant staff will "read and sign" a copy and the signature sheet will be filed.

Documentation packets, to include form DC4-650 (Observation Checklist), DC4-650A (Restraint Observation Checklist) and DC6-229B (for security to document all pertinent inmate events) will be created by August 24, 2010. They will be readily available for staff's use.

Effective immediately each episode of placement of restraint will be reviewed on the next business day by the institution's leadership team, to include the Warden (or designee), the Chief Health Officer, the Psychological Services Director, the Major and the Senior Nursing Supervisor at the minimum.

Effective immediately, a certified isolation management room, with pre-placed restraints, will be maintained to expedite the process of placing an inmate in restraints.

Effective immediately all clinical and security staff will have regular drills in their pertinent roles in placement of psychiatric restraints and, for security staff, cell extraction. These drills will be logged and reviewed by administration and relevant department heads.