

CORRECTIONAL MEDICAL AUTHORITY (CMA)
PHYSICAL HEALTH SURVEY
 OF
LOWELL CORRECTIONAL INSTITUTION
(Men's Unit)

in
 Lowell, Florida

October 12 - 14, 1999

INSTITUTIONAL STATISTICS PROVIDED CMA ON SEPTEMBER 28, 1999				
Population	Custody	Type	Maximum Capacity	Current Occupied Beds
Adult	Close	Male	1,206	1,133

MEDICAL GRADES				
I	II	III	IV	Impaired
438	535	150	10	53

Executive Summary

Lowell Correctional Institution (Men's Unit) (formerly Marion Correctional Institution) is a close custody adult male institution with a maximum capacity of 1,206. At the time the pre-survey questionnaire was submitted by the institution, it housed 1,133 inmates. The most recent prior survey conducted at the institution was in September 1996.

Overall, survey results suggested to the survey team that the physical health services provided at the institution were barely adequate in some areas, and below standards in several others. Currently operating under the strain of critical nursing staff shortages

(nearly a 50% vacancy rate), and sharing what staff is available between the men's and women's (formerly Florida Correctional Institution) units, delays in access to care and poorly documented provider encounters were commonplace. Clear trends were revealed during record reviews of inadequate assessments, treatments, and continuity of care plans, as well as a marked deficiency in providing and documenting inmate health education. Several concerns were also noted when the institution's infirmary was inspected, including the observation that inmates were frequently left unattended, that inpatient infirmary records were not utilized as required, that unclean conditions went unchecked, and that the infirmary's bathroom may not be totally accessible to physically impaired inmates.

In total, the areas of concerns identified by the survey team resulted in the issuance of six Level I citations – three Access, two Clinical Management/Documentation, and one Administrative. Seven Level II Clinical Management/Documentation and two Level II Administrative citations were also issued. It should be pointed out that it was the conclusion of the survey team that many of the problems identified during the survey were not necessarily present because the staff was unwilling or unqualified, but rather, resulted because the present staff was insufficient to meet the demands placed upon them. It is therefore recommended that renewed effort toward the recruitment and retention of qualified nursing staff be immediately undertaken, and that additional incentives be considered to attract agency nurses on a temporary basis in the interim.

Physical Health Citations - Level I

Access

1. The health care staff vacancy rate was critically high.
 - a. One of three (33%) physician positions was vacant.
 - b. Both (100%) senior registered nurse supervisors positions were vacant.
 - c. Eight of 14 (57%) registered nurse positions were vacant.
 - d. Seven of 19 (37%) licensed practical nurse positions were vacant.
 - e. Two of four (50%) health support positions were vacant.
2. Concerns regarding potential access to care impediments in the infirmary were observed by members of the survey team.
 - a. Although a call system was present in the open bay portion of the infirmary suite by which inmates could request nursing assistance, it consisted only of a call monitor on a table several feet from the beds. Inmates were observed by surveyors left unattended for several hours a day in the infirmary without benefit of a method to call for help should it be required.
 - b. No emergency call device was located in the infirmary bathroom.
3. Although standard departmental procedures for sick call operation were in place, in practice, problems were noted regarding delays in assessments and treatments.
 - a. Observations by the survey team suggested that inmates attempting to access sick call often experienced significant delays.

- b. Staff acknowledged that inmates “often waited long periods of time for assessments/treatments”, and that “because staffing was down, the quality and continuity of care of inmates was not consistent”.
- c. It was reported to the survey team that it was not unusual for there to be only one day shift nurse on duty, with the responsibility to draw morning blood samples, conduct sick call, evaluate declared emergencies, and monitor inmates housed in the infirmary.
- d. Record reviews corroborated inmate claims of delayed care.

Clinical Management/Documentation

- 4. Concerns were noted in 89% (eight of nine) of the infirmary records reviewed regarding the documentation of nursing/physician encounters and/or the maintenance of the medical/infirmary record.
- 5. Survey team members observed several occasions at the “pill window” when inmates were told their medications were not available.

Administrative

- 6. A tour of the infirmary’s physical layout revealed a number of cleanliness and/or potential safety concerns.
 - a. Bathroom sinks were unclean and dirty linen was scattered about on the floor.
 - b. The infirmary shower stall was not wheelchair accessible.
 - c. At least one toilet in the infirmary bathroom leaked from the wall connection when flushed.

Physical Health Citations - Level II

Clinical Management/Documentation

7. Concerns were noted in 33% (three of nine) of the sick call records and 78% (seven of nine) of the emergency care records reviewed related to either a lack of appropriate documentation or delays in referral to a higher level of care.
8. Concerns were noted in 75% (nine of 12) of the asthma records reviewed related to the inadequate documentation of assessment information, the lack of provision of health education, and in one case, delayed clinic visits.
9. Concerns were noted in 75% (three of four) of the diabetes records reviewed related to inadequate documentation of assessment information and/or the lack of documentation of ongoing health education on diet and medication compliance.
10. Concerns were noted in 17% (two of 12) of the hypertension records reviewed related to the inadequate documentation of assessment information, and the untimely completion, appropriate mounting and filing of electrocardiograms (EKG).
11. Concerns were noted in 70% (seven of 10) of the records that were comprehensively reviewed related to inadequate documentation of assessment information and the lack of documentation of ongoing health education.
12. Concerns were noted in 27% (six of 22) of the focused reviewed records related to the poor maintenance of the health record, the untimely administration of prescribed medications and/or ordered appliances, and the non-completion of necessary assessment/diagnostic consultations.
13. Complete emergency event documentation and a final summary of care were lacking in one of the two mortality records reviewed.

Administrative

14. No evidence was available that mock code drills had been conducted and critiqued at the required intervals.
15. No evidence was available that mass casualty disaster drills had been conducted and critiqued at the required intervals.

Physical Health Additional Issues Noted

16. Assessment and/or clinical management concerns were noted in 10% (two of 22) of the dental records reviewed.