

CORRECTIONAL MEDICAL AUTHORITY (CMA)

PHYSICAL & MENTAL HEALTH SURVEY

OF

WASHINGTON CORRECTIONAL INSTITUTION

in

Chipley, Florida

July 20 -22, 1999

INSTITUTIONAL STATISTICS PROVIDED CMA ON July 6, 1999				
Population	Custody	Type	Maximum Capacity	Current Occupied Beds
Adult	Minimum-Close	Male	1,234	1,181

MEDICAL GRADES				
I	II	III	IV	Impaired
518	494	173	31	44

"S" GRADES				
I	II	III	IV	Impaired
758	38	409	0	8

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.

Washington Correctional Institution (WASCI), was constructed in 1993 and is a minimum to close security institution for adult male offenders with a capacity for 1,234 inmates. At

the time of survey WASCI held an inmate population of 1,181 and 30 percent of the occupied beds at WASCI were confinement beds.

This was the second survey conducted by the Correctional Medical Authority at WASCI. The first survey was conducted in 1996. That survey yielded no Level I or Level II citations and three italicized issues. The italicized issues concerned elevated water temperatures at hot water taps, correctional officers signing for inmates when dispensing over-the-counter (OTC) medications and concerns over growth in the institutional pharmacy's responsibilities in a limited work space. Strengths were identified in cleanliness and organization of the medical unit, complete surgery and consultation logs, availability of inmate health education materials, clinical management for three of six chronic illness clinics and dental care.

The current survey resulted in three Level I and four Level II citations. There were three additional issues reported, as well. Strengths were noted in the institution's smoking cessation program and in three of the six chronic illness clinics.

Review of problematic mortalities and emergency care events resulted in adverse findings related to inadequate assessments and prolonged delays in indicated follow-up care. Forty-four percent (4 of 9) of the mortalities and 50% (4 of 8) of emergency care records reviewed fell into this category of deficiency. Similar deficiencies were observed in reviews of one of eight sick call records and one of four comprehensive record reviews. The majority of inmates interviewed expressed similar concerns regarding sick call and emergency care.

Dental care deficiencies were reported in eight of 15 records reviewed.

Physical Health Strengths

1. A smoking cessation program had been implemented in conjunction with a four month wellness program. They reported a 25% total program completion rate.
2. The reviewed records in three of six chronic illness clinics; chronic obstructive pulmonary disease (COPD), diabetes and TB/INH prophylaxis, reflected the provision of care that met minimum standards.

Physical Health Citations - Level I

Clinical Management/Documentation

1. Four of nine deaths presented inadequate clinical management and shared an area of concern. They demonstrated a lack of adequate assessments and/or timely follow-up care in response to the presenting symptoms. Delays were noted in transfers to outside acute care facilities.
2. Assessment and clinical management was deficient in four of the eight emergency care records, one of eight sick call records and one of four general records reviewed. Documentation deficiencies were also identified in four of the eight emergency records and in one of four general records reviewed.
3. The logs for laboratory and radiology studies were incomplete, containing only the inmate number, date, study requested, and results. There were no recordings indicating date of return of results, initialed reviews by clinicians or any need for follow-up.

Physical Health Citations - Level II

Clinical Management/Documentation

4. Two infirmary admissions lacked admission records and clinical management deficiencies were noted in two reviewed admissions.
5. Documentation regarding the provision of chronic illness-related counseling/monitoring was lacking in the records from the following three clinics:
 - a. Two of eight reviewed hypertension clinic records,
 - b. Four of ten reviewed HIV/immunodeficiency clinic records, and
 - c. Three of five seizure disorder clinic records.
6. Eight of 15 reviewed dental records demonstrated inadequate clinical management.
7. A review of monthly inspection reports indicated a trend in dispensing or documentation errors on the medication administration records (MARs). The deficiencies noted included: missed medication doses or documentation of administration; failure to note allergies; start – stop dates not indicated; missed doses labeled “drug not available”; and medications given beyond the stop date. Errors ranged from 15 to 130 monthly.

Physical Health Additional Issues Noted

8. Concerns were identified regarding the space allocated for pharmacy services. The space was very crowded and was problematic for the existing staff of pharmacists and pharmacy technicians. The unfilled pharmacist position, when

filled, would create even greater crowding in the area. This issue was cited in the 1996 survey report.

9. Determination of compliance with staff orientation and training requirements was impossible due the unavailability of aggregated STARS (employee training) data.
10. Seven of ten inmates expressed concerns about both sick call and emergency care. Five inmates reported instances in which inmate deaths occurred due to what they perceived as inadequate responses to emergency requests for care. Another two inmates stated that qualification for emergency care in the confinement units was defined as “bleeding or dying.” These allegations could not be confirmed or refuted during the survey.

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.

The institution housed minimum to close custody males with a maximum capacity of 1,234 inmates. The institution has housed S3 inmates (psychological grade designating inmates receiving outpatient mental health services and psychotropic medication) since May 1996. The pre-survey questionnaire completed by the institution in July 1999 reported 409 S3 inmates, a 33% increase since the November 1996 Correctional Medical Authority (CMA) mental health survey. As in 1996, the institution had a significant close management mission with approximately 25% of the total inmate population classified as “close management.” Of these inmates, 51% were S3s (46% were S3s in 1996).

It is recognized that the inmate population at Washington Correctional Institution is difficult to manage. However, significant problems were identified regarding the delivery of mental health services. Four Level I citations, 12 Level II citations, and ten additional issues were identified. A number of these issues had been previously cited in the 1996 CMA survey report. A summary of the Level I citations follows:

- The practice of designated alternate housing placed two S3 close management inmates at serious risk for mental health de-compensation and self-harm.
- Close management and confinement inmates did not have adequate access to mental health treatment.
- Routine confinement and close management evaluations were not consistently completed in a timely manner.
- There was a lack of patient access to psychiatric evaluation and follow-up.

Mental Health Strengths

1. Cameras were used to observe the infirmary isolation management rooms.

Mental Health Citations - Level I

Clinical Management/Documentation

1. The practice of Designated Alternate Housing placed two S3 close management inmates at serious risk for mental health de-compensation and self-harm. The management of the inmates resulted in an emergency notification from the CMA to the Secretary of the Department of Corrections on July 23, 1999 regarding a life-threatening or otherwise serious situation.

Access

2. Close management/confinement inmates did not have adequate access to mental health treatment including individual therapy and group treatment. Furthermore, these inmates were labeled and approached by health care staff primarily as behavior management problems despite significant and often untreated psychopathology.

One case was notable for the use of pepper spray with a seriously mentally ill individual. This issue is of grave concern given that over 400 S3 inmates are housed at Washington Correctional Institution, many in close management cells.

3. While there had been some improvement noted since the 1996 survey, routine confinement and close management evaluations were not consistently completed in a timely manner (this issue was cited in the 1996 survey report).
4. There was a lack of patient access to psychiatric evaluation and follow-up. The psychiatrist was concerned about her inability to complete face-to-face evaluations of all new patients requiring one (this issue was cited in the 1996 survey report). Furthermore, record review data indicated that psychiatric follow-up had not been consistently provided at the required or ordered frequency in the records reviewed.

Mental Health Citations - Level II

Clinical Management/Documentation

5. Institutional medication administration practices compromised the therapeutic application of psychotropic medications in two areas (these issues were also cited in the 1996 survey report):
 - a. Hour of sleep medications continued to be administered at 5 p.m.
 - b. Liquid psychotropics continued to be given with water. These medicines are extremely unpleasant to take with only water, which can serve as a disincentive to medication compliance.
6. Deficiencies were noted regarding the screening and assessment of inmates in the following areas:
 - a. The psychiatric evaluations did not consistently document strengths and weaknesses.

- b. The nursing assessments were incomplete in two areas:
 - 1. The reason for admission to the infirmary on suicide observation status was not consistently documented.
 - 2. Documentation of mood and affect was inconsistent in the mental health observation cases reviewed.
 - c. Biopsychosocial assessments were not consistently documented in a timely manner (this issue was cited in the 1996 survey report).
- 7. The clinical management of sex offenders was deficient in two areas (HSB 15.05.03, HSB 15.05.11; Minimum Standard):
 - a. The diagnosis was inaccurate and/or incomplete in each of the records reviewed.
 - b. The sex offender treatment was not individualized; the treatment plans were identical photocopies.
- 8. Three deficiencies were identified in the treatment planning process. (HSB 15.05.11)
 - a. The treatment plans were not consistently reviewed at the required intervals.
 - b. The treatment plans were not consistently modified to reflect changes or critical events (this issue was cited in the 1996 survey report).
 - c. Inmate signatures and/or refusals were inconsistently documented.
- 9. Known drug allergies and reactions were not consistently addressed as part of the psychotropic medication history.
- 10. The overall quality of the mental health documentation was seriously deficient. Progress notes were frequently out of order, photocopied, illegible, and lacking in detail; and key documentation was missing.

Access

11. Inmate requests for mental health services were not consistently answered in a timely manner.
12. Inmate grievances regarding mental health services were not consistently answered in a timely manner.
13. In two of the four psychological emergency cases reviewed, the rationale for denying the emergency was not clearly documented.

Administration

14. There was one psychiatrist position allocated to the institution (housing 400 S3 inmates). This does not meet the guidelines of the 1996 DC Mental Health Services Plan, which specifies one psychiatrist per 200 S3 inmates.
15. Inmates with IQ scores less than 70 or with a diagnosis of mental retardation inconsistently accessed needed mental health evaluation and treatment.
16. The mental health training provided to correctional officers and nursing staff was insufficient to prepare them for working with mental health patients (this issue was cited in the 1996 survey report).

Mental Health Additional Issues Noted

17. Inmate interview data indicated that disciplinary reports were issued in response to self-injurious behavior. This was not confirmed or refuted at the time of the survey. (This issue was cited in the 1996 survey report; the issue was found not corrected during the 1997 corrective action plan assessment visit).
18. The institution-wide use of force was significant. One correctional officer interviewed bragged about using pepper spray to deter the inmates' self-abusive behavior.

19. The substance abuse treatment needs were significant among the inmate population. Washington Correctional Institution did not provide substance abuse treatment other than an Alcoholics Anonymous group (this issue was noted in the 1996 survey report).
20. There continued to be a high staff turnover in the mental health department. (This issue was noted in the 1996 survey report.)
21. The mental health staff requires additional training in the diagnosis, assessment and treatment of sex offenders.
22. Mental health staff training was inconsistently documented.
23. A number of issues were identified regarding written information describing the mental health program:
 - a. The close management mental health orientation guide was not available in Spanish.
 - b. There was a discrepancy in the Spanish and English versions of the open population mental health services orientation guide regarding the amount of the inmate co-payment.
 - c. Written material describing access to mental health services was posted in the dormitories in English, but not in Spanish.
 - d. Written materials describing access to mental health services were not consistently posted in close management, or administrative and disciplinary confinement.
24. To guide inmates as they move to the medical building, specific lines were painted on the walkways on the compound. One line was labeled “mental health.” This resulted in a breach of privacy for mental health patients.
25. The institutional operating procedure regarding cleaning and fireproofing of security blankets, shrouds, and mattresses did not address the frequency of cleaning.

26. One of the six isolation management rooms was used for storage.