



CORRECTIONAL MEDICAL AUTHORITY

PHYSICAL & MENTAL HEALTH SURVEY

of

APALACHEE CORRECTIONAL INSTITUTION EAST UNIT

in

Sneads, Florida

on

November 18-21, 2003

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DEMOGRAPHICS

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

| INSTITUTIONAL INFORMATION | | | |
|---------------------------|-------------|---------------|---------------|
| Population | Type | Custody Level | Medical Level |
| Adult | Male | Close | 3 |

Institutional Potential/Actual Workload

| | | | |
|------------------------------------|-------------|------------------------------------|-------------|
| Main Unit Capacity | 1094 | Current Main Unit Census | 1066 |
| Annex Capacity | N/A | Current Annex Census | N/A |
| Satellite Unit(s) Capacity* | 736 | Current Satellite(s) Census | 379 |
| Total Capacity | 1830 | Total Current Census | 1445 |

*River Junction Work Camp is served by the APACI medical unit. Refer to the Apalachee Correctional Institution West Unit report for their demographics.

Inmates Assigned to Medical/Mental Health Grades

| Medical Grade | 1 | 2 | 3 | 4 | Impaired | |
|----------------------------|--|------------|------------|----------------------------|-----------------|-----------------|
| | 686 | 666 | 93 | 0 | 0 | |
| Mental Health Grade | <u>Mental Health Outpatient</u> | | | <u>MH Inpatient</u> | | |
| (S-Grade) | 1 | 2 | 3 | 4 | 5 | Impaired |
| | 820 | 85 | 540 | 0 | 0 | 0 |

Inmates Assigned to Special Housing Status

| Confinement/ Close Management | DC | AC | PM | CM3 | CM2 | CM1 |
|--|-----------|-----------|-----------|------------|------------|------------|
| | 84 | 49 | 9 | 0 | 0 | 0 |

OVERVIEW

The Correctional Medical Authority conducted a thorough review of the medical, mental health and dental systems at Apalachee Correctional Institution-East Unit (APACI-East). 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. A review of medical care at River Junction Work Camp was excluded during this survey due to its separate location. A review will be conducted at the Work Camp during a separate survey.

Physical Health Findings

Despite a lack of management longevity and a high percent of nursing hours being filled by staffing agencies, survey findings suggest the staff is providing an appropriate level of physical health care to the inmate population. There were no major concerns regarding the overall delivery of physical health care.

Mental Health Findings

Numerous findings were identified related to mental health care at APACI-East, many of which were a result of insufficient staffing. Caseloads for the psychological specialists were reaching over one hundred. Three locum tenens psychiatrists were employed and shared between the East and West Units. As a result, the three physicians served approximately one thousand S3 inmates. Continuity of care was, therefore, compromised as many of the recent psychiatrists stayed at the institution only briefly.

In addition to staffing deficiencies, physical plant concerns were also a primary finding. Despite having been cited repeatedly in past surveys, the mental health department was still located in a section of the institution that had inadequate security measures and minimal privacy for clinical encounters. Plans for improvement submitted to the authority in the past as corrective action had not been implemented. Monitoring of these concerns will be key in future corrective action plan assessments.

Two issues surrounding the suicide prevention practices at APACI-East were also of concern. Interviews and observation of one incident during the course of the survey suggested that searches of inmates placed in Isolation Management Rooms did not prevent inmates identified at risk for self-harm from having access to sharp objects. Also, clarification was needed regarding the use of 23-hour observation for mental health reasons.

Despite the significant issues identified, the dedication and determination of the mental health staff in the face of rapidly increasing workloads was a strength at APACI-East. It is recommended that efforts to alleviate the high caseloads be a priority for change to ensure that the current staff may continue to function optimally as dedicated public servants.

Department Findings

In addition to the findings referenced above, other areas of concern were noted. These findings may be based on standards adopted by the CMA, and may not be addressed in OHS policy, procedure or directive. Or, they may be based on issues beyond institutional control and require intervention at the department level. The department should submit a separate corrective action plan for these findings.

Exit Conference and Final Report

At the conclusion of the survey, an exit conference was held with institutional personnel to discuss preliminary survey results. The findings and final conclusions presented in the physical health and

mental health sections of this report are a result of further analysis of the information collected during the survey. The suggested corrective actions(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. Monitoring by a clinician peer must be documented by a monthly compilation of the following:

- 1) The criteria/finding being reviewed;
- 2) The inmate names and DC numbers corresponding to the charts (medical records) reviewed;
- 3) An indication of whether or not the criteria/finding was met for each chart reviewed;
- 4) The percentage of charts reviewed each month that complied with the criteria;
- 5) Back-up documentation consisting of copies of the relevant sections reviewed from the sampled charts.

SUMMARY OF INSTITUTIONAL SCORES

The goal of the survey is to determine if the administration of the medical unit and the provision of care at the institution are consistent with medical, dental and mental health care standards of care established by the CMA and with prevailing professional practice standards. For a detailed description of the survey goals and processes refer to the "Survey Process" section of this report. The following table lists the results of the systems and record reviews conducted during the survey.

| Area of Review | | Score* | | | |
|---------------------------------|---------------------------------------|-------------------------------------|------------|-----|----|
| | | Systems | Clinical | | |
| PHYSICAL HEALTH | Episodic Care | Episodic Care Systems | 80 | | |
| | | Emergency Care | | 76 | |
| | | Episodic Care Follow-Up | | 98 | |
| | | Infirmery Care | | 92 | |
| | | Sick Call | | 98 | |
| | Chronic Care | Asthma/Pulmonary Clinic | | 100 | |
| | | Diabetes Clinic | | 99 | |
| | | General Medicine Clinic | | 95 | |
| | | Hypertension Clinic | | 93 | |
| | | Immunity Clinic | | 98 | |
| | | Seizure Clinic | | 93 | |
| | Preventative Care | | 83 | | 98 |
| | Dental Services | | 89 | | 90 |
| | Mortality Review | | 100 | | 93 |
| | Other | Administrative Processes | 94 | | |
| | | Consultation Requests | 100 | | 98 |
| | | Food Services | 82 | | |
| | | Infection Control | 86 | | |
| | | Intake Process (Reception) | NA | | NA |
| | | Intrasystem Transfers | 100 | | 97 |
| Medical Area and Inmate Housing | | 88 | | | |
| Medication Administration | | 92 | | 86 | |
| OBIS/Health Record Content | | 100 | | 81 | |
| Pharmacy Services | | 100 | | | |
| Quality Management | | 94 | | | |
| Area of Review | | | Area Score | | |
| MENTAL HEALTH | Mental Health Systems | | 69 | | |
| | Access to Mental Health Services | | 82 | | |
| | Inpatient Mental Health Services | | NA | | |
| | Intellectual Functioning | | 77 | | |
| | Outpatient Mental Health Services | | 80 | | |
| | Psychiatric Restraint | | NA | | |
| | Psychotropic Medication Practices | | 68 | | |
| | Reception/Intake Process | | NA | | |
| | Self-Injury/Suicide Prevention | 23-hour MH Observation | | NA | |
| | | SOS Status | | 71 | |
| | | Other Self-injury Prevention Status | | NA | |
| | Sexual Offender Services | | 76 | | |
| | Special Housing | | 82 | | |
| | Use-of-Force | | 73 | | |

*Shaded Area: No survey instrument for the applicable area. NA: No applicable files at the institution.

PHYSICAL HEALTH FINDINGS

SYSTEMS

| DENTAL SERVICES | | Systems Score 89 |
|---|---|-----------------------------------|
| Finding(s) | Suggested Corrective Action(s) | |
| PH-1: The dental area had no displays of preventive dentistry/oral hygiene posters and/or plaques displayed. | <p>Ensure that appropriate posters and/or plaques are displayed.</p> <p>Place documentation in the CMA CAP assessment closure file.</p> | |
| PH-2: A water leak in the supply closet was dripping on some paper supplies. Also staff and inmates are possibly being subjected to potentially hazardous airborne particles from exposed fiberglass in the ceiling. | <p>Submit appropriate documentation for necessary maintenance.</p> <p>Place documentation in the CMA CAP assessment closure file.</p> | |

| EPISODIC CARE | | Systems Score 80 |
|--|--|-----------------------------------|
| Finding(s) | Suggested Corrective Action(s) | |
| PH-3: There was no system for weekly supervisory review of sick call and emergency encounters. | <p>Establish a system for supervisory review of sick call and emergency encounters. Select several sick calls and emergency encounters each week and review for accuracy, treatment modality, medication distribution, vital signs, documentation, education, and completeness.</p> <p>Place documentation in the CMA CAP assessment closure file.</p> | |
| PH-4: The infirmary log was not properly maintained. All admissions were not logged. The logged date of admission and/or the date of admission in the medical record did not always match the date of admission entered in OBIS. The log was not always completed at the time of admission and lacked evidence of supervisory review. | <p>Provide in-service training to relevant staff on maintaining current and complete logs. Logs should be reviewed and signed by designated supervisory staff.</p> <p>Place documentation in the CMA CAP assessment closure file.</p> | |

| FOOD SERVICES | | Systems Score 82 |
|--|--|-----------------------------------|
| Finding(s) | Suggested Corrective Action(s) | |
| PH-5: The area had a sour odor, damp floors and boxes on the floor. | <p>Steps should be taken to address odor and any standing water in floors. Also supplies should be maintained on shelves that are at least six inches off the floor to allow for adequate cleaning of floors.</p> <p>Place documentation in the CMA CAP assessment closure file.</p> | |
| PH-6: Appropriate monitoring of inmates' adherence to prescribed therapeutic diets was not being completed. | <p>Food service staff should record inmate's adherence to prescribed therapeutic diets on the Diet Attendance Roster, DC4-668 and forward it to medical each month.</p> <p>Place documentation in the CMA CAP assessment closure file.</p> | |

| MEDICAL AREA AND INMATE HOUSING | | Systems Score 88 |
|---|--|-----------------------------------|
| Finding(s) | Suggested Corrective Action(s) | |
| PH-7: The medical unit lacked eye wash stations and appropriate signage indicating the institutional health area is a doctor's office. | <p>Signage should be prominently posted indicating the institutional health care area is a doctor's office. Eye wash stations should be strategically placed throughout the medical facility.</p> <p>Place documentation in the CMA CAP assessment closure file.</p> | |
| PH-8: The emergency room linen was soiled and was not changed even after it was pointed out to medical staff. | <p>Provide in-service training to relevant staff on the need for good sanitation practices with emphasis on soiled linen being changed as soon as possible.</p> <p>Place documentation in the CMA CAP assessment closure file.</p> | |
| PH-9: No call system was available in the infirmary. This was a particular concern within the infirmary restroom area. | <p>Action should be taken to ensure that at a minimum the infirmary restroom is appropriately equipped to accommodate a disabled patient's ability to get assistance if needed.</p> <p>Place documentation in the CMA CAP assessment closure file.</p> | |

| MEDICAL AREA AND INMATE HOUSING | | Systems Score 88 |
|--|---------------------------------------|-----------------------------------|
| Finding(s) | Suggested Corrective Action(s) | |

Discussion: Even though it is not being identified as a finding, it was suggested that management be made aware of the possible safety hazards associated with the walkway from administrative confinement to medical. It was confirmed by staff as being a very difficult to maneuver a wheelchair down the dirt path.

CLINICAL

| Records Reviewed 6 | EMERGENCY CARE | Record Review Score 76 |
|--|--|---|
| Finding(s) | Suggested Corrective Action(s) | |
| PH-10: One record's documentation of an emergency encounter consisted of an assessment form with just subjective information and vital signs. | <p>Provide in-service training to relevant staff on documentation requirements for emergency encounters.</p> <p>Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.</p> | |

| Records Reviewed 64 | CHRONIC ILLNESS CLINICS | Record Review Score ** |
|---|--|---|
| Finding(s) | Suggested Corrective Action(s) | |
| PH-11: Documentation did not reflect that pneumococcal and or influenza vaccines were always offered or refusals documented. Clinics: General Medicine, Hypertension, Immunity, Seizure, Tuberculosis/INH | <p>Provide in-service training to relevant staff on appropriate chronic illness clinic protocols and documentation requirements. Review OHS Technical Instruction 15.03.05</p> <p>Review five records from each chronic illness clinic per month for compliance.</p> <p>Continue until corrective action is affirmed through the CMA CAP assessment.</p> | |
| PH-12: Several records lacked evidence of a neurological consultation or a written explanation as to why one was not indicated. Clinics: Seizure | See PH-11 for suggested corrective actions. | |
| PH-13: A disease related diagnosis was not always identified on the problem list. | See PH-11 for suggested corrective actions. | |

| Records Reviewed | CHRONIC ILLNESS CLINICS | | Record Review Score |
|---|--------------------------------|--|---------------------|
| 64 | | | ** |
| Finding(s) | Suggested Corrective Action(s) | | |
| Clinics: Hypertension, Tuberculosis/INH | | | |

**See summary for individual chronic illness clinic scores.

| Records Reviewed 10 | DENTAL SERVICES | Record Review Score 90 |
|--|---|----------------------------------|
| Finding(s) | Suggested Corrective Action(s) | |
| PH-14: Most records lacked documentation identifying a prescription pretreatment rinse when used. | Proved in-service training to relevant staff on appropriate documentation requirements. Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment. | |

| Records Reviewed 10 | MEDICATION ADMINISTRATION | Record Review Score 86 |
|--|---|----------------------------------|
| Finding(s) | Suggested Corrective Action(s) | |
| PH-15: Several medication orders were found to be incomplete by lacking route of administration, time and or signature. | Proved in-service training to relevant staff on appropriate documentation requirements. Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment. | |

| Records Reviewed 5 | OBIS/HEALTH RECORD | Record Review Score 81 |
|--|---|----------------------------------|
| Finding(s) | Suggested Corrective Action(s) | |
| PH-16: Most problem lists were incomplete and were not always immediately visible on the left side of the record. | Provide in-service training to relevant staff on medical record organization in accordance with technical instruction 15.12.03, dated 4/9/03. Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment. | |
| PH-17: The most current PULHESDXTI in the medical record did not always match the PULHESDXTI reflected in OBIS. | See PH-16 for suggested corrective action. Also review process in which changes are made both in the medical record and OBIS. | |

Discussion: Even though many records did not have chronic illness clinic forms organized in accordance with current DC Policy, medical records staff was aware of the change and were making steady progress toward compliance.

The following areas of review resulted in no significant negative system or record review problems.

System Reviews

- Consultation Requests
- Infection Control
- Intrasystem Transfers
- Mortality Review
- OBIS/Health Record
- Pharmacy Services

Record Reviews

- Asthma/Pulmonary Clinic
- Consultation Requests
- Diabetes Clinic
- Follow-Up Care
- Intrasystem Transfers
- Preventative Care
- Sick Call

CONCLUSION

Staff at Apalachee Correctional Institution had a professional demeanor and seemed knowledgeable regarding the process of providing care. The survey of this facility revealed that, overall, staff provides a level of physical health care consistent with expected and required standards. The medical facility was clean and well organized. There was good cooperation and communication between the medical department and security.

MENTAL HEALTH FINDINGS

Description of Mental Health Department

At the time of the survey, the East Unit of APACI was comprised of one senior psychologist, seven psychological specialists, one registered nurse specialist, and one clerk typist specialist. Psychiatric services were provided through the use of locum tenens physicians. Notably, one of these temporary physicians was a psychiatrist who recently retired from full-time employment at APACI.

Strengths

- Many longstanding, experienced staff members were employed in the mental health department of APACI-East. They expressed commitment and determination to provide the best possible care despite the severe lack of resources.
- Regular staff meetings were held to inform staff of policy updates and changes.
- Evening medication administration occurred at 8:00 pm rather than the typical 4:00 pm.

| Records Reviewed: | ACCESS TO MENTAL HEALTH SERVICES | Area Score |
|---|---|------------|
| 9 | | 82 |
| Finding(s) | Suggested Corrective Action(s) | |
| MH-1: The <i>Mental Health Emergency Log (DC4-781A)</i> did not accurately reflect time of referral. Time of referral and time seen were recorded as the same time in all instances. | <p>Develop a system to ensure that the record keeper of this log receives accurate information.</p> <p>Administrative staff should monitor the log monthly to ensure accuracy.</p> | |
| MH-2: After-hours mental health emergencies were not logged on the <i>Emergency Nursing Log (DC4-781M)</i> as required by policy. | <p>Develop a system to ensure that after-hours mental health emergencies are recorded on the log.</p> <p>Administrative staff should monitor the log monthly to ensure accuracy.</p> | |
| MH-3: In all records reviewed, an incidental note on the chronological record of outpatient mental health care indicating that an inmate request was received was omitted. | <p>Provide inservice training to all staff that respond to mental health inmate requests on this requirement.</p> <p>Monitor a minimum of five records per month of those inmates who have sent an inmate request to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p> | |

| Records Reviewed: INTELLECTUAL FUNCTIONING | | Area Score |
|---|---|------------|
| 7 | | 77 |
| Finding(s) | Suggested Corrective Action(s) | |
| MH-4: Orange psychological files were not kept in a secure location: <ul style="list-style-type: none"> • The file cabinet had no locking mechanism. • The file cabinet was located in a high traffic area, of concern due to the lack of a lock on the cabinet. | Obtain a locking file cabinet or move files to a secure storage room. | |
| MH-5: Clinical response to low intellectual functioning was insufficient: <ul style="list-style-type: none"> • In two cases reviewed, no documentation was present that assignment to S-grade 2 or Impairment grade I was considered for individuals who were assessed as intellectually impaired. • In one case reviewed, no documentation was present that intellectual testing had been administered. | Provide inservice training regarding the need for a full assessment to include applicable service planning. For those inmates deemed not in need of further services, justification for this determination should be clearly documented. Select a sample each month of newly arriving inmates whose initial reception screening includes a score on the BETA of 75 or lower. Monitor for appropriate assessment and service planning to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |

| Records Reviewed: OUTPATIENT MENTAL HEALTH SERVICES | | Area Score |
|---|--|------------|
| 22 | | 80 |
| Finding(s) | Suggested Corrective Action(s) | |
| MH-6: No current group therapy was offered. | Provide sufficient mental health staff to permit a range of therapeutic groups to meet the needs of the inmate population. | |
| MH-7: Medical records were disorganized with information filed in the wrong sections and/or out of chronological order. | Provide inservice training regarding filing requirements. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |
| MH-8: Documentation of written and verbal orientation on access to mental health care by healthcare staff within 24 hours of arrival was absent in the majority of records reviewed. | Provide inservice training to healthcare staff regarding the need for documentation of orientation upon arrival. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |
| MH-9: Documentation of written and | Provide inservice training to mental health staff | |

| Records Reviewed: | OUTPATIENT MENTAL HEALTH SERVICES | Area Score |
|---|---|------------|
| 22 | | 80 |
| Finding(s) | Suggested Corrective Action(s) | |
| verbal orientation to mental health services by mental health staff within eight days of arrival was absent in the majority of records reviewed. | regarding the need for documentation of orientation upon arrival. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |
| MH-10: Prior treatment records were not consistently requested. | Provide inservice training to case managers on the requirement to request prior treatment records. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |
| MH-11: Individualized Service Plans were not consistently completed within the required time frame of 14 days after arrival. | Provide adequate staffing to permit timely treatment planning. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |
| MH-12: Mental health problems were not always recorded on the problem list. | Provide inservice training regarding the need to record problems on the problem list. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |
| MH-13: Documentation of aftercare planning was absent in the majority of reviewed records of inmates who were nearing release. | Develop a system to ensure aftercare planning is completed as required. Monitor a minimum of five records per month of inmates nearing release to ensure that aftercare planning is completed. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |

| Records Reviewed: | PSYCHOTROPIC MEDICATION PRACTICES | Area Score |
|---|---|------------|
| 15 | | 68 |
| Finding(s) | Suggested Corrective Action(s) | |
| MH-14: No medication education group was provided. | Provide a medication education group. | |
| MH-15: No oral cavity checks were conducted at the medication administration line. | Post a staff member on the outside of the pharmacy window to ensure that medications are being swallowed. | |

| Records Reviewed: 15 | PSYCHOTROPIC MEDICATION PRACTICES | Area Score 68 |
|--|--|-------------------------|
| Finding(s) | Suggested Corrective Action(s) | |
| MH-16: Patients were not consistently seen by the psychiatrist within 10-days of arrival. | Provide adequate psychiatric staff to ensure that new patients are evaluated in a timely manner. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |
| MH-17: Annual physical health appraisals were not consistently completed for patients receiving psychotropic medications. | Provide inservice training on the requirement for an annual health appraisal. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |
| MH-18: Follow-up laboratory studies were not consistently completed as required. | Develop a system, such as a quick reference guide, for temporary physicians to ensure that required tests are ordered. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |
| MH-19: AIMS tests were not consistently present in the record every six months for patients on antipsychotic medications. | Develop a system to track the completion of AIMS tests during the required time frames. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |
| MH-20: Outdated medication consent forms (circa 1989) were in use that did not provide specific information regarding side effects. | Utilize only the most recent forms. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |

Additional Discussion Item:

Interviews during the survey indicated that the current system of referral for psychiatric care was inadequate due to the insufficient number of psychiatrists available to manage the population. This resulted in psychological specialists, the psychologist, and the psychiatric nurse attempting to work in the many referrals that occurred on nearly a daily basis. This time-consuming process suggested a need for a standardized protocol to determine which patients are the most critical referrals.

It is recommended that Regional Staff and the Office of Health Services consider developing such a protocol for use at all institutions.

| Records Reviewed: | | SELF-INJURY/SUICIDE PREVENTION | Area Score |
|-------------------|---|--------------------------------|------------|
| 23-hr | 0 | | 71 |
| SOS | 7 | | |
| Other | 0 | | |

| Finding(s) | Suggested Corrective Action(s) |
|--|--|
| <p>MH-21: Policy and procedural responses for management of self-injurious inmates were not consistently followed.</p> <ul style="list-style-type: none"> • 23-hour observation was ordered in response to after-hour emergencies for patients who were threatening self-harm. This is contrary to department policy. • Patients placed on 23-hour observation status were not logged on the infirmary log and, therefore, not tracked. | <p>Provide inservice training to all ordering clinicians regarding the requirement that self-injurious inmates be placed on SOS status (See TI 15.03.26, VI, 4.)</p> <p>Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p> |
| <p>MH-22: Physician's orders were not consistently timed and verbal orders were not always countersigned.</p> | <p>Provide inservice training on the required components for physician's orders.</p> <p>Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p> |
| <p>MH-23: SOS status was not consistently reordered every 24-hours.</p> | <p>Provide inservice training on the need for a new SOS order every 24 hours.</p> |
| <p>MH-24: Management of inmates on SOS status exceeded the temporal guidelines in three of seven cases reviewed.</p> | <p>Provide inservice training on time limits for SOS status.</p> <p>Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p> |
| <p>MH-25: Daily contact by the psychiatrist and case manager did not occur consistently in records reviewed.</p> | <p>Provide inservice training on the requirement for daily assessments, excluding weekends and holidays.</p> <p>Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p> |
| <p>MH-26: Post-discharge follow-up sessions did not occur at the required intervals.</p> | <p>Develop a system to ensure follow-up occurs at 3, 10, and 30 days after discharge.</p> <p>Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p> |

| Records Reviewed: | | SELF-INJURY/SUICIDE PREVENTION | Area Score |
|---|---|---|------------|
| 23-hr | 0 | | 71 |
| SOS | 7 | | |
| Other | 0 | | |
| Finding(s) | | Suggested Corrective Action(s) | |
| MH-27: Inmates reporting suicidal feelings during clinical encounters were not consistently referred for suicide precautions or other higher-level intervention. See discussion below. | | Provide inservice training regarding the need to clearly document clinical rationale and plan when an inmate reports suicidal ideation. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |

MH-27 Discussion:

In several records reviewed, documentation of clinical encounters included inmates' reports of suicidal ideation. However, there was no documentation of referral for suicide prevention measures or referral for psychiatric evaluation. It was unclear if a proper assessment of risk was done or if the documentation of the results of this assessment was omitted. It is critical that in instances where a risk of self-injury is introduced, the clinician's rationale for a decision that the patient may remain in outpatient care must be fully documented to include a plan for follow-up.

Additional Discussion Item:

Physicians' orders used abbreviations, "BMS" or "BMW", to indicate that the patient should be given a blanket, mattress, and shroud/privacy wrap. These, however, are not standard medical abbreviations and should not be used.

Additional Discussion Item:

Interviews and observation of an event that occurred during the survey suggested that searches of inmates placed into the Isolation Management Rooms were insufficient to ensure that potentially injurious objects were not smuggled into the cells. The need for thorough searches was discussed with institutional staff during the exit conference.

| Records Reviewed: | | SEX OFFENDER SERVICES | Area Score |
|--|----|---|------------|
| | 10 | | 76 |
| Finding(s) | | Suggested Corrective Action(s) | |
| MH-28: No sex offender treatment was provided. | | Provide sex offender treatment. | |
| MH-29: A refusal form for sex offender treatment was not consistently obtained in the event an offender was unwilling to participate. | | Provide inservice training. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |
| MH-30: Documentation of clinical rationale was insufficient to support a | | Regional staff or an outside training program should provide inservice training in assessment | |

| Records Reviewed: SEX OFFENDER SERVICES | | Area Score |
|---|---|------------|
| 10 | | 76 |
| Finding(s) | Suggested Corrective Action(s) | |
| finding of no sexual disorder in three records reviewed. See discussion below. | for sexual disorders. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |
| MH-31: Documentation of aftercare planning was not present in four of five records of inmates nearing release. | Develop a system to ensure that aftercare planning is provided for inmates within 180 days of release. | |

MH-30 Discussion:

Several records were reviewed in which inmates with clear histories of sexual offenses were determined to have no evidence of a sexual disorder following the completion of a sex offender screening. Other than the inmate's denial of having a problem during the screening, there was no documentation of why the inmate did not meet criteria for diagnosis of a sexual disorder.

| Records Reviewed: SPECIAL HOUSING | | Area Score |
|--|--|------------|
| 9 | | 82 |
| Finding(s) | Suggested Corrective Action(s) | |
| MH-32: Psychiatric encounters were conducted at cell-front. | Provide inservice training on the need to conduct clinical encounters in a setting that ensures confidentiality. | |
| MH-33: Documentation of mental status examinations consisted primarily of a photocopied template. See discussion below. | Provide inservice training on the need for individualized documentation of care. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |
| MH-34: Problems in adjustment, when identified, did not always result in appropriate follow-up. | Provide inservice training on the criteria for follow-up. Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment. | |

MH-33 Discussion:

In the majority of records reviewed for monitoring of adjustment in special housing, the required periodic mental status examination consisted only of a photocopied progress note, including a mental status examination with results within normal limits in all spheres. The note had a blank for the subjective complaint, which often documented a phrase similar to; "I've been doing OK since I've been confined." The clinician's signature was photocopied.

Additionally, it was also noted that contacts with other mental health staff such as the psychiatrist or case manager documented problems in adjustment. This, coupled with the use of non-individualized documentation, challenged the validity of the mental status exams.

| Records Reviewed: | | USE OF FORCE | Area Score |
|--|---|---------------------|-------------------|
| 8 | | | 73 |
| Finding(s) | Suggested Corrective Action(s) | | |
| MH-35: A referral for mental health care using form DC4-529, Staff Referral/Request, was not completed for S2 and S3 inmates. | <p>Provide inservice training to nursing staff regarding the requirement for a written referral to mental health at the conclusion of the Post Use of Force Exam for S2 and S3 inmates.</p> <p>Monitor a minimum of five records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p> | | |

Additional Discussion Item:

In one record reviewed, the Risk Assessment for the Use of Chemical Restraint Agents and Electronic Immobilization Devices (DC4-650B) failed to identify the inmate's history of a seizure disorder as a contraindication to electronic immobilization devices.

| OTHER ADMINISTRATIVE ISSUES | |
|---|--|
| Finding(s) | Suggested Corrective Action(s) |
| MH-36: There was no documentation that security staff had been trained in the use of psychiatric restraints. | Provide required training, particularly for those security officers assigned to the infirmary area. |
| MH-37: Office space allocated to the mental health department did not provide adequate privacy for patients or safety for staff. | <p>Relocate mental health staff or renovate existing facilities.</p> <p>Issue all mental health staff personal body alarms such as those in use in many other institutions throughout the state.</p> |

MH-37 Discussion:

The mental health department is located in a section of the institution separated from the rest of the compound by a locked gate. Individual offices have been created by partitioning large rooms into several smaller rooms. Some partitions are solid, others are glass. None, however, reach to the ceiling.

No security staff is posted in this area, and the individual offices are not visible in any way to security staff posted at the center gate. Mental health offices have switches referred to as panic buttons that will summon security staff in the event that they are pushed. However, the staff member must be in proximity to the switch, which is sometimes located on the other side of the room. It should be noted that one sexual assault of a psychological specialist has occurred in this area.

As a result of insufficient security, staff have resorted to conducting clinical interviews with open doors or only in rooms divided by glass partitions. This in itself does not cause a lack of privacy and confidentiality because the use of the partitioned walls does not impede the transfer of sound even if the doors are shut.

Concerns regarding the location of the mental health unit have been cited in CMA surveys since 1992. Plans for modifying the area, posting security, or moving the staff have all been submitted as components of Corrective Action Plans, but the facilities remain essentially unchanged. As a result, monitoring of institutional and department response to this finding will be prioritized in the CAP process for the 2003 survey.

Additional Discussion Item:

In one record reviewed, a patient was instructed by the psychiatrist to report any further auditory hallucinations to mental health staff. During a clinical encounter with his psychological specialist, the patient reported that the symptoms were recurring. The documentation of this encounter read:

“states he is coughing some and agrees he may be coming down with a respiratory infection. He did not understand that minor colds flu etc. can sometimes cause interference with medications effectiveness.”

The accuracy of this statement is questionable, and it is beyond the scope of this practitioner to provide medical advice.

CONCLUSION

For several years, APACI has been one of Florida’s most complex institutions. They provide mental health care to half of the inmate population across two separate units, each large enough to be considered its own institution. As a result, the CMA approached the survey process by separating the two units, surveying with two teams and producing two reports.

Despite the ever-increasing complexity of APACI, numerous dedicated mental health staff have remained committed to providing the best possible care to the inmates in their charge. This task has gotten increasingly more difficult as the caseloads have risen. Most psychological specialists have caseloads reaching over 100 and there was no permanent psychiatric staff at the time of the survey, despite a count of 540 S-3s. As a result, services have suffered with weekly, or even biweekly therapy, considered a luxury.

The majority of the findings are easily attributed to the high caseloads of high acuity patients. Lack of permanent psychiatric staff further complicates this problem. Although it was reported during the survey that two additional psychological specialist positions were being added to APACI in January, the number of cases are soaring at a rate such that these new positions will do little to return the caseloads to a manageable size. Until the workload is reduced, it is unlikely that lasting change will be successfully implemented in the findings identified.

DEPARTMENT FINDINGS

In addition to the physical and mental health findings referenced previously in this report, several other areas of concern were noted. These findings are beyond the scope of the institution to correct. These findings may be based on standards adopted by the CMA, but not addressed in department policy, procedure or directive. Or, they may be based on other issues beyond institutional control. Therefore, the department must initiate corrective action.

PHYSICAL HEALTH

ADMINISTRATIVE PROCESSES

Finding(s)

Dept - 1: Special housing inmates were not offered one hour of exercise per day outside the cell five days per week.

Dept - 2: There was no evidence of a policy that prohibits the medical staff from participating in gathering forensic information and participating in body cavity searches for forensic purposes.

FOOD SERVICE

Finding(s)

Dept - 3: Written procedures that addressed actions to be taken in a suspected food-borne illness outbreak were not available in the food service facility.

QUALITY MANAGEMENT

Finding(s)

Dept - 4: No evidence was available demonstrating annual peer review of the licensed health care practitioners.

MENTAL HEALTH

MENTAL HEALTH SYSTEMS REVIEW

Finding(s)

Dept - 5: A review of administrative logs and interviews suggested that significant delays in transferring patients for inpatient mental health care have occurred.

Dept - 6: Allocated mental health positions were insufficient to meet the needs of the mental health caseload.

Dept - 7: Lack of permanent psychiatric staff disrupted continuity of care.

**MENTAL HEALTH SYSTEMS
REVIEW**

Finding(s)

Dept - 8: Observation intervals greater than 15-minutes were in use for self-injury prevention.

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, service/treatment plans, schedules, logs, administrative reports, physician orders, 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.