



CORRECTIONAL MEDICAL AUTHORITY

PHYSICAL & MENTAL HEALTH SURVEY

of

BROWARD CORRECTIONAL INSTITUTION

in

Pembroke Pines, Florida

on

May 29- June 1, 2007

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DEMOGRAPHICS

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

INSTITUTIONAL INFORMATION			
Population	Type	Custody Level	Medical Level
738	F	Close	5

Institutional Potential/Actual Workload

Main Unit Capacity	750	Current Main Unit Census	738
Annex Capacity	NA	Current Annex Census	NA
Satellite Unit(s) Capacity	NA	Current Satellite(s) Census	NA
Total Capacity	750	Total Current Census	738

Inmates Assigned to Medical/Mental Health Grades

<i>Medical Grade</i>	1	2	3	4	<i>Impaired</i>	
		291	152	268	6	8
<i>Mental Health Grade (S-Grade)</i>	<u><i>Mental Health Outpatient</i></u>			<u><i>MH Inpatient</i></u>		
	1	2	3	4	5	<i>Impaired</i>
	286	100	426	28	5	7

Inmates Assigned to Special Housing Status

<i>Confinement/Close Management</i>	DC	AC	PM	CM3	CM2	CM1
		28	9	0	NA	NA

OVERVIEW

The Correctional Medical Authority (CMA) conducted a thorough review of the medical, mental health and dental systems at Broward Correctional Institution (BROCI) May 29-June 1, 2007. The last CMA survey of BROCI was in October 2002. As in 2002, this survey included record reviews evaluating the provision and documentation of physical and mental health care. Additionally, reviews 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 four findings 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 June 1, 2007.

“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:

Medical care provided to inmates at this institution is inconsistent with acceptable standards of care. This is evidenced by medical conditions not being identified in a timely manner, unacceptable delays in evaluation, diagnosis and treatment, and lack of appropriate follow up. There appear to be several reasons for this including: staff turnover, poor leadership, lack of a functional quality assurance system and absence of accountability for delivery of medical care and supporting administrative systems. According to the Department's draft action plan for Summer 2007, "health services at BROCI have historically been distinguished by poor quality, lack of organization, and less than optimal staff performance at all levels." These issues have been identified repeatedly since 2001. The Office of Health Services has been unsuccessful in addressing these significant problems to date.

Emergency Finding 2:

Inpatient mental health treatment for inmates in the Crisis Stabilization Unit and Corrections Mental Health Institution appears to consist primarily of medication management. Other interventions consist of group counseling and individual counseling, but these are held on an inconsistent basis resulting in inmates being in a locked down cell the majority of time. It is unclear to even an experienced observer how these "treatment" programs differ from isolation or confinement. Further, it appears that the

management of the admission and discharge of inmates to these "programs" is characterized by waiting lists and conflict between meeting the needs of close management inmates and appropriate utilization of scarce resources.

Emergency Finding 3:

There is disorganization in the medication administration process including absence of a system to reliably monitor whether inmates are receiving medications as prescribed (staff reported that they relied on memory regarding who had received or refused their medication for more than 200 inmates.) There is no reliable documentation of the use of Emergency Treatment Orders (ETO) which prevents a determination of whether ETOs are being used in accordance with statute. There were no oral cavity checks observed during medication administration.

There is no reliable system in place in the pharmacy to ensure that medication is tracked and stored in a manner consistent with good pharmacy practice. Five boxes of expired drugs were found in the pharmacy.

Emergency Finding 4:

There is evidence that clinical decisions have been inappropriately influenced by security to the extent that appropriate medical and mental health care for inmates may have been compromised. [Revised June 18, 2007]

On June 5, 2007, the CMA was provided a copy of the department's corrective action plan (CAP) addressing the emergency findings (EF), titled, "CMA Matrix" (Attachment 1). Once the department is in receipt of this full survey report, the CMA looks forward to receiving an even more specific and detailed CAP.

Many of the findings contained in this report are "stand alone" findings and are not necessarily major contributing factors in the emergency notification. Other findings, however, are directly related. Some findings in both categories were also noted in some form in the survey conducted in 2002. These recurring issues are identified as such. In the case of findings directly related to the emergency notification sent to the Secretary, these are identified following the text of the finding as [EF-1, EF-2, EF-3, or EF-4.] In a column next to all findings is a list of "suggested corrective action(s)". It is the CMA's expectation that, in addition to considering these suggestions, the department also include the specifics of the framework of corrections described in its submitted matrix. Once the department's final CAP is received and reviewed by the CMA, the department will have at least 90 days to implement corrections before the institution is re-visited for a status evaluation. At that time, a full survey will be performed during which progress on all findings will be assessed. In addition, at a point prior to the follow up survey, all mortalities that have occurred at BROCI since 2002 will be reviewed through the CMA Quality Management (QM) Committee.

Department Findings

In addition to the emergency and routine findings referenced above, other areas of concern were noted. These findings may be based on standards adopted by the CMA, and not addressed in OHS policy, procedure or directive. They may be based on issues beyond institutional control, requiring intervention at a higher level. The OHS should submit a separate corrective action plan for these findings. These findings are clearly identified as "Department Findings" and appear following the body of the Mental Health section of this report. Department findings from all institutional surveys, including those from the BROCI survey will be routinely reviewed by the CMA QM Committee and reported in the CMA Annual Report.

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 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. 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

SYSTEMS

ADMINISTRATIVE PROCESSES

Finding(s)	Suggested Corrective Action(s)
<p>PH-1: Deficiencies noted during a review of general administrative policies/procedures/practices include:</p> <p>(a) Institutional statistics not gathered, including at a minimum, the use of health care services, outside consultations, prescriptions written, etc. [EF-1]</p> <p>(b) No supervisory signature on Review and Performance Planning documents in employee files</p> <p>(c) Staff unable to locate policy manuals</p> <p>(d) No evidence that job descriptions exist for inmate assistants, or that the assistants are appropriately trained</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues identified are examined on a regular basis.</p> <p>Conduct weekly monitoring of applicable identified issues, ensuring the development, then the adequacy and accuracy of required documentation. 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 a CMA corrective action plan assessment</p>

Discussion: PH-1 (d): The training should be documented on the DC4-526 (Inmate Assistant Skills Checklist). During the survey, two job descriptions were provided for review, but were dated the same day of the request (May 31, 2007.)

CONSULTATIONS

Finding(s)	Suggested Corrective Action(s)
<p>PH-2: Deficiencies noted during a review of the administrative aspects of the consultation process include:</p> <p>(a) Incomplete consultation log [EF-1]</p> <p>(b) No documentation responsible parties review the consultation log at least monthly</p>	<p>Provide in-service training for staff regarding the importance of properly completing log entries.</p> <p>Conduct weekly monitoring of the consultation log to ensure adequacy and accuracy. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring efforts until closure is affirmed through a CMA corrective action plan assessment.</p>

EPISODIC CARE

Finding(s)	Suggested Corrective Action(s)
<p>PH-3: Deficiencies noted during a review of the administrative aspects of episodic care processes include:</p> <p>(a) Incomplete sick call and infirmary logs (also noted in 2002 review) [EF-1] (b) No supervisory review of weekly emergency or sick call encounters (also noted in 2002 review) (c) No clear differentiation on infirmary log of infirmary admissions versus placement in observation status (23 hours or less) (d) No posted schedule of on-call physicians, including their beeper or pager numbers, and no contact numbers for the designated back-up physician or Director of Regional Health Care</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Ensure the posting of the schedule of on-call physicians, including their beeper or pager numbers, and the posting of contact numbers for the designated back-up physician or Director of Regional Health Care.</p> <p>Conduct weekly supervisory monitoring of sick call and emergency care encounters and at least weekly monitoring of logs to ensure adequacy and accuracy. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring efforts until closure is affirmed through a CMA corrective action plan assessment.</p>

MEDICATION ADMINISTRATION

Finding(s)	Suggested Corrective Action(s)
<p>PH-4: Deficiencies noted during a review of the medication administrative process include:</p> <p>(a) No system in place to monitor which inmates did not receive prescribed medications [EF-3] (b) Medication administration records (MAR) not consistently completed at the time the medication was administered [EF-3] (c) No documentation available the nurse administering the pill line was trained in the process (d) Oral cavity checks not consistently conducted by health services staff or security during pill line</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues identified are examined on a regular basis.</p> <p>Conduct weekly monitoring of no less than ten records, if applicable, to evaluate the effectiveness of corrections. 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 a CMA corrective action plan assessment.</p>

Discussion: PH-4 (a): It was reported to surveyors during staff interviews that nurses kept track of missed medication by memory rather than by appropriately completing the MAR at the time medications were administered. Relying on memory for a population often exceeding over 200 inmates increases the likelihood of error.

Prior to and during the pill line (between patients as needed) observations of the pill line indicated hand washing was not practiced by staff at intervals commensurate with good hygiene habits.

OBIS/HEALTH RECORD	
Finding(s)	Suggested Corrective Action(s)
<p>PH-5: A weekly review is not conducted of past due appointments (Offender Based Information System [OBIS] screen HSS-15). (also noted in 2002 review). [EF-1]</p>	<p>Provide applicable in-service training for staff regarding the importance of, and the procedural steps required for running the HSS-15 review on a weekly basis.</p> <p>Conduct weekly monitoring to ensure accurate statistical review is conducted.</p> <p>Continue monitoring efforts until closure is affirmed through a CMA corrective action plan assessment.</p>

PHARMACY SERVICES	
Finding(s)	Suggested Corrective Action(s)
<p>PH-6: Deficiencies noted during a review of the administrative aspects of pharmacy services include:</p> <p>(a) Copies of invoices for controlled substances purchases for the past two years not on file [EF-3]</p> <p>(b) Procedures inadequate for ensuring timely delivery and receipt of medications ordered from the cluster pharmacy [EF-3]</p> <p>(c) No log book documenting expired, misbranded or damaged products [EF-3]</p> <p>(d) No stock level inventory order sheet in each pharmaceutical storage area [EF-3]</p> <p>(e) Quarterly Pharmacy and Therapeutics Committee (P&T) meeting minutes not available for the previous twelve months</p> <p>(f) No documentation that when unusable medication returned to</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Provide evidence in the closure file of the development and completion of required documentation for findings (a), (c), (d), (e), (f) and (g).</p> <p>Conduct weekly monitoring of pharmacy issues to ensure the development, then the adequacy and accuracy of required documentation. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring efforts until closure is affirmed through a CMA corrective action plan assessment.</p>

PHARMACY SERVICES

Finding(s)	Suggested Corrective Action(s)
supplier or destroyed, process is witnessed by the Health Services Administrator or pharmacy staff (g) No documentation the consulting pharmacist provides annual in-service training for medical staff	

Discussion: PH-6 (b): Inmates reported they were often told by the nurse at the pill line their medication was not available and to return the next day.

PH-6 (c): Surveyors discovered five boxes of expired medications stored in the pharmacy; reported to be awaiting return/disposal.

QUALITY MANAGEMENT

Finding(s)	Suggested Corrective Action(s)
PH-7: Deficiencies noted during a review of the Quality Management (QM) program include: (a) No evidence the DC4-511C (Institutional Indicator Trending Report) and DC4-511E (Clinical Quality Management Indicator Report) are completed and submitted to Central Office on a monthly basis [EF-1] (b) Minutes of QM Committee not available for review (c) Committee member attendance for QM meetings unavailable (d) No documentation each health care provider had annual clinical review	Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column. Create one monitoring instrument on which all issues are examined on a no less than monthly basis. Continue monitoring until closure is affirmed through a CMA corrective action plan assessment.

DENTAL SYSTEMS

Finding(s)	Suggested Corrective Action(s)
PH-8: American Heart Association (AHA) prophylactic regimens posted in the dental unit are not up-to-date.	Ensure posting of appropriate and up-to-date prophylactic regimens. Provide evidence in the closure file issue resolved.

Discussion: PH-8: The 2000 guidelines are posted without the March, 2007 update from the AHA.

FOOD SERVICE

Finding(s)	Suggested Corrective Action(s)
<p>PH-9: A tour of the food service area resulted in the identification of the following sanitation issues posing potential infection control risks:</p> <p>(a) Storage shelves/and or platforms not a minimum of six inches from the floor to allow for adequate cleaning (b) No hot water in hand washing sinks in the kitchen and both dining halls (c) Proper sanitation measures not applied during dishwashing (d) Inadequate equipment for preparing and transporting meals</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Findings column.</p> <p>Provide evidence in the closure file that the issues described in items (a) - (d) have been corrected. This may be in the form of copies of work orders, acquired training materials, etc.</p>

Discussion: PH-9 (c): Dishwashers at both dining halls have broken temperature and water pressure sensors.

PH-9 (d): The kitchen is operating with only one tilt skillet and cook top. A portable cooler to ensure the food is kept at the proper temperature is not utilized.

NOTE: The food service manager indicated that requests for new equipment/ repairs have been submitted.

INFECTION CONTROL

Finding(s)	Suggested Corrective Action(s)
<p>PH-10: No evidence was available that the infection control coordinator receives and reviews the monthly inspection reports related to overall facility sanitation, or weekly inspection reports related to sanitation and cleanliness (including preparation and dining areas) for the dining facility.</p>	<p>Include documentation that the infection control coordinator is reviewing the reports related to facility sanitation on a monthly basis and dining areas on a weekly basis.</p> <p>Continue monitoring until closure is affirmed through a CMA corrective action plan assessment.</p>

MEDICAL AREA and INMATE HOUSING

Finding(s)	Suggested Corrective Action(s)
<p>PH-11: The following deficiencies were noted during tours of the medical area and inmate housing units:</p> <p>(a) Infirmary lacked a two-way communication device for inmates in the bathroom to signal the nurse (also noted in 2002 review) (b) No hot water available for showering and hand washing in</p>	<p>Provide evidence in the closure file that the issues described in items (a) - (d) have been corrected. This may be in the form of copies of work orders, acquired training materials, etc.</p>

**MEDICAL AREA and INMATE
HOUSING**

Finding(s)	Suggested Corrective Action(s)
<p>confinement and "P" dorm (c) Posted written procedures to access medical/dental sick call and mental health services available only in English (d) Pill line schedules not posted in inmate common areas</p>	

CLINICAL

COMPREHENSIVE CHART REVIEWS

Finding(s)	Suggested Corrective Action(s)
<p>PH-12: Comprehensive clinical reviews of ten randomly selected medical records revealed the following deficiencies:</p> <p>(a) Cursory and incomplete physician conducted physical exams and assessments [EF-1] (b) Record reviews suggest poor continuity of care [EF-1] (c) Medical records generally disorganized, often with missing or misfiled documents [EF-1] (d) Significant numbers of inmate-generated medical complaints [EF-1] (e) Illegible, difficult to read handwriting</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues identified are examined on a regular basis.</p> <p>Conduct weekly monitoring of no less than ten records, if applicable, to evaluate the effectiveness of corrections. 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 a CMA corrective action plan assessment.</p>

Discussion: PH-12 (a): Cursory and incomplete physical exams and assessments - e.g., a chronic illness clinic note on May 29, 2007 indicated an abdominal mass noted on exam, but nothing was noted in the assessments.

PH-12 (b): Poor continuity of care - During reviews, multiple examples were found of medical concerns not followed up in a timely manner or not addressed at all. Examples are illustrated below.

PH-12 (c): Chart disorganization - In several instances, the condition for which the inmate was diagnosed was not identified on the medical record problem list. Also, in some records, documents were filed in the wrong section and/or contained notes and reports of other inmates. Physicians interviewed expressed concern regarding a lack of organization in the medical records department. These physicians indicated records are not organized appropriately, referrals are not made in a timely manner (if at all),

consultation reports are filed inappropriately, and appointments are not scheduled as needed.

PH-12 (d): More inmate complaints than average - It often takes two to six weeks to address an inmate medical complaint; e.g., complaint made in November 2006 not answered until December 28, 2006 and complaint made on October 17, 2006 not answered until December 5, 2006.

PH-12 (e): Poor handwriting - During reviews, surveyors had difficulty interpreting notes due to poor handwriting (primarily physician notes). Because of this, it was difficult to clearly follow the course of care in many charts.

Case reviews: The case reviews described below are taken from surveyor notes and represent findings at the time of the survey. This information was provided to institutional, regional and central office staff on-site during the course of the survey. Subsequently, in response to these findings and the issuance of the Emergency Notification to the Secretary, these cases were re-examined by department staff and a response was provided to the CMA regarding some of the cases. In the below examples, when review comments were provided to the CMA, the department's response is summarized and noted.

- A routine mammogram was conducted in April 2006 on a 43 year old inmate. A cranio-caudal (CC) view was suggested, but not done until December 2006, eight months later. The CC view was normal, but the inmate complained in December of a green discharge from the right breast. The radiologist suggested lactography because of the discharge, but this had not been completed at the time of the survey. A culture of the discharge showed normal flora (November 2006), which suggests infection is not the cause of the discharge. The chart indicates the inmate's mother had breast cancer, but the mother's age is not noted. This is not reported in any other places in the chart where family history is documented. A mammogram was repeated in May 2007 with a finding of a 1.8 centimeter density in the right breast. At the time of the survey, the physician was waiting for the radiologist to re-read the mammogram and use old films for comparison studies. In addition to the breast mass issue, this inmate also had a gastrointestinal (GI) consult for hepatitis C in 2006. Liver biopsy was suggested, but had not been done at the time of the survey. **NOTE:** Following department review, a comparison study of mammograms from 2006 and 2007 was ordered by Radiologist that same day. Regarding Hepatitis C status, the Chief Health Officer ordered follow-up lab tests to determine present values. No information was provided about the suggested liver biopsy.
- A PAP smear conducted on a 42 year old HIV positive inmate in August 2006 was reported as abnormal. Community standard indicates a colposcopy is indicated. For multiple reasons over the year, the colposcopy was not done (menses, vaginitis, etc.) The most recent appointment scheduled for the colposcopy per documentation in the record was May 21, 2007. There was no documentation the colposcopy had been performed at the time of the survey. Despite a repeat PAP done May 3, 2007 which did not show dysplasia, a colposcopy is still indicated because of the previous abnormal PAP. Discussion with a treating physician during the survey indicated a PAP had been done in February 2007. This is not reflected in the chart. Also of note is that during the PAP on May 3, 2007, the inmate was diagnosed with trichomonas infection. This

was not treated in the physician's clinic when the patient was seen for the PAP follow-up. **NOTE:** Treatment for trichomonas was started on June 1, 2007. The department's review indicates a colposcopy is not indicated since the inmate showed no dysplasia at the May 3, 2007 PAP.

- During a chronic illness clinic visit for hypertension, the physician noted that the inmate's blood pressure was not controlled. He documented in the treatment plan to increase the inmate's Vasotec medication to three times daily. However, the physician's order continued to reflect twice daily treatment. Also, an abdominal ultrasound was ordered on the chronic illness plan for this inmate, but the order is not noted elsewhere. The physician's physical exam stated possible "right lower quadrant mass." The physician did not note that the hematocrit on this inmate had fallen from 36.6% in September 2006 to 33.3% in May 2007 (possibly indicating anemia). **NOTE:** The correct prescription information was documented on the physician order sheet, but was erroneous in the progress note (Vasotec cannot be prescribed three times daily -- Clonidine prescription appropriately adjusted instead). A sonogram was re-ordered and the necessary form completed. It was also reported that although anemia was not uncommon in a menstruating 44 year old, the hematocrit lab test was re-ordered.
- This inmate was seen by a licensed practical nurse (LPN) for urinary difficulty, and then referred to a physician. She was seen on September 22, 2006 in the physician's clinic. A urinalysis (UA) was ordered at that time, but was not accomplished until October 6, 2006. The lab result was reviewed on October 11, 2006. There was a note on the lab report to repeat the UA with a clean catch specimen, but this was never done. Additionally, because this inmate suffers from hepatitis C, vaccines for types A & B were also ordered. The hepatitis B vaccine series was completed, but the second hepatitis A vaccine had not been given at the time of the survey. The second dose was due September, 2006. **NOTE:** Following the survey, this inmate was re-evaluated for urinary problems; no complaints were noted and no further treatment was indicated. The inmate was provided a final Hepatitis A vaccine.
- A mammogram was ordered for a 43 year old inmate in February 2007. The mammogram was scheduled in March 2007 but had not been completed at the time of the survey. A PAP was done on February 22, 2007 but results of a pelvic exam were not documented. A 30-day supply of medications for asthma and hypothyroidism were ordered for this inmate in February 2007 when she arrived at the institution. She wrote a complaint on April 18, 2007 that she needed medications, but the prescriptions were not refilled until May 3, 2007. At the time of the survey, she had not yet been seen in a chronic illness clinic. **NOTE:** A mammogram has been re-ordered and documentation will be addressed with the gynecologist.
- On March 20, 2007, an inmate complaining of vaginal discharge was seen in sick call by an LPN. At that time, the inmate was scheduled to see an advanced level practitioner for a gynecology appointment on March 23, 2007. She reported as instructed to the appointment, but was turned away because her annual physical exam was not due until November, 2008. She still complained of the vaginal discharge when seen by a physician on May 18, 2007 for another reason. The inmate was prescribed Diflucan at that time without an exam. **NOTE:** Information provided by the department did not address the issue of the inmate

being turned away from the scheduled appointment. Regarding the prescription of Diflucan for vaginal discharge, the department indicated it is not uncommon for a physician to order treatment with an antifungal medication empirically, especially in a diabetic female.

- On May 28, 2007, an inmate housed in the Transitional Care Unit (TCU) was examined by a registered nurse (RN) following an incident during which she banged her head against a wall during “time out”. Medical record notes indicate the inmate had a large hematoma with swelling and abrasion on her forehead. The RN also noted, “denies nausea, vomiting and pupils equal and reactive to light.” Another nurse noted on May 29, 2007 that the inmate had a reddened and swollen forehead. In addition to the nursing notes, a psychiatrist noted “very large ecchymosis, forehead and eyes.” The inmate was seen in clinic on May 29, 2007 for a pelvic exam; no reference was made at that time to the head injury. A review of the inmate’s vital signs revealed her blood pressure had increased over her usual readings, but this was not addressed (previously 103/74, on May 29, 2007 was 135/97). On May 30, 2007, another mental health staff noted swelling and bruising of forehead and around eyes. The survey team was concerned that documentation does not indicate whether the inmate was evaluated for a concussion. There is no indication in the chart that she was evaluated for deteriorating neurological status due to possible bleeding into the brain from her head injury. A survey team member who interviewed this inmate reported the inmate complained of blurry vision since the head injury. **NOTE:** The department’s review of this case indicated the inmate was in the IMR* and therefore under 24-hour monitoring by nursing staff who would have ordered a re-evaluation had there been any change in status. The review also indicated the increased blood pressure reading was expected since she was undergoing a pelvic examination that day which is a “stressful procedure”.

* **CMA Note:** The inmate was housed in the TCU, not an IMR.

CONSULTATIONS	
Finding(s)	Suggested Corrective Action(s)
<p>PH-13: Clinical reviews of eight records containing consultation encounters revealed the following deficiencies:</p> <p>(a) Three records lacked progress notes from an advanced level health care provider documenting consultant’s findings [EF-1]</p> <p>(b) Two records lacked evidence of ongoing treatment plan [EF-1]</p> <p>(c) Two records lacked progress notes outlining medical problem and/or other issues related to consultation</p> <p>(d) Three records lacked fully completed consultation forms</p> <p>(e) Two records lacked evidence inmate was informed of results of consultation</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues identified in the Findings column are examined on a regular basis.</p> <p>Conduct weekly monitoring of no less than 10 records to evaluate the effectiveness of the 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 a CMA corrective action plan assessment.</p>

EPISODIC CARE

Finding(s)	Suggested Corrective Action(s)
<p>PH-14: Clinical reviews of seven episodic care records revealed the following deficiencies:</p> <p>(a) Two records lacked evidence that indicated diagnostic studies were ordered and scheduled in timely manner [EF-1]</p> <p>(b) Two records indicated evaluation by physician not timely [EF-1]</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues identified in the Findings column are examined on a regular basis.</p> <p>Conduct weekly monitoring of no less than 10 records to evaluate the effectiveness of the 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 a CMA corrective action plan assessment.</p>

Discussion: PH-14: Information about the following cases was provided to department staff at the time of the survey.

- One inmate had an abnormal mammogram in March 2006. Spot compression/lateral views and ultrasound were recommended. A new physical exam was done on April 10, 2006 and a left breast mass was identified. The recommended spot compression/lateral views were not approved to be done, but an ultrasound was done on May 19, 2007. The ultrasound revealed three cysts; spot compression/lateral views were again recommended, but not done. A physical exam on June 12, 2006 indicated the mass was still there and a biopsy was recommended. On August 23, 2006 the biopsy referral was placed on hold. The referral was subsequently completed on September 13, 2006. The inmate asked to see a doctor on October 11, 2006 to obtain the biopsy results, but the request was not addressed until October 25, 2006. Pathology results indicating the mass was benign were not received until November 11, 2006, but were misfiled in the miscellaneous section of the inmate's medical record. A physical exam on March 6, 2007 indicated the mass was still present in the same location. Spot compressions/laterals were again ordered; an ultrasound is pending based on that report. This had not been achieved at the time of the survey. Evaluation by the surgeon was not timely in this case. It would be appropriate to have the inmate followed by the surgeon because she has fibrous breasts with history of prior biopsy in 2004. This would save the staff and inmate from unnecessary imaging of a benign lesion.
- On May 17, 2007, another inmate complained of a mass in the left side of her neck. An ultrasound was ordered on an "urgent" basis, but was not completed as of May 30, 2007. The order stated a pregnancy test was to be done before the ultrasound. Pregnancy test is not required with an ultrasound. This was discussed with the

provider who stated the case was not life threatening and scheduled the inmate for an ultrasound on June 6, 2007.

- An inmate with an abnormal PAP with high risk human papillomavirus (HPV) had a repeat PAP ordered in six months. Current prevailing practice standards indicate a referral for colposcopy rather than a repeat PAP as the diagnostic tool of choice.

GENERAL CHRONIC ILLNESS CLINIC ISSUES	
Finding(s)	Suggested Corrective Action(s)
<p>PH-15: General reviews of ten chronic illness clinic records revealed deficiencies in the following areas: [EF-1]</p> <p>(a) Pneumococcal vaccine or inmate refusals (b) Influenza vaccine or inmate refusals (c) Initial clinic visit physical exam and baseline diagnostic data (d) Problem lists which do not reflect the current chronic condition</p> <p>Records from the following clinics lacked the required documentation indicated above:</p> <p>Cardiovascular (a) (b) Gastrointestinal (a) (b) (c) (d) Endocrine (a) (d) Immunity (including HIV) (a) (b) (c) (d) Miscellaneous (a) Neurology (b) (c) Renal (a) Respiratory (a) (b) (c) Tuberculosis (a) (b) (c) (d)</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues are examined on a regular basis.</p> <p>Conduct weekly monitoring of no less than ten records to evaluate the effectiveness of the 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 a CMA corrective action plan assessment.</p>

GASTROINTESTINAL CLINIC	
Finding(s)	Suggested Corrective Action(s)
<p>PH-16: Clinical reviews of eleven Gastrointestinal Clinic records revealed the following deficiencies:</p> <p>(a) Two records reflected significant delays in scheduling follow-up appointments [EF-1] (b) Two records lacked evidence of complete physical exam [EF-1]</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues are examined on a regular basis.</p> <p>Conduct weekly monitoring of no less than ten records to evaluate the effectiveness of</p>

GASTROINTESTINAL CLINIC

Finding(s)	Suggested Corrective Action(s)
	<p>the 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 a CMA corrective action plan assessment.</p>

Discussion: PH-16 (a): No documentation of follow-up was present in one inmate's record diagnosed with hepatitis C in August of 2005. Another inmate seen in Gastrointestinal Clinic on July 25, 2006, with recommended follow-up in 90 days, had not been reevaluated at the time of the survey.

IMMUNITY CLINIC

Finding(s)	Suggested Corrective Action(s)
<p>PH-17: Clinical reviews of fifteen Immunity Clinic records (including HIV) revealed that thirteen records did not contain evidence that appropriate lab studies were completed on an annual basis; e.g., toxoplasmosis (IGG)). [EF-1]</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Conduct weekly monitoring of no less than ten records to evaluate the effectiveness of the 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 a CMA corrective action plan assessment.</p>

INTAKE PROCESS (RECEPTION)

Finding(s)	Suggested Corrective Action(s)
<p>PH-18: Clinical reviews of seven records selected to evaluate the intake process revealed the following deficiencies:</p> <p>(a) Three of seven records lacked documentation of a gynecological exam [EF-1]</p> <p>(b) Six of seven records lacked evidence of all required immunizations; e.g., tetanus.</p> <p>(c) Two of seven records lacked documentation of complete physical examination, including visual screening</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues are examined on a regular basis.</p> <p>Conduct weekly monitoring of no less than ten records to evaluate the effectiveness of the 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 a CMA corrective action plan assessment.</p>

NEUROLOGY CLINIC

Finding(s)	Suggested Corrective Action(s)
<p>PH-19: Clinical reviews of twelve Neurology Clinic records revealed eight records lacked evidence that upon clinic enrollment, inmates received a physical examination focusing on neurological exam and side effects from previous medications.</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Conduct weekly monitoring of no less than ten records to evaluate the effectiveness of the 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 a CMA corrective action plan assessment.</p>

Discussion: PH-19: One record reviewed indicated the inmate's Dilantin level was above the accepted range. The medication was held for two days, then restarted without any subsequent lab studies conducted.

PREVENTATIVE CARE

Finding(s)	Suggested Corrective Action(s)
<p>PH-20: Clinical reviews of five records selected to evaluate the provision of Preventative Care activities revealed the following deficiencies:</p> <p>(a) Three of five records contained evidence gynecological exams conducted instead of required complete physical exams [EF-1]</p> <p>(b) Four of five records lacked evidence the most recent physical exam was performed within one month of annual review date</p> <p>(c) Three of five records lacked documentation a PPD test was administered and read every year (or if past positive, lacked documentation of annual screening for symptoms)</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues are examined on a regular basis.</p> <p>Conduct weekly monitoring of no less than ten records to evaluate the effectiveness of the 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 a CMA corrective action plan assessment.</p>

TUBERCULOSIS CLINIC

Finding(s)	Suggested Corrective Action(s)
<p>PH-21: Clinical reviews of eleven Tuberculosis Clinic records revealed the following deficiencies:</p> <p>(a) Four of eleven records lacked documentation of nursing follow-up (DC4-719) [EF-1]</p> <p>(b) Eight of eleven records lacked documentation of physical exam focusing on upper respiratory tract</p> <p>(c) Eight of eleven records lacked complete medical history</p> <p>(d) Three of eleven records lacked documentation of individual counseling regarding benefits of treatment and importance of adherence to treatment regimen</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues are examined on a regular basis.</p> <p>Conduct weekly monitoring of no less than ten records to evaluate the effectiveness of the 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 a CMA corrective action plan assessment.</p>

Discussion: PH-21 (a):

- One inmate found to have a positive Tuberculin Skin Test (PPD) in August 2006 was not seen again in the Tuberculosis Clinic until April 2007.
- In another case, an inmate with documentation of a positive PPD in 2004 was not started on treatment until February 2007.

NOTE: Neither of the cases described above had active TB.

CARDIOVASCULAR CLINIC	
Finding(s)	Suggested Corrective Action(s)
PH-22: Clinical reviews of ten Cardiovascular Clinic records revealed that three records lacked evidence low dose aspirin therapy was prescribed or considered for patients over age 40.	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Conduct weekly monitoring of no less than ten records to evaluate the effectiveness of the 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 a CMA corrective action plan assessment.</p>

DENTAL	
Finding(s)	Suggested Corrective Action(s)
PH-23: Clinical reviews of twenty dental records revealed the following deficiencies: (a) Six records lacked evidence of complete regional head and neck examination (soft tissue/oral cancer examination) at last periodic examination or at initiation of most recent treatment plan, whichever is later (b) Six records lacked adequate number of appropriately mounted and identified radiographs of diagnostic quality to aid in diagnosis (c) Nine records lacked evidence of periodontal screening and recording (PSR) (d) Four records lacked evidence of	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues are examined on a regular basis.</p> <p>Conduct weekly monitoring of no less than ten records to evaluate the effectiveness of the 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 a CMA corrective action plan assessment.</p>

DENTAL	
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Finding(s)	Suggested Corrective Action(s)
<p>complete and accurate charting of dental findings</p> <p>(e) Five records lacked evidence of post-treatment/operative instructions when applicable</p> <p>(f) Four records lacked evidence of oral hygiene instructions as part of dental treatment plan</p>	

ENDOCRINE CLINIC	
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Finding(s)	Suggested Corrective Action(s)
<p>PH-24: Clinical reviews of seven Endocrine Clinic records revealed the following deficiencies:</p> <p>(a) Four records lacked evidence of annual test for presence of microalbuminia</p> <p>(b) Four records lacked evidence low dose aspirin therapy prescribed or considered</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues are examined on a regular basis.</p> <p>Conduct weekly monitoring of no less than ten records to evaluate the effectiveness of the 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 a CMA corrective action plan assessment.</p>

INTRASYSTEM TRANSFER	
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Finding(s)	Suggested Corrective Action(s)
<p>PH-25: Clinical reviews of eight records selected to evaluate the effectiveness of intrasystem transfer activities revealed that four records lacked documentation of a DC4-760A or progress note indicating inmate vital signs were checked.</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Conduct weekly monitoring of no less than ten records to evaluate the effectiveness of the 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 a CMA corrective action plan assessment.</p>

RESPIRATORY CLINIC

Finding(s)	Suggested Corrective Action(s)
<p>PH-26: Clinical reviews of thirteen Respiratory Clinic records revealed the following deficiencies:</p> <p>(a) Four records that indicated the inmate had reactive airway disease lacked documentation categorizing the severity of the disease (mild intermittent, mild persistent, moderate persistent or severe persistent)</p> <p>(b) Two records that indicated the inmate had moderate to severe persistent airway disease lacked evidence of prescribed anti-inflammatory inhalers</p> <p>(c) Two records lacked stamped provider signatures</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues are examined on a regular basis.</p> <p>Conduct weekly monitoring of no less than ten records to evaluate the effectiveness of the 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 a CMA corrective action plan assessment.</p>

SICK CALL

Finding(s)	Suggested Corrective Action(s)
<p>PH-27: Clinical reviews of ten records in which a sick call encounter was documented revealed the following deficiencies:</p> <p>(a) Three records lacked evidence the sick call encounter was timed</p> <p>(b) Three records lacked documentation of health education pertinent to the inmate’s presenting condition; e.g., exercise, diet, importance of adherence to treatment regimen, etc.</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues are examined on a regular basis.</p> <p>Conduct weekly monitoring of no less than ten records to evaluate the effectiveness of the 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 a CMA corrective action plan assessment.</p>

Conclusion: A general lack of organization at Broward Correctional Institution has resulted in multiple instances of medical problems not being followed and resolved. A void in leadership, combined with a high staff turnover rate has resulted in serious concerns regarding the provision of care at this institution. Many of these concerns have been known to Office of Health Services for some time, and efforts continue to resolve these issues.

MENTAL HEALTH FINDINGS

OVERVIEW

Broward Correctional Institution provides the full range of mental health services including inpatient and outpatient services. The following are the mental health grades used by the department to classify inmate mental health needs:

- 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 Corrections Mental Health Institution (CMHI). Placement in CMHI requires a 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.

SYSTEMS

ADMINISTRATIVE ISSUES	
Finding(s)	Suggested Corrective Action(s)
<p>MH-1: Medical records were disorganized. Pages in the chart were out of order or missing (also noted in the 2002 review). [EF-1]</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>
<p>MH-2: The posting procedure for mental health call-outs does not protect confidentiality. The posted list includes names and the service/discipline that is the subject of the request.</p>	<p>Provide evidence in the closure file that the issue described has been corrected. This may be in the form of copies of work orders, acquired training materials, etc.</p> <p>Ensure confidentiality is ensured during efforts to correct the call out process.</p>

ADMINISTRATIVE ISSUES

Finding(s)	Suggested Corrective Action(s)
<p>MH-3: Program descriptions, including a description of the mental health unit level system, are not posted in the inpatient unit.</p>	<p>Provide evidence in the closure file that the issue described has been corrected. This may be in the form of copies of work orders, acquired training materials, etc.</p> <p>Ensure program descriptions are posted in the inpatient unit.</p>
<p>MH-4: There are an insufficient number of blankets and shrouds in the IMR.</p>	<p>Provide evidence in the closure file that the issue described has been corrected. This may be in the form of copies of work orders, acquired training materials, etc.</p> <p>Ensure an appropriate number of blankets and shrouds are available.</p>

CLINICAL

INPATIENT PSYCHOTROPIC MEDICATION PRACTICES

Finding(s)	Suggested Corrective Action(s)
<p>MH-5: A clinical review of fourteen inpatient records evaluating psychotropic medication practices revealed the following deficiencies:</p> <p>(a) Physician's orders not clearly or consistently documenting the use of emergency treatment orders (ETO) (also noted in the 2002 review) [EF-2]</p> <p>(b) Procedures for the use of ETOs not clearly understood by staff [EF-2]</p> <p>(c) ETO log not consistently completed [EF-2]</p> <p>(d) Three records lacked evidence laboratory tests were ordered prior to initial dose of medication</p> <p>(e) Three records lacked evidence medications prescribed were appropriate for the diagnosis and/or treatment</p> <p>(f) Ten records contained evidence medication ordered for bedtime was administered at 5 p.m.</p> <p>(g) Three records lacked evidence of Assessment of Involuntary Movement Scale (AIMS) testing</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>Create one monitoring instrument on which issues identified in the findings column are examined on a regular basis.</p> <p>Monitor all applicable inpatient 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>

**INPATIENT PSYCHOTROPIC
MEDICATION PRACTICES**

Finding(s)	Suggested Corrective Action(s)
(h) Four records lacked date, time, and/or signature stamps on physician orders	

Discussion: MH-5 (a), (b), and (c): Physicians in the inpatient units are writing “PRN”, “stat” or “now” orders for intramuscular (IM) psychotropic medications. It is difficult to determine from the documentation in the record if these constitute emergency treatment orders and if they are being used in accordance with s. 945.48(2), F.S. Documentation in progress notes indicating the inmate is willingly taking these medications or indicating that medication is being administered involuntarily is inconsistent or absent. Interviews with nursing staff revealed confusion among the staff regarding the ETO policy, including what is considered an ETO and under what circumstances administration of medication should be recorded on the Emergency Treatment Order log. There is no reliable tracking system allowing the appropriate assessments of inmate response to daily medication regimens, combined with administration of psychotropic medication on a PRN, stat, now, or ETO basis.

**INPATIENT MENTAL HEALTH
SERVICES**

Finding(s)	Suggested Corrective Action(s)
<p>MH-6: A comprehensive clinical review of fourteen inpatient mental health records revealed the following deficiencies:</p> <p>(a) Seven records lacked sufficient documentation that required planned treatments, including groups, are provided [EF-2] [EF-4]</p> <p>(b) Four records lacked adequate documentation of risk assessments for violence (also noted in the 2002 review). [EF-2]</p> <p>(c) Nine records lacked documentation of weekly inmate weights by nursing staff</p> <p>(d) Nine records lacked adequate individualized nursing SOAP notes (also noted in the 2002 review)</p> <p>(e) Seven records lacked date, time, and/or signature stamps on progress notes</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>Develop a process to ensure no less than three times weekly monitoring of inpatient treatment units to ensure required group therapy sessions are conducted.</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 (a): Staff interviews, record reviews, and reviews of administrative meeting minutes suggest that boundaries between security and health care staff regarding medical/mental health care may be diffuse and unclear. Several examples support this finding:

- On an agenda provided to the survey team of a February 28, 2007 inpatient staff meeting, two security concerns were scheduled for discussion, (1), “Big time problem with officers possibly interfering with inmate treatment goals and manipulating treatment issues”, and (2), “certain specific officers interfere in treatment issues well beyond security needs.”
- While touring the isolation management room (IMR) on May 29, 2007, at approximately 12:30 p.m., CMA staff were informed by one of the officers on duty that an inmate was confined due to having shingles and that she was scheduled for release later that day. Upon review of the health record it was determined the inmate had been isolated in the IMR for this condition since May 21, 2007. The physician’s order read “transfer to IMR due to security request”. The physician noted in the assessment, “will transfer to IMR only due to securities [sic] unrealistic fear of contracting shingles from this inmate (in order to avoid conflict).....” This followed an encounter with a medical doctor on May 15, 2007 in which documentation noted, “not contagious/no isolation needed, cover rash”.
- A November 15, 2006 note by a Behavioral Health Specialist (BHS) indicated an inmate had been told, “.....the treatment team would recommend that pt [sic] be taken off suicide observation status (SOS). However she was further informed that this recommendation would have to be approved by the warden and Colonel... Pt [sic] also informed that team would also recommend that pt. [sic] be taken off 2 pt [sic] restraints w/ [sic] warden’s approval....” A subsequent note by the Sr. Psychologist indicated the warden did not approve the inmate’s release. Later that day the BHS documented “The undersigned was informed by Sgt.... that per Captain ...’s order, pt [sic] is not allowed out for group therapy on this date....” On November 17, 2006, a psychiatrist note indicated the warden gave approval for the inmate to attend groups. In this case, mental health staff was not guiding the mental health decisions regarding this inmate’s care.
- Finally, according to information provided by staff and confirmed through record reviews, security may be making decisions regarding who attends groups and activities without collaborating with mental health. Inmates in the CSU and CMHI are not being brought out of their cells for the required 12 hours of planned treatment activities, including groups, per week. Staff also reported that security determines who will attend group activities in the TCU. Documentation of group activities in TCU records indicated many groups were cancelled or the inmate was excused.

Discussion: MH-6 (d): SOAP notes were not individualized. Several notes quoted the same subjective comment such as “I’m okay” day after day. Notes lacked a clear description of the treatment being provided and lacked an evaluation of the inmate’s mental status sufficient to assess if symptoms improved or worsened over time.

PSYCHIATRIC RESTRAINTS

Finding(s)	Suggested Corrective Action(s)
<p>MH-7: In the only record available for review, an episode during which wrist restraints were applied to control an inmate's movement was inadequately documented (also noted in the 2002 review). [EF-2]</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 all episodes of restraints monthly for compliance. Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

Discussion: MH-7: The inmate was placed in wrist restraints, however, there was no rationale for the use of restraints documented in the record. There was no evidence that circulation checks were performed and no documentation of 15 minute observation checks. The nurses on the unit were unclear regarding the procedure to be followed for wrist restraints.

OUTPATIENT MENTAL HEALTH SERVICES

Finding(s)	Suggested Corrective Action(s)
<p>MH-8: A comprehensive clinical review of fourteen outpatient mental health records revealed the following deficiencies:</p> <p>(a) Seven records lacked evidence that newly arriving inmates were oriented to mental health services, or if oriented, the process was completed within twenty-four hours</p> <p>(b) Four records inadequately documented timely service planning interviews for newly arriving inmates</p> <p>(c) Eight records inadequately documented Bio-Psychosocial Assessments (BPSAs) or updates in a timely manner</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>Create one monitoring instrument on which issues identified in the findings column are examined on a regular basis.</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>

OUTPATIENT MENTAL HEALTH SERVICES	
Finding(s)	Suggested Corrective Action(s)
<p>(d) Eight records inadequately documented completion of Individualized Service Plans (ISP's) within fourteen days (untimely, problems not listed, and/or missing signatures) (also noted in the 2002 review).</p> <p>(e) Four records lacked evidence that mental health problems were identified on the problem list and/or problems listed were inconsistent with issues being addressed in treatment</p>	

SELF HARM OBSERVATION STATUS	
Finding(s)	Suggested Corrective Action(s)
<p>MH-9: A comprehensive review of three records of inmates housed in self harm observation status (SHOS) revealed the following deficiencies:</p> <p>(a) All records lacked a copy of Form DC-642G, Mental Health Emergency Evaluation</p> <p>(b) All records lacked evidence of physician orders specifying every fifteen minute observations, or if the orders were present, the observations were not consistently documented by nursing staff (also noted in the 2002 review).</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>

CONCLUSION:

There was a great deal of disorganization at Broward CI. This was apparent first when the pre-survey questionnaire was not completed and provided to CMA staff on time. Upon arrival at the institution, the records needed for the mental health portion of the survey were unavailable for over an hour and surveyors had difficulty obtaining records throughout the survey. Problems were encountered by the surveyor assigned to conduct formal staff interviews. The surveyor assigned to interview officers had difficulty getting officers to meet with her although an appointment was scheduled in advance for officers to come to the visiting park at 1:00 p.m., no officers reported at the scheduled time and no explanation was offered regarding their absence.

During our visit there were no activities observed on any of the inpatient units. The CSU housed several close management inmates, who according to staff and group activity documentation, are rarely allowed out of their cells. Available documentation also indicates that inmates in the CSU and CMHI are locked in their cells the majority of the time.

Inpatient staff were unable to articulate to the survey team many of the policies and procedures of the institution, including restraints and emergency treatment orders. Outdated observation forms for SHOS are being used in the CSU/TCU.

DEPARTMENT FINDINGS

In addition to the physical and mental health findings referenced previously in this report, there are several other areas of concern. These findings are beyond the scope of the institution to correct as they 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

Finding(s)
Dept-1: There was no evidence of a policy addressing elective medical or surgical procedures and how the inmate may pursue elective medical or surgical procedures the department declines to provide.
Dept-2: There was no evidence of a policy prohibiting the medical staff from participating in gathering forensic information and participating in body cavity searches for forensic purposes.
Dept-3: Inmates in special housing (administrative confinement, disciplinary confinement, protective management) did not receive one hour of exercise per day, outside the cell five days per week. They are offered three hours per week.

MENTAL HEALTH

Finding(s)
Dept-4: Staff reported long delays in obtaining court orders for involuntary medication for inmates committed to CMHI. Medication orders are in effect for 90 days. When these lapse, there are delays getting the orders renewed. This results in inmates not receiving the needed treatment in a timely manner or an interruption in the treatment being provided.
Dept-5: There is no direct access to the nursing station or the TCU unit from the security control room. If an altercation or health emergency were to occur on the unit, security staff must exit through one locked interior door and two locked exterior doors to enter the unit and another locked interior door to enter the nursing area.

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.

CMA Matrix

Responsible Party: Maureen C. Olson, Deputy Director of Health Services, Administration

What the Department has already done to address the issues	What the Department is currently doing to address the issue	What the Department will be doing to address the issues moving forward
<p>Emergency Finding 1:</p> <p>Medical care provided to inmates at this institution is inconsistent with acceptable standards of care. This is evidenced by medical conditions not being identified in a timely manner, unacceptable delays in evaluation, diagnosis and treatment, and lack of appropriate follow up. There appear to be several reasons for this including: staff turnover, poor leadership, lack of a functional quality assurance system and absence of accountability for delivery of medical care and supporting administrative systems. According to the Department's draft action plan for Summer 2007, "health services at Broward have historically been distinguished by poor quality, lack of organization, and less than optimal staff performance at all levels." These issues have been identified repeatedly since 2001. The Office of Health Services has been unsuccessful in addressing these significant problems to date.</p>		
<p>March 3, 2007 – Region IV Regional Health Services Manager, Regional Nurse Consultant, Regional Mental Health Consultant, and the Regional Offender Based Information System (OBIS) Coordinator identified scheduling backlogs, issues with proper follow-up and consult processes flow. They immediately handled emergent issues and developed and implemented an extensive process improvement plan with a target date of 5/1/07. Specific interventions included in that plan:</p> <ul style="list-style-type: none"> ▪ Revised consultation process including re-orientation of consultation coordinator to facilitate more timely appointment follow ups and specialty referrals. ▪ Began aggressive mentoring program with the Broward Correctional Institution (BCI) health services leadership team with the goal of developing, educating and 	<ul style="list-style-type: none"> ▪ Reorganizing Medical Records Department to include a complete inventory of all medical records; instituting a new inmate medical record check in/check out system to provide for better inmate record tracking and accountability; and establishing a physician record review process and provided adequate work space within medical records for this review process (Target date June 15, 2007). ▪ Developed nursing staffing plan to include three sub-teams (A, B, &C) with responsible registered nurse (RN) team leadership on each team. Currently completing written nursing team assignments and tasks for each of the three (3) teams (Target date June 29, 2007). ▪ Actively working to fill the remaining vacant nurse position. 	<ul style="list-style-type: none"> ▪ Hire and train SRNS (RNC acting until accomplished) ▪ Re-organization of the data entry, scheduling, and consultation coordination process to better support each medical team (Target date June 15, 2007) ▪ Acquire current patient education materials in English, Spanish and Creole including both print and video media to be made available to all inmates (July 6, 2007) ▪ Reorganize medical staff into two teams, each consisting of a physician, nurse practitioner, clerical support and nurse, to ensure there is no delay in evaluation, diagnosis, treatment and appropriate follow up (Target date July 29, 2007)

<p>supporting current staff.</p> <ul style="list-style-type: none"> ▪ Implemented weekly BCI health services management/regional leadership development meetings where issues were discussed, recommendations made, and actions taken. ▪ Conducted staff training on State-wide Departmental best practices regarding policies and procedures implementation, sick-call flow, records maintenance, etc., to nursing, medical records, and mental health staff. ▪ March 8, 2007 – Terminated BCI Chief Health Officer (CHO). Continued to provide medical care by using temporary locum tenens and other contracted providers. ▪ April 16, 2007 - Hired permanent BCI CHO possessing clinical, forensic, and leadership skills. This addressed the issues of appropriate diagnosis, treatment, and follow-up by eliminating the practice of hiring temporary medical providers. Formed a permanent medical staff that functions under Chief Health Officer's (CHO) leadership providing adequate continuity of care. ▪ April 18, 2007 - FLDOC health services regional leadership team recognized that the process improvement plan they developed on March 3, 2007 was not progressing as planned and with assistance from Central Office Health Services staff, 	<ul style="list-style-type: none"> ▪ Develop more robust orientation and leadership training for all health services staff (Target date July 20, 2007). 	<ul style="list-style-type: none"> ▪ Set up rotational assignments to promote cross training and broad knowledge base (both ARNP, RN, and LPN) (Target date July 29, 2007) ▪ Complete cross training of all nurses to competently perform all team tasks and assignments. This action will address the issue of accountability for delivery of medical care and will stabilize administrative processes and systems (Target date August 1, 2007) ▪ Fill the two vacant clerk/data entry positions (one for each team) ▪ Assign patients to teams with physician attention primarily focused on complex cases and nurse practitioner assigned to less complex, more routine clinical cases (Target date August 1, 2007) ▪ Orient medical records staff to new medical team organization and related responsibilities (Target date August 1, 2007) ▪ Update medical exam rooms with appropriate medical equipment, supplies and forms to provide necessary clinical services (Target date August 1, 2007) ▪ Reorganize outdated physical plant to better utilize current space and ensure timely identification, evaluation, diagnosis, treatment and follow up of clinical conditions (ongoing)
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<p>implemented revised, more aggressive plan.</p> <ul style="list-style-type: none"> ▪ April 30, 2007 - Replaced Senior Health Services Administrator (SHSA) and temporarily placed experienced Department of Corrections Senior Health Services Administrator from Hillsborough Correctional Institution in that position to provide on site stabilizing leadership until a new SHSA could be hired. ▪ April 30, 2007 - Infused BCI with subject matter experts from other regions to assist with reorganization in the areas of medical records, consultation, medicine, and nursing. Attempted to strengthen nursing administration by providing three weeks of full-time supervision/mentoring by an experienced SRNS from Region III. ▪ May 1 and May 11, 2007 – hired remaining two ARNP positions and oriented them to their roles, policies and procedures, and technical instructions with start dates of May 14 and May 16 respectfully. The hiring of these two permanent clinical staff addresses the issues of accountability for delivery of medical care, lack of adequate administrative/clinical processes, and staff turnover. ▪ May 3, 2007 – Hired 2nd physician with a start date of May 9, 2007. The hiring of this permanent full-time physician addresses 		<ul style="list-style-type: none"> ▪ Obtain and install necessary PCs in order to establish widespread employee access to databases, OBIS, and communication channels (ongoing) ▪ Assist nurses in accessing on-line continuing education units (CEU) courses and develop incentive system for completion of on-line education which will help in addressing staff turnover (ongoing)
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<p>the issues identified with accountability of delivery of medical care, delays in evaluation, and staff turnover.</p> <ul style="list-style-type: none"> ▪ May 18, 2007 - Terminated BCI Nursing Supervisor; Region IV regional nurse consultant (RNC) now acting until a new nursing supervisor can be hired. ▪ May 21, 2007 – Moved health services regional team offices from South Florida Reception Center to Broward CI to provide temporary focused on-site monitoring, intervention, and staff education. ▪ May 21, 2007 - Filled remaining two ARNP positions and oriented them to their roles, policies and procedures, and technical instructions. These permanent clinical staff addresses the issues of accountability for delivery of medical care. ▪ May 21, 2007 - Assigned health services regional team to Broward CI on interim basis to provide focused on-site monitoring, intervention, and staff education. ▪ May 29, 2007 - Hired an experienced SHSA who is also a physician assistant (PA) with a start date of June 4, 2007. ▪ June 1, 2007 - The Department's Director of Health Services and Deputy Director of Health Services traveled to BCI where the Director and BCI CHO completed a 		
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comprehensive review of CMA cited cases for clinical appropriateness and necessary follow-up actions.		
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Emergency Finding 2:

Inpatient mental health treatment for inmates in the Crisis Stabilization Unit and Corrections Mental Health Institution appears to consist primarily of medication management. Other interventions consist of group counseling and individual counseling, but these are held on an inconsistent basis resulting in inmates being in a locked down cell the majority of time. It is unclear to even an experienced observer how these "treatment" programs differ from isolation or confinement. Further, it appears that the management of the admission and discharge of inmates to these "programs" is characterized by waiting lists and conflict between meeting the needs of close management inmates and appropriate utilization of scarce resources.

<p>October, 2006 – Central Office Mental Health staff identified issues with inpatient mental health services and immediately addressed them with our contractor Mental Health Management Services, Inc. (MHM) with the following actions directed at improving the provision of mental health services taken:</p> <ul style="list-style-type: none"> ▪ October 24, 2006 - MHM brought in a consultant (John S. Wilson, Ph.D.) to develop a specific behavioral intervention program for an inmate (J11525) who frequently required the use of psychiatric restraints. Implementation of this program has resulted in a decreased utilization of restraints with this inmate. ▪ November, 29, 2006 – MHM Terminated Senior Psychologist at the request of the Department due to poor leadership and performance. ▪ January 31, 2007, MHM transferred Senior Psychologist from South Florida Reception Center to BCI to be the unit director for inpatient mental health 	<ul style="list-style-type: none"> ▪ Ensuring that BCI management/regional leadership meetings held on weekly basis (on going) ▪ Ensuring that Inpatient mental health staff meetings held on weekly basis (on going) ▪ Routinely review documentation, scheduled programming, and timely patient assessment of targeted population (CSU, CMHI) to ensure that out-of-cell therapeutic activity is maximized (on going) ▪ Conducting semi-weekly scheduled meetings with risk assessment team (security, classification, and healthcare staff). ▪ Improved collaboration between unit security staff and healthcare staff in order to create an integrated, multidisciplinary treatment team by implementing a morning unit briefing involving security and healthcare staff and including security staff in individualized service planning conferences (on going) ▪ To ensure that timely risk assessments 	<ul style="list-style-type: none"> ▪ February 13-15, 2007 – the Department’s Deputy Director of Health Services, Director of Mental Health, Chief of Psychiatry, and Facilities Director conducted a site visit to the inpatient unit at BCI to review the mental health spaces and identified physical plant modifications that would enhance the provision of inpatient mental health services to BCI inmates. Recommended modifications will begin with the beginning of the new Fiscal Year (FY) in July 2007. ▪ Region IV Health Services staff will monitor the CMA Emergency Notification CAP closure files biweekly until the CAP is closed (on going) ▪ Central Office of Health Services will begin monitoring referrals to the mental health inpatient units at BCI in order to identify areas where services may be improved (Target July 2, 2007)
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<p>services with a start date of April 1, 2007.</p> <ul style="list-style-type: none"> ▪ March 12, 2007, MHM hired psychiatric nursing supervisor with a start date of April 2, 2007. ▪ May 14-16, 2007 – Central Office Health Services conducted a Clinical Quality Review audit at BCI. While the hours of planned therapeutic activities exceeded requirements in the Transitional Care Unit (TCU) the team noted the hours of planned activities for the Crisis Stabilization Unit (CSU) and Correctional Mental Health Institute (CMHI) units were far less than the required 12 hours per week. Subsequent to these findings, the MHM Senior Psychologist initiated efforts to increase the provision of planned activities. ▪ Developed a therapeutic activities schedule for inpatient units to provide for 12 or more hours of out-of-cell therapeutic activity (on going) ▪ Made copy of the completed risk assessments log available to all appropriate healthcare and security staff (on going) 	<p>are conducted (Targeted date June 15, 2007)</p> <ul style="list-style-type: none"> ○ Risk Assessment Team will meet at least two times weekly to ensure each patient's risk level reflects the least restrictive environment for treatment. ○ Initial risk assessment will be completed within 72 hours of admission. ○ If the Risk Assessment Team requires the use of restraints or places other restrictions on an inmate, those restrictions will be reviewed by the Team weekly. ○ All inmates admitted to CSU, TCU, or CMHI shall participate in a minimum of 12 hours of planned scheduled services per week in accordance with TI 15.05.05. Inmate/patients who are determined by the MDST to be not appropriate for group participation due to security concerns shall be provided these 12 hours of services on an individual basis. ○ Review of 10 charts (or all cases if fewer than 10) from each inpatient level (CSU, TCU and CMHI) weekly to insure that participation in 12 hours of planned, scheduled activities is occurring unless 	
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	<p>documentation exists to justify the inability to provide out-of-cell activity for that patient. The results of this weekly review will be signed by the inpatient unit psychologist, the Chief Health Officer and the Warden or Warden's designee with copy to closure file</p> <ul style="list-style-type: none"> ○ Staff training on scheduled services procedural and documentation issues <ul style="list-style-type: none"> ▪ To ensure scheduling and documentation of planned, scheduled therapeutic activities (Target date June 15, 2007) <ul style="list-style-type: none"> ○ Regularly updated schedule of therapeutic activities will be available to healthcare staff and security staff. ○ The Chief of Security, Chief Health Officer, and inpatient psychologist shall meet weekly to ensure that inpatient inmate/patients are being provided with the required 12 hours of planned program activities. Meeting notes will be provided to the Warden with a copy placed in the closure file. ○ The inpatient psychologist will notify the Warden or Warden's designee verbally if there are any 	
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	<p>difficulties bringing inmate/patients out of their cells for scheduled therapeutic activities. The inpatient psychologist will follow-up the verbal communication the same day with an e-mail to the Warden, Chief of Security, and Chief Health Officer noting the difficulty encountered and the steps taken to ensure planned therapeutic activities were provided. A copy of this e-mail will be placed in the closure file.</p> <ul style="list-style-type: none">○ Staff training regarding appropriate tracking and documentation of patient involvement in therapeutic activities.	
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Emergency Finding 3:

There is disorganization in the medication administration process including absence of a system to reliably monitor whether inmates are receiving medications as prescribed (staff reported that they relied on memory regarding who had received or refused their medication for more than 200 inmates.) There is no reliable documentation of the use of Emergency Treatment Orders which prevents a determination of whether ETO's are being used in accordance with statute. There were no oral cavity checks observed during medication administration.

There is no reliable system in place in the pharmacy to ensure that medication is tracked and stored in a manner consistent with good pharmacy practice. Five boxes of expired drugs were found in the pharmacy.

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| <ul style="list-style-type: none">▪ June 6, 2007 – The Department’s Director of Mental Health, the Chief of Psychiatry, and MHM’s Director of Mental Health held a meeting with all MHM mental health staff (mental health nurses, security and psychiatrist) and provided re-education on the proper ordering and use of Emergency Treatment Orders (ETO). All mental health staff will be re-educated on applicable technical instructions and procedures. Dr. Pages also addressed the proper use of the chain of command, dispute and conflict resolution, and the critical importance of documenting any and all actions taken | <ul style="list-style-type: none">▪ In-service all nurses on Procedure 403.007 (Medication Administration) with an emphasis on documentation – section 2(e), and the Health Services Nursing Intervention and Documentation Manual. (June 13, 2007)▪ Hire vacant pharmacy tech position with experienced and certified pharmacy tech (on going)▪ Provide intensive remedial training for current Pharmacy tech on best practices from correctional institutions throughout the other three (3) regions (June 13, 2007).▪ Regarding oral cavity checks on the pill line, the Clinic Officer's Post Orders will reflect how medications will be observed. Additionally, the shift supervisors will be trained in procedure 403.007 and advised of their responsibility to ensure this process occurs on their shift (Immediately: June 6, 2007)▪ Monitoring of the pill line process will be conducted daily by the shift supervisor to ensure that inmates are compliant with medications as prescribed by clinicians | |
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	(Immediately: June 6, 2007)	
<p>Emergency Finding 4:</p> <p>There is evidence that clinical decisions have been inappropriately influenced by security to the extent that appropriate medical and mental health care for inmates may have been compromised. There appears to be an organizational culture at this institution that is detrimental to the welfare of inmates. We believe that the warden is motivated to address these concerns. However, we believe that she will need the support of Department leadership to effectively change this culture.</p>		
	<ul style="list-style-type: none"> ▪ Mental health staff will educate security staff on procedures involving the treatment and movement of inmates housed in the CMHI, TCU, and CSU (Immediately and on going). <ul style="list-style-type: none"> • MHM Director of Mental Health will continue to monitor MHM staff to ensure that DC policies, procedures, and technical instructions are followed appropriately (on going) • The Warden will continue to ensure that the Multi-Disciplinary Services Team meets on a regular basis, no less than twice per week to assign each inmate in the SCU, TCU, and CMHI a level as outlined in the "Levels and Privileges System for Inpatient Mental Health Units". (on going) • The Warden will meet with mental health and security staff once per week to ensure the effective operation of the mental health units. The meetings will be documented by a sign-in sheet. Security staff assigned will also receive training regarding the handling of mentally ill patients. These actions will facilitate the overall operation of the units, ensuring 	<ul style="list-style-type: none"> ▪ BCI Warden will establish and Chair a weekly Mental Health Advisory Committee, consisting of the inpatient and outpatient mental health staff, representatives of security staff, and the Warden (Week of June 4, 2007)

	inmates' regular access to treatment and other beneficial activities and services (on going)	
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