CORRECTIONAL MEDICAL AUTHORITY

PHYSICAL & MENTAL HEALTH SURVEY

of

CENTRAL FLORIDA RECEPTION CENTER

in
Orlando, Florida

on
October 16 – 19, 2001

INSTITUTIONAL STATISTICS PROVIDED CMA on October 8, 2001		
Population	**Custody**	**Type**
Adult/Youthful Offender	**Close**	**Male**

Main Unit Capacity	Main Unit Census	East Unit Capacity	East Unit Census	South Unit Capacity	South Unit Census	Total Capacity	Total Census
1,842	1,525	853	840	160	118	2,855	2,483

CMA Physical Health Team Leader:
Paul R. Cornish

Physical Health Team Members:
Joe Gonzalez, MD
Bernard Kimmel, MD
Paul Burtner, DMD
David Habell, PA
Barbara Murphree, PA
Kaye Harris, RN

CMA Mental Health Team Leader:
Deborah McNamara, LCSW

Mental Health Team Members:
Benjamin Ogburn, MD
Michael E. Clark, PhD
Paree M. Stivers, PsyD
Larry Goble, LCSW

OVERVIEW

On October 19, 2001, the Correctional Medical Authority concluded a physical and mental health survey of Central Florida Reception Center, located in Orlando, Florida. At the time of the survey, CFRC served an adult male population of approximately 2,483 inmates assigned to medical grades 1 through 4 and psychological grades 1 through 3. A small number of youthful offenders were also housed at the institution awaiting the reception process or medical staging. CFRC was classified as a medical level 4 facility. Inmates requiring complex medical/dental care or psychotropic medication services were housed at this institution.

Medical Grade	***1***	***2***	***3***	***4***	***Impaired***	
	1,377	**735**	**273**	**9**	**16**	
Psychological Grade	***Mental Health Outpatient***			***MH Inpatient***		
	1	***2***	***3***	***4***	***5***	***Impaired***
(S-Grade)	**2,076**	**116**	**195**	**0**	**0**	**2**
Confinement/ Close Management	***DC***	***AC***	***PM***	***CM3***	***CM2***	***CM1***
	35	**24**	**N/A**	**N/A**	**N/A**	**N/A**

The above figures represent a total of all three units.

The goal of the survey was to determine if the physical/dental and mental health care systems in place at the institution were consistent with the standards of care established by the CMA and with prevailing professional practice standards. For a detailed description of the survey goals and processes refer to the “Survey Process” section of this report.

From a physical health perspective, services provided at CFRC include new admission medical processing, medical specialty consultations, and a cluster pharmacy serving 11 other institutions. These services, combined with providing care to permanently assigned inmates, make the medical mission of the facility very complex. Assessing this medical system through survey was also very complex. However, a thorough review of the physical health-related systems in place at the institution, including the physical plant, administrative processes, and the provision and documentation of care was conducted. This review revealed several departures from the Department of Corrections' standards or with standards generally accepted in the health care community at large.

Findings requiring correction by the institution were varied, but included concerns with appropriate documentation of medical histories, the provision of appropriate patient health education during care encounters, the timeliness of laboratory tests and follow-up of abnormal results, and the legibility of written entries in medical records. Of most concern to the survey team, however, was the denial by the institution for the survey team to examine internal quality management documents as had been historically

permitted. This denial prohibited the team from evaluating the adequacy and sufficiency of the program as is required as a part of the authority's survey process.

An examination of the systems in place and a review of clinical documentation revealed many areas of concern regarding the mental health care provided at CFRC. The complex mission of providing assessment to inmates in the reception process as well as traditional mental health treatment to those inmates awaiting transfer to a permanent institution seemed to pose unique challenges. Documentation of care as well as initiation of the treatment planning process were areas that indicated a need for improvement. Of particular concern to the mental health survey team was the practice of providing suicide/self-injury prevention in confinement through direct observation by a correctional officer while the patient was confined in security restraints.

At the conclusion of the survey, an exit conference was held on site with department staff to discuss the preliminary findings of the team members. The physical health and mental health sections of this report reflect the findings and final conclusions drawn following an analysis of the information collected during the survey. Where suggested corrective actions are provided, these suggestions should not be construed as the only action required to demonstrate corrections, but should be viewed as guidance for development of a corrective action plan.

The following table lists the results from the systems and record review instruments used during the survey:

Findings Summary			Numeric Score*	
			Systems	Records
PHYSICAL HEALTH	**Episodic Care**	Sick Call	100	89
		Emergency Care	97	90
		Physician/CA Follow-Up Care	N/A	N/A
		Infirmary Care	N/A	89
	Chronic Care	Chronic Illness Clinic Systems	100	
		Asthma		96
		Diabetes		93
		General Medicine		89
		Hypertension		87
		Immunity		65
		Seizure		64
		TB/INH		70
	Preventative Care		100	100
	Dental Care		100	97
	Mortality		N/A	96
	Other	Administrative Audit	87	
		Consultations	100	100
		Infection Control	72	
		Intake Process (Reception)	100	100
		Intrasystem Transfers	100	100
		Medication Administration	94	82
		OBIS	100	100
		Pharmacy	100	
		Quality Management	0	
MENTAL HEALTH		Inmate Access to Mental Health Services	71	52
		Outpatient Mental Health Services	53	S1 65
				S2 47
				S3 61
		Intellectual Functioning	100	44
		Sexual Offender Services	50	23
		Special Housing	100	66
		Psychotropic Medication	33	91
		Self-Injury/Suicide Prevention	57	29
		Psychiatric Restraints	60	N/A
		Reception/Intake Process	90	59
A score of 100 represents meeting all minimum care/systems standards. A score of less than 80 represents an unacceptable level of care/systems standards.				

PHYSICAL HEALTH FINDINGS

Survey Results
The following areas of review resulted in findings requiring attention or corrective action.

EPISODIC CARE

Records Reviewed:	SICK CALL (Nursing Encounter)	Systems Score	Records Score
10		100	89

Finding(s)	Suggested Corrective Action(s)
PH-1: (Institutional Finding) Incomplete or missing components of documentation were identified in 30% of the sick call records reviewed.	Develop an inservice training session specific to sick call procedures and medical record documentation requirements. Implement an internal medical records monitoring program to ensure all critical components necessary for accurate and complete SOAP format charting is completed during sick call encounters. Review 5 records per month with a critical eye toward the documentation of the areas identified in the discussion paragraph below. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Discussion of PH-1:
The records score of 89 identified above represents an average of the scores earned from reviews of the sick call processes at the main, east, and south units. Although care generally appeared adequate, documentation deficiencies such as a failure to consistently record encounters in the SOAP format, a failure to consistently document the date and time of encounters, and a failure to consistently and clearly document patient health education was noted. These problems may be due in part to the relatively high number of staff vacancies of registered (RN) and licensed practical (LPN) nurses (approximately 32%). It is recommended special attention be given to improving the training provided at orientation to agency staff.

Records Reviewed:	EMERGENCY CARE (Nursing Encounter)	Systems Score	Records Score
13		97	90

Finding(s)	Suggested Corrective Action(s)
PH-2: (Institutional Finding) Incomplete or missing components of documentation were identified in 46% of the emergency care records reviewed.	Develop an inservice training session specific to emergency care encounters and medical record documentation requirements. Implement an internal medical records monitoring program to ensure all critical components necessary for accurate and complete SOAP format charting is completed during emergency care encounters. Review 5 records per month with a critical eye toward the documentation of the areas identified in the discussion paragraph below. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Discussion of PH-2:

Same comments as reflected in the discussion of PH-1. The same concerns identified in that discussion were also reflected during reviews of records containing documentation of emergency care encounters.

Records Reviewed:	INFIRMARY CARE	Systems Score	Records Score
3		N/A	89

Finding(s)	Suggested Corrective Action(s)
PH-3: (Institutional Finding) None of the infirmary records reviewed contained clear evidence that nursing rounds had occurred or that vital signs had been taken/documented at least once per shift. NOTE: None of the records reviewed contained evidence that physician orders had decreased the frequency requirement for nursing rounds and/or vital signs.	Conduct inservice training on patient care components required during infirmary stays. Implement an infirmary records monitoring program to ensure all required components of care are conducted at the required time frame. Review 5 records per month with a critical eye toward the documentation of the areas identified in the finding. Continue monitoring until closure is affirmed through the CMA CAP assessment.

CHRONIC CARE

Records Reviewed: 10	ASTHMA CLINIC RECORD REVIEW	Records Score 96

Finding(s)	Suggested Corrective Action(s)
PH-4: (Institutional Finding) In 20% of the records reviewed, concerns were noted in one or more of the following areas: • **medical histories that included all required components;** • **evidence of patient education on the use of and side effects of medications; and/or,** • **a current chest x-ray.**	Conduct inservice training on patient care components required during asthma clinic encounters. Implement an asthma clinic records monitoring program to ensure all required components of care are conducted at the required time frame. Review 5 records per month with a critical eye toward the documentation of the areas identified in the finding. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Records Reviewed: 6	DIABETES CLINIC RECORD REVIEW	Records Score 93

Finding(s)	Suggested Corrective Action(s)
PH-5: (Institutional Finding) In 83% of the records reviewed, concerns were noted in one or more of the following areas: • **medical histories that included all required components;** • **evidence of the results of glucose finger-sticks; and/or,** • **evidence of annual influenza/pneumococcal vaccine (or signed refusal).**	Conduct inservice training on patient care components required during diabetes clinic encounters. Implement a diabetes clinic records monitoring program to ensure all required components of care are conducted at the required time frame. Review 5 records per month with a critical eye toward the documentation of the areas identified in the finding. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Records Reviewed: 8	GENERAL MEDICINE CLINIC RECORD REVIEW	Records Score 89

Finding(s)	Suggested Corrective Action(s)
PH-6: (Institutional Finding) In 38% of the records reviewed, concerns were noted in one or more of the following areas: • **evidence that all abnormal laboratory studies were addressed;** • **evidence that laboratory studies were completed prior to clinic visits;** • **evidence of reviews of medication compliance and/or medication adjustments; and/or,** • **documentation of complete medical histories, with attention to risk factors, initial diagnosis of the disease, and previous treatment interventions.**	Conduct inservice training on patient care components required during general medicine clinic encounters. Implement a general medicine clinic records monitoring program to ensure all required components of care are conducted at the required time frame. Review 5 records per month with a critical eye toward the documentation of the areas identified in the finding. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Records Reviewed: 14	HYPERTENSION CLINIC RECORD REVIEW	Records Score 87

Finding(s)	Suggested Corrective Action(s)
PH-7: (Institutional Finding) In 29% of the records reviewed, concerns were noted in one or more of the following areas: • **evidence of baseline laboratory studies;** • **evidence that laboratory studies were completed prior to clinic visits;** • **evidence of reviews of medication compliance and/or medication adjustments;** • **problem list did not reflect a diagnosis of hypertension;** • **chronic clinic visits did not occur at the prescribed 180 day intervals; and/or,** • **chronic clinic forms and/or**	Conduct inservice training on patient care components required during hypertension clinic encounters. Implement a hypertension clinic records monitoring program to ensure all required components of care are conducted at the required time frame. Review 5 records per month with a critical eye toward the documentation of the areas identified in the finding. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Records Reviewed: 14	HYPERTENSION CLINIC RECORD REVIEW	Records Score 87

Finding(s)	Suggested Corrective Action(s)
related progress notes not legible.	

Records Reviewed: 9	IMMUNITY CLINIC RECORD REVIEW	Records Score 65

Finding(s)	Suggested Corrective Action(s)
PH-8: (Institutional Finding) In 100% of the records reviewed, concerns were noted in one or more of the following areas: • **evidence of pre-and post-test counseling;** • **evidence of documentation of baseline laboratory studies;** • **evidence of TB preventative therapy;** • **evidence that appropriate medication regimes were provided;** • **medical histories that included all components, including the findings of physical examinations;** • **evidence of Western Blot test;** • **evidence of a clinic visit at least every 90 days;** • **evidence of patient health education; and/or,** • **chronic illness forms and/or related progress notes not legible.**	Conduct inservice training on patient care components required during immunity clinic encounters. Implement an immunity clinic records monitoring program to ensure all required components of care are conducted at the required time frame. Review 5 records per month with a critical eye toward the documentation of the areas identified in the finding. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Records Reviewed: 5	SEIZURE CLINIC RECORD REVIEW	Records Score 64

Finding(s)	Suggested Corrective Action(s)
PH-9: (Institutional Finding) In 100% of the records reviewed, concerns were noted in one or more of the following areas: • **incomplete medical histories;** • **incomplete physical examinations and/or documentation of the frequency and type of seizure and any acute complications;** • **evidence that laboratory studies were completed prior to clinic visits; and/or,** • **chronic clinic forms and/or related progress notes not legible.**	Conduct inservice training on patient care components required during seizure clinic encounters. Implement a seizure clinic records monitoring program to ensure all required components of care are conducted at the required time frame. Review 5 records per month with a critical eye toward the documentation of the areas identified in the finding. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Records Reviewed: 14	TB/INH CLINIC RECORD REVIEW	Records Score 70

Finding(s)	Suggested Corrective Action(s)
PH-10: (Institutional Finding) In 100% of the records reviewed, concerns were noted in one or more of the following areas: • **missing components in the documented physical examination;** • **incomplete medical histories; and/or,** • **evidence of annual influenza vaccine, or signed refusal.**	Conduct inservice training on patient care components required during TB/INH therapy clinic encounters. Implement a TB/INH clinic records monitoring program to ensure all required components of care are conducted at the required time frame. Review 5 records per month with a critical eye toward the documentation of the areas identified in the finding. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Discussion of PH Findings PH-4-10 above:

Problems noted in reviews of each of the chronic illness clinics listed above may have been more of a result of poor documentation than of failure to comply with the care requirements. The general sense of the survey team was that, in some of the instances

described above, components identified as missing or incomplete may, in fact, have been present, but were so poorly or inconsistently documented that an accurate and complete picture of the patient's care could not be re-created. As was noted in the discussion of sick call and emergency care records, staffing shortages and the use of agency staff may have contributed to this problem, but this in itself does not explain the large number of negative findings. It was also felt the institution's practice of sometimes documenting care in the computer assisted reception process (CARP) format (electronic documentation) and sometimes on paper clinic forms made the surveyors job of documenting care cumbersome and oftentimes impossible.

The authority recommends the Office of Health Services examine the policies and practices of CARP use at CFRC, and compare the practices with those in place at the other reception centers in the state. Anecdotal reports provided by staff at various "receiving" institutions during authority surveys suggest there is confusion even among department staff related to locating and/or tracking care documented through CARP.

DENTAL CARE

Records Reviewed:	DENTAL	Systems Score	Records Score
20		100	97

Finding(s)	Suggested Corrective Action(s)
PH-11: (Institutional Finding) In 20% of the records reviewed, patient oral hygiene instructions were not adequately documented.	Conduct inservice training on the requirements for conducting and documenting oral hygiene education. Implement a dental records monitoring program to ensure all required components of care are conducted at the required time frame. Review 5 records per month with a critical eye toward the documentation of the area identified in the finding. Continue monitoring until closure is affirmed through the CMA CAP assessment.

MORTALITY

Records Reviewed:	MORTALITY	Systems Score	Records Score
22		N/A	96

Finding(s)	Suggested Corrective Action(s)
PH-12: (Institutional Finding) In 60% of the records reviewed, non clinical care concerns were noted in one or more of the following areas: • **no final physician summary;**	Initiate a system; i.e., checklist, to ensure all documentation components are completed prior to final closure of a mortality record.

Records Reviewed: 22	MORTALITY	Systems Score N/A	Records Score 96

Finding(s)	Suggested Corrective Action(s)
• no death certificate; • no documentation of notification to the medical examiner and/or a medical examiner's report; and/or, • no copy of hospital records for inmates transferred to a local facility.	

OTHER

ADMINISTRATIVE AUDIT	Systems Score 87

Finding(s)	Suggested Corrective Action(s)
PH-13: (Institutional Finding) There was no system in place to ensure review of episodic care (sick call and emergency care) records on a regular basis by the registered nursing supervisor (SRNS) and/or the chief health officer (CHO).	Institute a system for routine record review that audits at least appropriateness of care, medications, and completeness of documentation.
PH-14: (OHS Finding) No evidence was provided during the survey of an annual peer review of the CHO and the Senior Dentist.	Institute a system by which annual peer review of the CHO and Senior Dentist is conducted. This system should stand separately from annual state employee performance evaluation.

Discussion:

Although not listed as a specific finding under the heading of "administration", it should be noted significant staff shortages exist at CFRC, particularly in the nursing area. Staff allocation information provided by the institution reflect the following:

	MAIN UNIT		EAST UNIT		SOUTH UNIT	
	ALLOCATED	FILLED	ALLOCATED	FILLED	ALLOCATED	FILLED
Physician	12	11	1	1	1	1
Clinical Associate (PA)	1	1	N/A	N/A	N/A	N/A
Clinical Associate (ARNP)	2	1	N/A	N/A	N/A	N/A
RN Supervisor	1	1	1	1	1	1
RN	14	11	1	1	5	5
LPN	14	8	4	3	4	4
Dentist	2	2	1	1	N/A	N/A
Dental Assistant	3	2	2	1	N/A	N/A
Pharmacist	4	2	N/A	N/A	N/A	N/A
Pharmacy Assistant	8	7	N/A	N/A	N/A	N/A
Medical Records Supervisor	1	0	N/A	N/A	N/A	N/A
Health Information Specialist	3	2	N/A	N/A	N/A	N/A
Medical Clerical Staff	6	5	N/A	N/A	1	1

In addition to the numbers reflected above, it was reported that one RN and two LPNs were on extended medical leave and were therefore unavailable for duty.

From a budget standpoint, staff vacancies as reflected above are very costly to the institution and the department. For example, information provided by the institution reflected that through September 2001, approximately $55,000.00 per month was being expended to augment nursing staff with temporary agency nurses. In, October 2001, this figure rose to nearly $72,000.00 due to two staff pharmacist vacancies. These positions were also contracted to temporary agency staff.

	INFECTION CONTROL	Systems Score 72

Finding(s)	Suggested Corrective Action(s)
PH-15: (OHS Finding) Per instructions of the OHS, the following critical components of the Infection Control (IC) program were not provided for review: • **designation of an IC Coordinator; and,** • **a record of a comprehensive surveillance program that incorporates the entire facility.**	See discussion following Quality Management Finding.

Records Reviewed: 10	MEDICATION ADMINISTRATION	Systems Score 94	Records Score 82

Finding(s)	Suggested Corrective Action(s)
PH-16 (Institutional Finding) Medication administration records (MARs), were not consistently signed, dated, and/or timed. **PH-17 (Institutional Finding) The requirement that medication orders should be transcribed within four hours could not be determined in the records reviewed as times were omitted.**	Develop a review system to ensure that documentation on MARs includes the time and date of medication administration as well as the signature of the responsible party. Review 5 records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment.

	QUALITY MANAGEMENT	Systems Score 0

Finding(s)	Suggested Corrective Action(s)
PH-18 (OHS Finding) Per instructions of the OHS, no documentation was provided regarding any components of the institution's Quality Management Program.	See discussion.

Discussion of PH-15 and PH-18:

Section 945.603, F.S., requires the authority to evaluate the sufficiency, adequacy, and effectiveness of the department's quality management program. At the institutional level, this means members of the survey team must review QM products; i.e., QM Committee participants and attendance records at meetings, QM meeting minutes, licensing and privileging documents, corrective actions for identified concerns, infection control activities, etc. Because no QM materials were provided to surveyors, it was not possible to evaluate the effectiveness of the institution's program. It was reported to authority staff that instructions to deny access to QM materials were given by an Office of Health Services representative. Regional staff at the exit conference confirmed this.

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

System Reviews

- Chronic Illness
- Consultations
- Dental
- Emergency Care
- Intake (reception)
- Intrasystem Transfers
- Offender based information system (OBIS)
- Pharmacy
- Preventative Care
- Sick Call

Record Reviews

- Consultations
- Intake (reception)
- Intrasystem Transfers
- OBIS
- Preventative Care

CONCLUSION

Overall, the survey of CFRC indicated that an enthusiastic and cooperative staff provided an adequate level of complex physical health care to a large inmate population. Although many problems were identified during the survey, the vast majority is under institutional control and correctable. The difficulties faced by the permanent staff of position vacancies and caring for a largely transient inmate population will make correction of the findings challenging, but not impossible.

MENTAL HEALTH FINDINGS

Description of the Mental Health Department
The mental health department at Central Florida Reception Center (CFRC) was complex. The Main unit served as a reception center, receiving new inmates from county jails. Each inmate was assessed by all departments, including mental health, to determine which services should be rendered during the inmate's incarceration. The Main unit also served as a hub for higher level medical care to include specialty clinics.

To serve this diverse and challenging population, CFRC was staffed in the Main unit with two psychiatrists and one psychiatric nurse stationed in the medical building. In the classification building, there were two senior psychologists. One was charged as clinical supervisor for the screening and assessment program. The other was the clinical supervisor for treatment. There were twelve psychological specialists on staff, although one was on extended medical leave. Several were assigned to the screening process and others held caseloads of patients awaiting transfer or arriving at CFRC for medical care.

The East unit housed inmates assigned primarily to S-grade 1, although a small number of S-2s were in residence at the time of the survey. No mental health staff was assigned to this unit. Mental health staff from the Main unit served the population on an as-needed basis.

The South unit was a small institution located near the other two units that served patients being treated for HIV/AIDS. One psychological specialist served this population of S-grades 1 through 3 and a senior psychologist from another major institution served as the part-time clinical supervisor. Psychiatrists from the Main unit were responsible for the psychiatric care.

Survey Results
The following areas of review resulted in findings requiring attention or corrective action.

Records Reviewed:	INMATE ACCESS TO MENTAL HEALTH SERVICES	Systems Score	Records Score
12		71	52

Finding(s)	Suggested Corrective Action(s)
MH-1: The inmate request log did not always reflect that responses had been given. No documentation was provided to indicate that administrative staff reviewed the request log.	Add a component to the existing log that documents administrative review. Provide evidence of monitoring in the closure file that demonstrates 90% compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.

MH-2: Inmate request forms were not consistently filed in the medical record.	Provide inservice training on the inmate request process. Monitor five inmate requests received per month to monitor for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Records Reviewed:	INTELLECTUAL FUNCTIONING	Systems Score	Records Score
8		100	44

See findings listed under Reception/Intake Process

Records Reviewed:	OUTPATIENT MENTAL HEALTH SERVICES	Systems Score	Records Score
25		53	S1: 65 S2: 47 S3: 61

Finding(s)	Suggested Corrective Action(s)
MH-3: In the majority of records reviewed, there was no documentation to indicate that orientation to mental health services had been provided.	Provide inservice training on the importance of documenting that inmates have been advised of the available services and the means for accessing care. Monitor five records per month of new arrivals. Continue monitoring until closure is affirmed through the CMA CAP assessment.

MH-3 Discussion:

At CFRC, it was reported that orientation was provided in person at the time of the mental health screening, which occurred on the fifth day after arrival. However, those reviewed records that indicated orientation had taken place often reflected a delay of up to 14 days. The standards of the CMA, adopted following a review of national correctional standards, indicate that orientation to mental health services should be completed within 24 hours of arrival.

MH-4: A Consent for Evaluation and Treatment (DC4-663) was not obtained prior to treatment being rendered in all but one of the records reviewed. (South unit only)	Provide inservice training on documentation requirements. Monitor five applicable records per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
MH-5: In the majority of records reviewed, there was no documentation present in the record to indicate that a case manager was assigned within 3 days of S-grade assignment.	Provide inservice training on documentation requirements. Monitor five applicable records per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
MH-6: Biopsychosocial Assessments (BPSAs) were not consistently completed in required time frames for patients engaged in treatment.	Provide inservice training on documentation requirements. Monitor five applicable records per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment. The sample for review should be selected from both the Main and South units.

MH-6 Discussion:

Staff reports indicated that the completion of BPSAs was considered a time consuming activity that could not be completed with the current available staff. As a result, psychological specialists were instructed to complete the assessments for S-3 patients (those with severe impairment due to mental illness) but to defer this assessment for S-2 patients (those with mild to moderate impairments). The transitory nature of the reception population, it was explained, indicated that a patient would likely be transferred quickly to a permanent institution where a full assessment could then be completed. Unfortunately, a review of cases indicated that many patients had been in treatment at CFRC for several months. Due to the lack of rapid movement, as expected, and the prevailing practice standard to complete a full assessment prior to generating a treatment plan, it is important that this deficiency be corrected. Perhaps clarification from OHS on the delineation between a “reception inmate” and a “permanent inmate” would be helpful in ensuring that appropriate and timely care is rendered.

MH-7: Individualized Service Plans (ISPs) were not consistently completed and reviewed at required intervals.	Provide inservice training on documentation requirements. Monitor five applicable records per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment. The sample for review should be selected from both the Main and South units.
MH-8: Case management was not consistently conducted at required intervals. (South unit only)	Develop a system to ensure that required sessions are scheduled and completed. Monitor five applicable records per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
MH-9: Psychiatric evaluations and follow-up visits were not conducted at required intervals. (South unit only).	Develop a system to ensure that required sessions are scheduled and completed. Monitor five applicable records per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
MH-10: In all applicable records reviewed, prerelease planning had not been initiated for inmates within 180 days of End of Sentence (EOS).	Provide inservice training on departmental policy for prerelease planning. Monitor five applicable records each month. Continue monitoring until closure is affirmed through the CMA CAP assessment.
MH-11 (OHS): Numerous psychological specialists had not been privileged to conduct all required job duties.	Provide necessary inservice training to ensure that all employees are privileged to conduct all required job duties.
MH-12: The Multidisciplinary Services Team (MDST) did not meet on a regularly scheduled basis.	Schedule a meeting time for the MDST to ensure that all treatment team members may attend. Provide documentation in the CAP closure file to indicate attendance.

Records Reviewed:	PSYCHIATRIC RESTRAINTS	Systems Score	Records Score
0		60	N/A

Finding(s)	Suggested Corrective Action(s)
MH-13: Critical staff members were not trained in and could not demonstrate the application of psychiatric restraints. Their knowledge of the policies and procedures for psychiatric restraints was inadequate to ensure safe application should the need arise.	Provide inservice training to all institutional staff likely to be involved in the application of psychiatric restraints, to include security officers posted in the infirmary. Introduce psychiatric restraints as a topic during annual training for all institutional staff.

Records Reviewed:	RECEPTION/INTAKE	Systems Score	Records Score
14		90	59

Finding(s)	Suggested Corrective Action(s)
MH-14: Initial Suicide Profiles (DC4-646) were not consistently completed as required.	Provide inservice training on the requirements for completing a suicide profile. Monitor five records per month for inmates with a history of suicide attempts or a score of 9 or higher on the Beck Hopelessness Scale. Continue monitoring until closure is affirmed through the CMA CAP assessment.
MH-15: Intelligence testing, to include a BETA-III, ABC, and WAIS-III if indicated, was not consistently completed as required.	Provide inservice training on the requirements for intellectual assessment. Monitor five records per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
MH-16: Several records reviewed indicated a plan for further evaluation, to include further testing and/or psychiatric evaluations. In these records, the recommended action was never taken.	Develop a system to ensure that follow-up evaluations are scheduled and completed. Each month, review the records of five newly arriving inmates whose screening indicates a need for further assessment. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Records Reviewed:	SELF-INJURY/SUICIDE PREVENTION	Systems Score	Records Score
5		57	29

Finding(s)	Suggested Corrective Action(s)
MH-17: The method for self-injury prevention in practice at CFRC did not meet minimum standards. No policy directives could be located to guide the practices in place. • **Movement was restrained without a physician's order and without standard safety measures being taken, as described in the discussion that follows.** • **Physician's orders were not consistently obtained for admission and discharge and were not consistently obtained every 24 hours.** • **Physician's orders did not specify allowable items.** • **Observation checklists were not located in the medical record.** • **Guidelines and time restrictions for referral to a higher level of care were not observed.** • **Nursing assessments were not consistently completed each shift.** • **Assessments by mental health staff were not consistently conducted daily.**	Review current policies and procedures for the management of self-injurious patients. Revise current practices to achieve compliance. Provide inservice training to all relevant staff once the current practice is revised. Monitor five applicable records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment.

<u>MH-17 Discussion</u>:
CFRC served a population of inmates just entering the prison system. The potential for suicide ideation and intent in such a population is high. Despite this acuity, CFRC was only equipped with two certified Infirmary Management Rooms (IMRs). Several cells located in the confinement unit were retrofitted, but they had not been certified.

According to staff reports, an incident occurred in 2000 at a neighboring institution. As a result, a large number of youthful offender inmates were transferred to CFRC who had threatened self-harm. With only two IMRs, this posed a challenge to the institution. In response to this aberrant situation, most of the inmates were placed in handcuffs, leg irons, and waist chains and assigned to security officers for observation in locations throughout the compound to include confinement and the building used for intake, referred to as T&R. A review of records indicated that many of these young men remained in this

condition for several weeks. Staff reports indicated that there were no available beds in inpatient units throughout the state to which the young men could be transferred.

During the survey, it was determined that the practice of placing inmates at risk for self-harm in handcuffs, leg irons, and waist chains continues. By staff report, the procedure begins with an evaluation by either a psychiatrist or a psychological specialist. If it is determined that the patient is at risk for self-harm, a referral is made for placement in the IMR. Unfortunately, the IMRs, which are also used for the dual purpose of housing patients with respiratory disease, are frequently not available. If a psychiatrist evaluates the patient, an order may be written, frequently noted to be, "Place on SOS 1:1 Security Observation". Placement into security restraints ensues and the patient is constantly observed by a security officer in either the confinement unit or the T&R building.

Staff reports indicated that this status is used when a referral has been made to an inpatient unit and no bed is available. However, a review of the referral log and the medical records of several patients who have been on this status did not support staff reports. Frequently, patients were returned to open population following numerous days on this status. The time constraints for placement on SOS status (72 hours until transfer for SOS-I and 96 hours until transfer for SOS-II) were not observed in several cases reviewed.

The use of restraint with the mentally ill population is controversial in both correctional and community mental health settings. The ethical standard of providing care in the least restrictive environment and the medical implications of restricting movement for long periods of time both were of concern at CFRC. Other than a statement of ideation or intent for self-harm, most patients on this status had not demonstrated behavior indicating a need for personal restraint, either medically or from a security standpoint. Guidelines set forth in the Department of Corrections' Health Services Technical Instruction indicate that the use of psychiatric restraint requires a physician's order, periodic checks for circulation at the restraint sites, periodic vital signs, and release and movement of limbs to protect circulation. Furthermore, release after 30 minutes of calm behavior is mandated. None of these requirements were being met at CFRC with the use of the metal restraints.

Documentation required for placement on SOS status was not completed for many patients housed on this status. Some components of the documentation were completed in the records reviewed, but there was no consistency to indicate that there was a policy in place to guide clinicians in documenting the care.

No policy directives, either in the Institutional Health Services or Security department, could be located governing the use of this status. The CMA recommends discontinuation of the use of security restraints with self-injurious patients in this fashion, both in policy and practice, to ensure that minimum standards of care are protected.

Records Reviewed:	SEX OFFENDER SERVICES	Systems Score	Records Score
14		50	23

Finding(s)	Suggested Corrective Action(s)
MH-18: Sex offender screenings (DC4-647) were not completed for all but one record reviewed, which was completed nearly ten years earlier at another institution. (South unit only)	Develop a system to ensure that sex offender screenings are completed for all applicable cases. Monitor five applicable records per month. Continue monitoring until closure is affirmed through the CMA CAP assessment.
MH-19: ISPs and group notes for members of the sex offender treatment group were not individualized. (South unit only)	Monitor five applicable records per month to ensure that documentation is individualized. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Discussion:
Staff interviews indicated that CFRC Main unit did not complete sex offender screenings unless a request was forwarded from classification for completion of a Jimmy Ryce evaluation. Citing the transitory nature of the population, as was cited related to completion of BPSAs, and reference to the OHS Technical Instructions, staff explained that policy only requires the screening to be completed within 30 days of arrival at the permanent institution. Because many records were reviewed in which inmates had remained at CFRC well past the reception stage, it is recommended that this policy be reviewed and amended as necessary.

Records Reviewed:	SPECIAL HOUSING	Systems Score	Records Score
6		100	66

Finding(s)	Suggested Corrective Action(s)
MH-20 (OHS): Mental status exams were not consistently completed within 24 hours.	Revise current policy to ensure compliance with the standards of the CMA and national corrections standards.

Records Reviewed:	PSYCHOTROPIC MEDICATION PRACTICES	Systems Score	Records Score
10		33	91

Finding(s)	Suggested Corrective Action(s)
MH-21: Psychotropic medication is not offered later than 2:30 pm on the Main unit and 6:00 pm on the South unit.	Provide psychotropic medications at appropriate times.

M-21 Discussion:

Many psychotropic medications cause somnolence as a side effect. As a result, they are often prescribed in the evening to minimize the impact of this side effect on daily activities. Administration of these medications early in the evening can impair an inmate's ability to comply with staff directions due to sedation. Inappropriate timing of medication administration can disrupt sleep cycles and result in conflicts with institutional practices.

MH-22: Patients are not observed swallowing medications.	Provide inservice training on the importance of performing checks under the tongue to ensure that medication is swallowed.
MH-23 (OHS): No documentation was available on site to affirm the legality of the use of the electronic medical record password as an electronic signature for physician's orders.	Provide evidence that the current system meets all legal requirements for prescribing medication.

MH-23 Discussion:

At the time of the survey, an electronic record keeping system, referred to as CARP, was used to document the medical and mental health care provided to inmates, including psychiatric encounters. At the conclusion of an interview, the psychiatrist accessed the CARP system with a password and documented the care provided to the patient using the SOAP format. Under the "P", or plan, the psychiatrist indicated any orders for medications to be provided to the patient. This entry, as described by institutional staff, was then electronically transmitted to the pharmacy to be filled. No additional electronic code or signature by hand on a hard copy was completed in this process. Staff indicated that the use of the password was considered a legal electronic signature, but no documentation was available to indicate that this had been previously determined.

Records Reviewed: 1	**MORTALITY**

One suicide occurred in the period since the last CMA survey. A review of the case did not reveal any significant deficiencies that may have contributed to the death. However, it was noted that the patient was treated with Sinequan, despite having a history of cardiac arrhythmia. The use of Sinequan is typically discouraged in such a patient due to its potential cardiac side effects.

Records Reviewed: N/A	**OTHER ADMINISTRATIVE ISSUES**
Finding(s)	**Suggested Corrective Action(s)**
MH-24: Medical records were disorganized. Filed documents were frequently misplaced or out of chronological order.	Monitor five records per month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.

MH-25: 12 hours of clinical inservice was not provided to clinical staff annually.	Provide appropriate inservice training.

CONCLUSION

Although all interviewed staff expressed a desire to provide appropriate care to the patients they served, many problems were identified during the course of the survey that compromised effective treatment and patient safety. The use of handcuffs, leg irons, and waist chains for self-injury prevention was of particular concern to the survey team. The CMA recommends an examination by the Department of Corrections' Office of Health Services into the lack of appropriate suicide-resistant cells, or IMRs, for an institution with the mission of CFRC.

Ambiguity surrounding the requirements of treatment for those patients who had completed the reception process and were awaiting transfer should also be addressed by OHS. The mental health department at CFRC appears to have been created to provide assessment to a population of inmates in residence only briefly. However, at the time of the survey, many patients were staying much longer than anticipated. A review of the system in place at CFRC should result in adjusted policies and staffing patterns to better equip the institution to provide appropriate treatment.

SURVEY PROCESS

The goals of every survey performed by the CMA are (1) to determine if the physical, mental, and dental care provided to inmates in all state and privately operated correctional institutions is consistent with state and federal law and if that care conforms to 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 objectives are designed to evaluate inmate care and treatment in terms of effectiveness and fulfillment of statutory responsibility. 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 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, selected through purposeful sampling, are also conducted. The cases selected for review are representative of inmates who are receiving mental and/or physical health services (or who are eligible to receive such services). Conclusions drawn by members of the survey team are based on several methods of evidence collection:

- ♦ Physical evidence – direct observation by members of the survey team (tours and observation of evaluation/treatment encounters)
- ♦ Testimonial evidence – obtained through staff and inmate interviews (and substantiated through investigation)

- Documentary evidence – obtained through reviews of medical/dental records, service/treatment plans, schedules, logs, administrative reports, physician orders, medication administration reports, meeting minutes, training records, etc)
- Analytical evidence – developed by comparative and deductive analysis from several pieces of evidence gathered by the surveyor

During the course of a three or four day evaluation, the survey team examines the institution's health-related administrative systems, tours inmate housing and health treatment areas, conducts staff and inmate interviews, and conducts a clinical review of health care records.

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 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 to result in the compromise of inmate health care. All findings identified in the body of the report will require a corrective action by institutional and/or regional/central office health services staff.