



# **CORRECTIONAL MEDICAL AUTHORITY**

## **PHYSICAL & MENTAL HEALTH SURVEY**

of

## **DADE CORRECTIONAL INSTITUTION**

in

**Florida City, Florida**

on

**September 16-19, 2003**

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## DEMOGRAPHICS

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

INSTITUTIONAL INFORMATION			
Population	Type	Custody Level	Medical Level
1,291	Male	Maximum	3

### Institutional Potential/Actual Workload

Main Unit Capacity	1,488	Current Main Unit Census	1,291
Annex Capacity	NA	Current Annex Census	NA
Satellite Unit(s) Capacity	64	Current Satellite(s) Census	64
Total Capacity	1,552	Total Current Census	1,355

### Inmates Assigned to Medical/Mental Health Grades

	1	2	3	4	Impaired	
		539	321	448	3	61
<i>Mental Health Grade</i> <i>(S-Grade)</i>	<i>Mental Health Outpatient</i>			<i>MH Inpatient</i>		
		2	3	4	5	Impaired
	772	136	400	NA	NA	4

### Inmates Assigned to Special Housing Status

<i>Confinement/ Close Management</i>	DC	AC	PM	CM3	CM2	CM1
		44	23	6	NA	NA

## OVERVIEW

The Correctional Medical Authority conducted a thorough review of the medical, mental health and dental systems at Dade Correctional Institution (DADCI). Record reviews evaluating the provision and documentation of care were also conducted. Additionally, a review of administrative processes and a tour of the physical plant were conducted. 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 staff.

### **Physical Health Findings**

Physical Health at DADCI has a challenging task of providing health care to a large chronic illness population of which many must receive administered medications on a daily bases. A substantial number of intra-system transfers must be processed weekly. Even though most of the care provided appeared to be adequate there were many documentation-related findings. The systems review also uncovered several areas of concern, especially in the areas of OBIS/health record content and the quality management program.

### **Mental Health Findings**

Despite very large caseloads, the mental health department was providing appropriate standards of clinical care overall. The staff is skilled and caring. They work well as a team. The findings noted for this survey fall mainly into the category of documentation and systems issues. For example, repairs were needed to bring two of the infirmary isolation management cells up to standard and ensure patient safety. Also, inconsistencies were noted between several of the mental health logs and the medical records.

### **Department Findings**

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

Notably, the Department and Wexford Health Sources are currently considering licensure requirements under Florida Statutes, Chapter 490 and 491, for the Behavioral Health Specialists hired by Wexford in the mental health program. At issue is whether private providers of health care qualify for the same licensure exemptions as state employees. The CMA will review and comment as necessary on decisions by the Department and/or Wexford regarding this issue.

### **Exit Conference and Final Report**

At the conclusion of the survey, an exit conference was held with institutional personnel to discuss preliminary survey results. The findings and final conclusions presented in the physical health and mental health sections of this report are a result of further analysis of the information collected during the survey. The suggested corrective actions(s) included in this report should not be construed as the only action required to demonstrate correction, but should be viewed as a guide for developing a corrective action plan. Where recommended corrective actions suggest in-service training, a copy of the curriculum and attendance roster should be included in the corrective action plan files. Additionally, evidence of appropriate monthly monitoring should be included in the files for each finding. Monitoring by a clinician peer must be documented by a monthly compilation of the following:

- 1) The criteria/finding being reviewed;

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

## SUMMARY OF INSTITUTIONAL SCORES

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

Area of Review		Score*			
		Systems	Clinical		
<b>PHYSICAL HEALTH</b>	<b>Episodic Care</b>	Episodic Care Systems	80		
		Emergency Care		71	
		Episodic Care Follow-Up		93	
		Infirmatory Care		84	
		Sick Call		98	
	<b>Chronic Care</b>	Asthma/Pulmonary Clinic		82	
		Diabetes Clinic		91	
		General Medicine Clinic		95	
		Hypertension Clinic		99	
		Immunity Clinic		100	
		Seizure Clinic		84	
	<b>Preventative Care</b>		67		82
	<b>Dental Services</b>		100		100
	<b>Mortality Review</b>		88		92
	<b>Other</b>	Administrative Processes	92		
		Consultation Requests	86		57
		Food Services	82		
		Infection Control	85		
		Intake Process (Reception)	NA		NA
		Intrasystem Transfers	83		84
Medical Area and Inmate Housing		94			
Medication Administration		75		74	
OBIS/Health Record Content		67		65	
Pharmacy Services		100			
Quality Management	67				
Area of Review			Area Score		
<b>MENTAL HEALTH</b>	Mental Health Systems		93		
	Access to Mental Health Services		81		
	Inpatient Mental Health Services		NA		
	Intellectual Functioning		100		
	Outpatient Mental Health Services		96		
	Psychiatric Restraint		100		
	Psychotropic Medication Practices		98		
	Reception/Intake Process		NA		
	<b>Self-Injury/Suicide Prevention</b>	23-hour MH Observation		NA	
		SOS Status		83	
		Other Self-injury Prevention Status		NA	
	Sexual Offender Services		89		
	Special Housing		100		
	Use-of-Force		38		

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

# PHYSICAL HEALTH FINDINGS

## SYSTEMS

<b>CONSULTATION REQUESTS</b>	<b>Systems Score</b> <b>86</b>
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Finding(s)	Suggested Corrective Action(s)
<p><b>PH-1: The consultation log was not consistently reviewed and signed by the responsible staff on a monthly basis.</b></p>	<p>Ensure that responsible parties review and sign each month's consultation log.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>

<b>EPISODIC CARE</b>	<b>Systems Score</b> <b>80</b>
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Finding(s)	Suggested Corrective Action(s)
<p><b>PH-2: Extended waiting times were noted for inmates who reported for sick call. Based on discussions with staff follow-up appointments were not made for inmates who were not seen.</b></p>	<p>Provide in-service training to relevant staff on the importance of following up on patients not seen at sick call to ensure that their physical health needs are adequately addressed.</p> <p>Develop and implement guidelines for rescheduling a patient if necessary to prevent excessive wait times.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>
<p><b>PH-3: There was no tracking system for inmates with sick call encounters that documented chief complaint/diagnosis, referral, and disposition.</b></p>	<p>Maintain a sick call log or other suitable method for tracking encounters that includes chief complaint/diagnosis, referral, and disposition.</p> <p>Include copies of the completed logs in the CMA CAP closure file.</p>
<p><b>PH-4: There was no weekly supervisory review of sick call or emergency records for accuracy, treatment modality, medication distribution, documentation, education, completeness, and other clinically indicated actions.</b></p>	<p>Review three records from sick call encounters and two records from emergency encounters per week for complete and appropriate care.</p> <p>Provide documentation of reviews in the CMA CAP assessment closure file.</p>

<b>FOOD SERVICES</b>		<b>Systems Score</b>
		<b>82</b>
<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>	
<b>PH-5: Written procedures were not available in the food service facility that addressed actions to be taken in a suspected food-borne illness outbreak.</b>	<p>Provide in-service training to relevant personnel on management of suspected food-borne illness. DC procedure 401.003 should be reviewed and a copy along with any additional procedures and or notification checklists should be kept in the food service area for immediate reference.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>	
<b>PH-6: Hand wash sinks did not all have an adequate supply of paper towels or hand soap readily available, nor were all workers knowledgeable of appropriate hand washing techniques.</b>	<p>In-service training should be provided to all food service workers on hand washing techniques. Hand wash sinks should be checked frequently for adequate supplies and restocked promptly when needed.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>	

**Discussion:** Signs of insects were found, however appropriate actions had already been taken to address this issue. Health care staff should either provide corrective action monitoring or review the outcome of corrective action taken by the institution.

<b>INFECTION CONTROL SYSTEMS</b>		<b>Systems Score</b>
		<b>85</b>
<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>	
<b>PH-7: The infection control coordinator did not receive or review monthly reports related to the overall sanitation of the medical facility or weekly inspection reports related to the sanitation and cleanliness of the dining facility.</b>	<p>Include facility inspection reports as part of the infection control program. At a minimum ensure that medical staff maintains copies of reports and address issues that could have negative health implications.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>	
<b>PH-8: The infection control coordinator had not submitted required monthly infection data to the OHS central office infection control coordinator.</b>	<p>Relevant staff should review reporting requirements and ensure necessary action to maintain compliance.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>	

<b>INTRASYSTEM TRANSFERS</b>	<b>Systems Score</b> <b>83</b>
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Finding(s)	Suggested Corrective Action(s)
<p><b>PH-9: Confidentiality of medical records was not always maintained. During the review, security provided at least one transfer medical record to medical staff that was not in any type of concealed bag. The medical records that were received came in plastic bags with tape that could be removed and reapplied without evidence of tampering. Medical staff indicated that medical records are sometimes received in clear zip lock bags, which can be opened and closed without leaving any evidence of tampering. There was also a lack of privacy in the area in which inmate were processed in. This can discourage inmates from discussing their medical concerns with medical staff.</b></p>	<p>Action must be taken to ensure that all health information is protected according to the Health Insurance Portability and Accountability Act (HIPAA). Provide in-service training to relevant staff on TI 15.12.03. Complete incident reports for noncompliance.</p> <p>Provide an area that will allow inmates to discuss their medical concerns confidentially with health care personnel.</p> <p>Place corrective action documentation in the CMA CAP assessment closure file.</p>

<b>MEDICAL AREA AND INMATE HOUSING</b>	<b>Systems Score</b> <b>94</b>
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Finding(s)	Suggested Corrective Action(s)
<p><b>PH-10: OTC medications on hand did not always match the inventory log.</b></p>	<p>Perform a physical inventory of all OTC medications to ensure that inventories are correct. Ensure that inventory logs are maintained accurately.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>
<p><b>PH-11: Procedures to access medical and dental sick call and mental health services were posted only in English.</b></p>	<p>Post all access procedures and pill line schedules both in English and Spanish.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>

**Discussion:** It was noted that the recreation yard had a nonfunctioning urinal.

<b>MEDICATION ADMINISTRATION</b>	<b>Systems Score</b> <b>75</b>
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Finding(s)	Suggested Corrective Action(s)
<p><b>PH-12: Medical personnel dispensing medication were on the opposite side of the window from inmates and did not have a clear view of inmates taking medications. Oral cavity checks were not conducted to ensure that the inmate ingests the medication. Most</b></p>	<p>Provide in-service training to relevant staff on the medication administration protocols.</p> <p>Review DC procedure 403.007.</p> <p>Routinely monitor medication administration to</p>

<b>MEDICATION ADMINISTRATION</b>		<b>Systems Score</b>
		<b>75</b>
<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>	
inmates walked away from the pill line window before swallowing their medication. Security staff was not always present during medication administration.	<p>ensure compliance.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>	
<b>PH-13: Medication was being placed in cups prior to inmates reporting to the pill line.</b>	<p>Medications should not be placed in cups until immediately prior to individual administration.</p> <p>See PH-12 suggested corrective action.</p>	

<b>MORTALITY REVIEW</b>		<b>Systems Score</b>
		<b>88</b>
<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>	
<b>PH-14: No one was assigned as the mortality review coordinator. The mortality review tracking logs that were reviewed appeared in order, although most were not made available for review.</b>	<p>Coordination of the mortality review process should be assigned in writing to one individual.</p> <p>Mortality records and documentation should be organized to allow prompt retrieval of information.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>	

<b>OBIS/HEALTH RECORD</b>		<b>Systems Score</b>
		<b>67</b>
<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>	
<b>PH-15: The health records were not always arranged in accordance with OHS policy. Some problem lists and most chronic illness clinic forms were not filed appropriately.</b>	<p>Provide in-service training to relevant staff on medical record organization in accordance with technical instruction 15.12.03, dated 4/9/03.</p> <p>Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.</p>	
<b>PH-16: Encounters were not entered into the OBIS data system promptly.</b>	<p>Ensure that all encounters are entered into OBIS promptly. Assign other staff to assist if needed.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>	
<b>PH-17: Medical information in OBIS and the medical record did not always match or was missing from one or the other.</b>	<p>See PH-15 suggested corrective action.</p> <p>Every intake record should be screened to ensure that it has the most up-to-date information in the</p>	

<b>OBIS/HEALTH RECORD</b>		<b>Systems Score</b> <b>67</b>
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Finding(s)	Suggested Corrective Action(s)
	current volume. Emphasis should be placed on the verification of data.

**Discussion:** The OBIS/health record content review resulted in a score of 65. It was determined that findings were also system related and therefore are included in the above section. The HIS recently resigned her position and it was still vacant. Also see PH-9 for issue regarding HIPAA noncompliance.

<b>PREVENTATIVE CARE SYSTEMS</b>		<b>Systems Score</b> <b>67</b>
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Finding(s)	Suggested Corrective Action(s)
<b>PH-18: There was no up-to-date, complete log of all inmates who received or who are scheduled for annual or biennial physicals.</b>	Develop a computer or hand written log, which includes all inmates assigned to the institution and reflects information required to determine those who received or who are scheduled for annual or biennial physicals.  Place documentation in the CMA CAP assessment closure file.

<b>QUALITY MANAGEMENT</b>		<b>Systems Score</b> <b>67</b>
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Finding(s)	Suggested Corrective Action(s)
<b>PH-19: Required reports were not always forwarded to OHS as required.</b>	See PH-8 for suggested corrective action(s).
<b>PH-20: There were no descriptive minutes of the various required reports. They did not identify patterns, concerns or opportunities for improvement.</b>	Minutes need to include discussion and analysis of data. They should include outstanding reports and identify opportunities for improvement.  Monitor for compliance and include documentation in the CMA CAP assessment closure file.

## CLINICAL

Records Reviewed <b>4</b>	<b>EMERGENCY CARE</b>	Record Review Score <b>71</b>
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Finding(s)	Suggested Corrective Action(s)
<p><b>PH-21: One record lacked documentation of an encounter even though an ER log entry was made. One ER log entry indicated chest pain but the patient was admitted to the infirmary for abdominal pain. One record lacked documentation of EMS transport for an emergency that was transferred to Larkin Hospital.</b></p>	<p>Provide in-service training to relevant personnel on emergency care protocols and documentation requirements.</p> <p>Review five emergency care records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.</p>

Records Reviewed <b>8</b>	<b>EPISODIC CARE FOLLOW-UP</b>	Record Review Score <b>93</b>
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Finding(s)	Suggested Corrective Action(s)
<p><b>PH-22: Clinician orders taken by nursing staff were not always implemented in a timely manner and there were no evaluations of patient response to treatments.</b></p>	<p>Provide in-service training to relevant personnel on follow-up care protocols and documentation requirements.</p> <p>Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.</p>

Records Reviewed <b>7</b>	<b>INFIRMARY CARE</b>	Record Review Score <b>84</b>
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Finding(s)	Suggested Corrective Action(s)
<p><b>PH-23: Nursing admission notes lacked documentation of an orientation to the infirmary. Discharge summaries were not always complete or dated.</b></p>	<p>Provide in-service training to relevant personnel on infirmary care documentation requirements.</p> <p>Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.</p>

Records Reviewed <b>5</b>	<b>ASTHMA/PULMONARY</b>	Record Review Score <b>82</b>
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Finding(s)	Suggested Corrective Action(s)
<p><b>PH-24: Some records lacked DC4-710F, Chronic Illness Clinic form documenting the initial clinic visit physical examination and baseline diagnostic data.</b></p>	<p>Provide in-service training to relevant staff on appropriate chronic illness clinic protocols and documentation requirements. Review OHS Technical Instruction 15.03.05</p> <p>Review five records per month for compliance. Continue until corrective action is affirmed</p>

Records Reviewed <b>5</b>	<b>ASTHMA/PULMONARY</b>	Record Review Score <b>82</b>
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Finding(s)	Suggested Corrective Action(s)
	through the CMA CAP assessment.
<b>PH-25: Histories were not always sufficient for the indicated condition and the disease severity was not always appropriately categorized.</b>	See PH-24 suggested corrective action(s).

Records Reviewed <b>5</b>	<b>DIABETES</b>	Record Review Score <b>91</b>
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Finding(s)	Suggested Corrective Action(s)
<b>PH-26: Histories were not always sufficient for the indicated condition and the disease severity was not always appropriately categorized.</b>	See PH-24 suggested corrective action(s).

Records Reviewed <b>7</b>	<b>GENERAL MEDICINE</b>	Record Review Score <b>95</b>
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Finding(s)	Suggested Corrective Action(s)
<b>PH-27: Some medical records of patients diagnosed with liver disease lacked appropriate baseline or follow-up laboratory studies.</b>	See PH-24 suggested corrective action(s).

Records Reviewed <b>4</b>	<b>SEIZURE CLINIC</b>	Record Review Score <b>84</b>
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Finding(s)	Suggested Corrective Action(s)
<b>PH-28: Documentation did not reflect that influenza vaccine was always offered annually or that refusals were documented. Documentation also did not indicate that patients were considered for tapered medications when indicated.</b>	See PH-24 suggested corrective action(s).
<b>PH-29: Some medical records lacked a diagnosis on the problem list. Records also lacked a neurological consultation or a written explanation as to why one was not indicated.</b>	See PH-24 suggested corrective action(s).

Records Reviewed	<b>TUBERCULOSIS/INH THERAPY CLINIC</b>	Record Review Score
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Finding(s)	Suggested Corrective Action(s)
PH-30: There was not always a disease related diagnosis identified on the problem list.	See PH-24 suggested corrective action(s).
PH-33: Documentation did not indicate that pneumococcal and influenza vaccines were always offered when indicated or provide signed refusals.	See PH-24 suggested corrective action(s).
PH-34: Anti-tuberculosis drugs were not given under directly observed preventive therapy.	See PH-24 suggested corrective action(s).
PH-35: INH treatment was given to a patient based upon another's lab results.	See PH-24 suggested corrective action(s).  Patient should be informed of this error and it should be documented in the medical record.  This should be brought before the QM committee to investigate and provide recommendation to prevent future mishaps of this nature.

Records Reviewed	CONSULTATION REQUESTS	Record Review Score
7		57
Finding(s)	Suggested Corrective Action(s)	
PH-36: Some consultations were completed untimely. Some consultation forms lacked adequate information including the signature and date by the physician.	Provide in-service training to relevant staff on consultation documentation requirements.  Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.	
PH-37: Some records lacked a progress note from an advanced level provider documenting the consultant's findings and ongoing treatment plans. Documentation also lacked evidence that all inmates were informed of their results.	See PH-36 suggested corrective action(s)	

Records Reviewed	INTRASYSTEM TRANSFERS	Record Review Score
6		84
Finding(s)	Suggested Corrective Action(s)	
PH-38: The arrival summary did not always	Provide in-service training to relevant staff on	

Records Reviewed	INTRASYSTEM TRANSFERS	Record Review Score
6		84
Finding(s)	Suggested Corrective Action(s)	
include all key information and was not signed, dated or stamped.	<p>documentation requirements of intrasystem transfers.</p> <p>Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.</p>	

Records Reviewed	MEDICATION ADMINISTRATION	Record Review Score
7		74
Finding(s)	Suggested Corrective Action(s)	
PH-39: Medication orders in most records were not timed.	<p>Provide in-service training to relevant staff on documentation requirements for medication orders. Use of the most current form may help correct this finding.</p> <p>Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.</p>	

Records Reviewed	MORTALITY REVIEW	Record Review Score
9		92
Finding(s)	Suggested Corrective Action(s)	
PH-40: Documentation of clinical status was not always adequate.	<p>Relevant staff should review documentation requirements and ensure that adequate documentation is provided at all times.</p>	

Records Reviewed	PREVENTATIVE CARE	Record Review Score
7		82
Finding(s)	Suggested Corrective Action(s)	
PH-41: Some annual/biennial physicals lacked a digital rectal exam or a documented refusal.	<p>Provide in-service training to relevant staff on protocols and documentation requirements for annual/biennial appraisals.</p> <p>Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.</p>	
PH-42: Annual PPD testing or screening was not documented as required. Recording of completed PPD tests was inconsistently completed.	<p>See PH-41 suggested corrective action.</p>	

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

System Reviews

- Dental Services
- Pharmacy Services

Record Reviews

- Dental Services
- Hypertension Clinic
- Immunity Clinic
- Sick Call

**CONCLUSION**

Overall, staff at Dade Correctional Institution was professional and seemed knowledgeable regarding the process of providing care. The overall health care provided and the medical facility operations could benefit from an increased emphasis of supervisory review. Immediate attention must be given to the medical records section to ensure that medical documentation remains current. There was good cooperation and communication between the medical department and security.

## MENTAL HEALTH FINDINGS

### Survey Results

The mental health department at Dade Correctional Institution (DADCI) consisted of one psychiatrist, one senior psychologist, six behavioral health specialists (one position was vacant), and a nurse. The senior psychologist had been with the institution for approximately three months. A full range of outpatient mental health services was provided including individual and group treatment. Inmates requiring inpatient mental health services were not housed at this institution.

A number of strengths were noted in the delivery of mental health services at Dade Correctional Institution:

- Psychiatry, psychology, and support staff appeared skilled and caring.
- The psychiatrist effectively managed the psychotropic medication needs of the 400 psychiatric grade 3 (S3) inmates.
- Overall, clinical care was effective and well documented despite large caseloads that ranged between 67 and 147 S3 inmates per behavioral health specialist.
- A wide range of group treatment was available.

Records Reviewed:	<b>ACCESS TO MENTAL HEALTH SERVICES</b>	Area Score
14		81
Finding(s)	Suggested Corrective Action(s)	
<p><b>MH-1: Documentation of inmate requests was not consistent between the log and the records.</b></p> <p style="margin-left: 20px;">a. <b>The dates and times on the log did not consistently coincide with the records.</b></p> <p style="margin-left: 20px;">b. <b>The pink copies of the inmate request forms were not consistently filed in the records.</b></p> <p style="margin-left: 20px;">c. <b>An incidental note indicating the date the request was received and answered was not consistently documented (DC4-642) in each applicable record. (See discussion below).</b></p>	<p>Ensure the documentation is correct. Review requirements with all staff that have a role in documenting inmate requests on the log and in the records.</p> <p>Monitor a minimum of five requests per month to ensure accuracy between and on the log and records. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>	
<p><b>MH-2: The mental health program description was not posted in the inmate housing areas.</b></p>	<p>Post a written description of mental health services in each housing area.</p>	

### Discussion:

**MH-1:** Inaccurate or incorrect documentation of inmate requests for mental health services has the potential to negatively impact inmate access to mental health care.

Records Reviewed:	<b>OUTPATIENT MENTAL HEALTH SERVICES</b>	Area Score
15		96

Finding(s)	Suggested Corrective Action(s)
MH-3: Entries in the records were not consistently stamped or dated.	Review relevant documentation requirements with all applicable staff.  Monitor a minimum of five outpatient records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Records Reviewed:	<b>PSYCHOTROPIC MEDICATION PRACTICES</b>	Area Score
6		98

Finding(s)	Suggested Corrective Action(s)
MH-4: No oral cavity check was conducted at the medication administration line.	Post a staff member outside the medication window to observe that inmates are swallowing medications.
MH-5: A tracking system was not maintained for emergency treatment orders.	Create a tracking system for emergency treatment orders.
MH-6: Medications prescribed as "HS" were administered too early in the evening.	Physicians are required to write orders specifying the actual time of administration.  Medical, mental health, administrative and security staff should meet to determine how institutional procedures can be changed to support the administration of medications prescribed for evening hours outside of pill line.  Monitor a minimum of five records, or all cases for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.

**Discussion:**

**MH-5:** The senior psychologist obtained copies of emergency treatment tracking systems from other institutions and began implementation of corrective action during the survey.

Records Reviewed:	<b>SELF-INJURY/SUICIDE PREVENTION</b>	Area Score
23-hr		

SOS	6		83
Other			

Finding(s)	Suggested Corrective Action(s)
<b>MH-7: The showerheads in two infirmary isolation cells were unsafe; cloth or other material could be pushed through the holes drilled in them. The showerheads are not designed to breakaway under 40 lbs or more pressure.</b>	<p>Complete necessary repairs to ensure safety.</p> <p>If it is necessary to use these cells in the meantime, provide 1:1 continuous monitoring for suicide observation status (SOS) patients placed in these cells.</p>
<b>MH-8: Suicide isolation checklists were not consistently filed in the records. In two cases, the checklists were never located.</b>	<p>Locate the missing documentation.</p> <p>Monitor a minimum of five records, or all cases each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<b>MH-9: Documentation of infirmary admissions was not consistent between the log and the records. The dates on the log did not match the admission or discharge dates in the infirmary records; the dates were usually off by one or two days.</b>	<p>Ensure the documentation is correct. Review requirements with all staff that have a role in documenting infirmary admissions on the log and in the records.</p> <p>Monitor a minimum of five records, or all cases per month to ensure accuracy between and on the log and records. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<b>MH-10: Some inmates had multiple infirmary jackets (records) while others had documentation of all infirmary admissions filed in one jacket.</b>	<p>Ensure consistency in the filing of infirmary admission packets. Consider filing all admissions for each inmate in one jacket.</p>
<b>MH-11: Confusion was evident among clinical, administrative and security staff regarding the use of the retrofitted cells in confinement (referred to as alternate medical cells). (See discussion below).</b>	<p>Provide clarification to all relevant staff.</p>

**Discussion:**

**MH-7:** The department’s regional mental health consultant had certified both cells within the past year.

**MH-11:** There were two cells in the confinement wing, which had been retrofitted for safe housing of inmates on suicide observation status (SOS). Certain staff believed the cells were currently available for mental health patients on SOS. Other staff indicated the cells were used for security purposes only. During the exit conference, the warden indicated the cells should be used for suicide isolation/mental health observation only if the infirmary isolation cells were fully occupied. The warden stated that 1:1 continuous observation of inmates in these cells was required.

Records Reviewed:	<b>SEX OFFENDER SERVICES</b>	Area Score
7		89

Finding(s)	Suggested Corrective Action(s)
MH-12: The sex offender screenings were not consistently found in the records reviewed.	Review requirements with relevant staff.  Monitor a minimum of five records a month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Records Reviewed:	<b>USE OF FORCE</b>	Area Score
7		38

Finding(s)	Suggested Corrective Action(s)
MH-13: There was inconsistency between the Use of Force log and the corresponding documentation in the record of medical responsibilities post-use of force. The post-use of force physical examination was missing in the majority of the records reviewed.	Ensure the documentation of health care responsibilities post-use of force is correct. Review requirements with all staff that have a role in documenting use of force on the log and in the records.  Monitor a minimum of five records per month to ensure accuracy between and on the log and records. Continue monitoring until closure is affirmed through the CMA CAP assessment.

**Discussion:**

**MH-13:** Medical and mental health staff have responsibilities post use of force. Medical staff is required to provide a post-use of force physical examination. Very recent changes to standards in this area also require physical health staff to complete a written referral to mental health for S2/S3 inmates receiving the post-use of force physical examination. Mental health responsibilities include interviewing all referred inmates by the next working day, assessing recent changes in an inmate’s condition, and providing indicated follow-up care. If force was used to provide medical care such as forced medication or use of psychiatric restraint, a physician’s order must be present in the record.

The following areas of review resulted in no significant problems.

- Intellectual Functioning
- Outpatient Services
- Special Housing

**CONCLUSION**

Despite very large caseloads, the mental health department was providing appropriate standards of clinical care overall. The findings that are noted for this survey fall mainly into the category of documentation and systems issues. The staff is skilled and caring. They work well as a team.

## **DEPARTMENT FINDINGS**

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

### **PHYSICAL HEALTH**

:	<b>INSERT NAME OF INSTRUMENT HERE IN CAPS</b>
	<b>Finding(s)</b>
	<b>Dept-1: There was no evidence of a policy that prohibits the medical staff from participating in gathering forensic information and participating in body cavity searches for forensic purposes.</b>
	<b>Dept-2: Special housing inmates were not offered one hour of exercise per day outside the cell five days per week.</b>

### **MENTAL HEALTH**

:	<b>PSYCHOTROPIC MEDICATION PRACTICES</b>
	<b>Finding(s)</b>
	<b>Dept-3: Appointment intervals for psychiatric follow-up were greater than 30 days, as required in TI 15.05.19.</b>

## SURVEY PROCESS

The goals of every survey performed by the CMA are

- (1) to determine if the physical, dental and mental health care provided to inmates in all state public and privately operated correctional institutions is consistent with state and federal law, conforms to standards developed by the CMA, is consistent with the standards of care generally accepted in the professional health care community at large;
- (2) to promote ongoing improvement in the correctional system of health services; and,
- (3) to assist the Department of Corrections in identifying mechanisms to provide cost effective health care to inmates.

To achieve these goals, specific criteria designed to evaluate inmate care and treatment in terms of effectiveness and fulfillment of statutory responsibility are measured. They include determining:

- If inmates have adequate access to medical and dental health screening and evaluation and to ongoing preventative and primary health care.
- If inmates receive adequate and appropriate mental health screening, evaluation and classification.
- If inmates receive complete and timely orientation on how to access physical, dental and mental health services.
- If inmates have adequate access to medical and dental treatment that results in the remission of symptoms or in improved functioning.
- If inmates receive adequate mental health treatment that results in or is consistent with the remission of symptoms, improved functioning relative to their current environment, and reintegration into the general prison population as appropriate.
- If inmates receive and benefit from safe and effective medication, laboratory, radiology, and dental practices and have access to timely and appropriate referral and consultation services.
- If psychotropic medication practices are safe and effective.
- If inmates are free from the inappropriate use of restrictive control procedures.
- If sufficient documentation exists to provide a clear picture of the inmate's care and treatment.
- If there are sufficient numbers of qualified staff to provide adequate treatment.

To meet these objectives, the CMA contracts with a variety of licensed community and public health care practitioners, such as physicians, psychiatrists, dentists, nurses, psychologists and social workers. The survey process includes a review of the physical, dental and mental health systems; specifically, the existence and application of written policies and procedures, staff credentials, staff training, confinement practices, and a myriad of additional administrative issues. Individual case reviews are also conducted. The cases selected for review are representative of inmates who are receiving mental and/or physical health services (or who are eligible to receive such services).

Conclusions drawn by members of the survey team are based on several methods of evidence collection:

- ◆ Physical evidence – direct observation by members of the survey team (tours and observation of evaluation/treatment encounters)
- ◆ Testimonial evidence – obtained through staff and inmate interviews (and substantiated through investigation)
- ◆ Documentary evidence – obtained through reviews of medical/dental records, service/treatment plans, schedules, logs, administrative reports, physician orders, medication administration reports, meeting minutes, training records, etc)
- ◆ Analytical evidence – developed by comparative and deductive analysis from several pieces of evidence gathered by the surveyor

Administrative (system) reviews generally measure whether the institution has policies in place to guide and direct responsible institutional personnel in the performance of their duties and if those policies are being followed. Clinical reviews of selected inmate medical, dental and mental health records measure if the care provided to inmates meets the statutorily mandated standard. Encounters of an episodic nature, such as sick call, an emergency, an infirmary admission, restraints or a suicide episode, as well as encounters related to a long-term chronic illness or on-going mental health treatment are also reviewed. Efforts are also made to confirm that administrative documentation, i.e., logs, consultation requests, medication administration reports, etc. coincides with clinical documentation.

Findings identified as a result of the survey may arise from a single event or from a trend of similar events. They may also involve past or present events that either had or may have the potential of compromising inmate health care. All findings identified in the body of the report under the physical or mental health sections require corrective action by institutional staff. Findings identified in the department section require corrective action by central office security or program area staff.