

CORRECTIONAL MEDICAL AUTHORITY (CMA)
PHYSICAL & MENTAL HEALTH SURVEY
OF
GADSDEN CORRECTIONAL INSTITUTION

in
Quincy, Florida

October 26 - 28, 1999

INSTITUTIONAL STATISTICS PROVIDED CMA ON May 6, 1999				
Population	Custody	Type	Maximum Capacity	Current Occupied Beds
Adult	Medium	Female	800	789

MEDICAL GRADES				
I	II	III	IV	Impaired
471	241	70	18	5

"S" GRADES				
I	II	III	IV	Impaired
763	39	0	0	0

Physical Health Executive Summary

All conclusions were based on a sample review of medical records; interviews with offenders, health care providers and security staff; and a physical inspection of the institution.

Gadsden Correctional Institution (GADCI) was constructed in 1995. The Corrections Corporation of America acquired the United States Corrections Corporation, including the contract with the Florida Department of Corrections (DC) for the operation of Gadsden Correctional Institution, in April 1998. The institution provides minimum and medium custody levels for a maximum capacity of 800 adult female offenders. According to the pre-survey questionnaire (PSQ) prepared by the institution on October 14, 1999, the health care unit at this institution was serving a total of 789 offenders.

The Correctional Medical Authority (CMA) previously surveyed the physical health system of this institution on August 13 – 15, 1996. On May 20, 1997, CMA staff returned to assess corrective actions taken on 33 citations (18 Level I citations and 15 Level II citations) identified in the survey report. The closure files reviewed contained documentation verifying correction on 26 citations and partial correction on four citations selected for review.

In the previous survey the citations were categorized under clinical management/documentation, and administrative. Under clinical management/documentation there was inappropriate assessment, treatment and follow-up care. Additionally, there was insufficient or missing documentation. Under administrative there were deficiencies in maintenance of logs, storage of controlled medications, and infection control practices involving dental staff. Additionally inservice training programs for medical and security staff were not conducted as required and there were no regular scheduled meeting with the CHO and the warden.

This report contains two Level I citations, eight Level II citations and four additional issues with some similar to the 1996 survey findings.

Physical Health Strengths

1. All immunodeficiency records reviewed indicated that assessment; treatment and follow-up care was appropriate.

Physical Health Citations - Level I

Access

1. There had been 66 disciplinary reports (DRs) written by health care staff between August 28 – October 21, 1999 for medical emergencies declared by offenders.

Clinical Management/Documentation

2. One (17%) mortality record reviewed indicated a delay in treatment/care and all (100%) records lacked some of the following: death certificate, medical examiner's report, physician summaries, physician transfer and hospital notes.

Physical Health Citations - Level II

Clinical Management/Documentation

3. Four (66%) sick call, four (66%) emergency care, two (29%) infirmary, eight (100%) asthma, and two (40%) records selected for general record review indicated that entries were either not signature stamped and/or signed. Additionally, one (17%) mortality record indicated that entries were not signature stamped and/or signed.
4. Five (63%) cardiovascular, two (40%) diabetes, two (40%) seizure and three (60%) INH records lacked necessary documentation regarding health education, diet and medication compliance, and diagnostic tests. Additionally, one record selected for general record review lacked necessary documentation.
5. Four (80%) diabetes, and three (60%) seizure records indicated inappropriate clinical management. Additionally, one (20%) record selected for general record review indicated inappropriate clinical management.
6. Six (40%) dental records indicated delays in treatment, inappropriate clinical management, or missing documentation.

Administrative

7. Documentation indicated that meetings between the warden and the CHO had not occurred on a quarterly basis.
8. Two health care providers had expired CPR cards on file, and there was no documentation available for review to indicate that health care providers had received adequate health related training during the past year and/or annual inservice training.
9. There was no documentation that a disaster drill was conducted and/or critiqued.

10. Emergency and infirmary logs were inconsistently maintained.

Physical Health Additional Issues Noted

11. The lavatory for the confinement area had no hot water available.
12. A review of the confinement area first aid kit inspection tags/logs indicated that monthly inspections were inconsistent.
13. The temperature log for the refrigerator was inconsistently maintained.
14. Radiographs were taken and developed in the same room where dental instruments were sterilized.

Mental Health Executive Summary

All conclusions were based on a sample review of medical records; interviews with offenders, health care providers and security staff; and a physical inspection of the institution. This was the second CMA mental health survey of Gadsden Correctional Institution (GADCI). The first survey took place in August 1996.

The institution, constructed in 1995, is a minimum to medium custody facility housing psychological grade S1 and S2 female offenders. At the time of the survey, GADCI housed 789 offenders, 39 classified as psychological grade 2. The institution operates a substance abuse treatment program (Tier IV) in which 152 offenders are enrolled. Twenty-two offenders were in disciplinary or administrative confinement at the time of the survey.

GADCI is one of five institutions housing female offenders and the only privately operated female offender facility in the state. At the time of the survey, the institution was operated by Corrections Corporation of America (CCA) under contract with the State Privatization Commission. CCA assumed operations from the previous vendor, U.S. Corrections Corporation, in April 1998.

Despite the change of management, the findings from this survey are similar to the 1996 survey findings. Of the ten citations identified, eight were deficiencies identified by surveyors three years ago. Institutional corrective actions have not been sustained. Surveyors had serious concerns with the quality of the psychiatric evaluations, the manner in which services were provided, the continued use of a religious based values approach, the premature removal of offenders from the mental health caseload, the lack of therapeutic groups, poor documentation of suicide events, and documentation that was inappropriately brief and not individualized.

Survey findings indicate a number of areas requiring serious, expedient attention and improvement.

Mental Health Strengths

1. There was documentation of timely orientation to mental health services in all records reviewed.

Mental Health Citations - Level I

Access

1. Disciplinary reports were issued for declared emergencies determined to be false and not true emergencies.

Clinical Management/Documentation

2. A psychological specialist continued to use a religious-based values approach in counseling, which is not appropriate for all offenders and is ineffective counseling.
3. Documentation of psychiatric evaluations were frequently brief, leaving diagnoses unsupported, and without clear rationale. Diagnoses did not always reflect identified symptoms.
4. Often psychiatric symptoms were documented as manipulation in spite of long standing mental health histories.

5. Four suicide incidents were reviewed. In these records there was inadequate documentation of suicidal attempts/threats, making it impossible to discern the clinical rationale for the assessment that the event was manipulative.

Mental Health Citations - Level II

Clinical Management/Documentation

6. The full complement of required therapeutic groups was not offered, though there were offender waiting lists.
7. Mental health staff did not respond appropriately to requests for services.
8. Service plans were not individualized, did not specify objectives or interventions, and did not incorporate significant events in the offender's life.
9. Offenders who refused services were prematurely reassigned lower psychological grades.

Mental Health Additional Issues Noted

10. There was limited documentation of substance abuse referrals and treatment status.