CORRECTIONAL MEDICAL AUTHORITY

PHYSICAL & MENTAL HEALTH SURVEY

of

GADSDEN CORRECTIONAL FACILITY

in

Quincy, Florida

on

September 3-6, 2002

CMA Physical Health Team Leader:
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Physical Health Team Members:
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DEMOGRAPHICS

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

INSTITUTIONAL INFORMATION			
Population	**Type**	**Custody Level**	**Medical Level**
Adult	**Female**	**Medium**	**3**

Institutional Potential/Actual Workload

Main Unit Capacity	896	Current Main Unit Census	863
Annex Capacity	N/A	Current Annex Census	N/A
Satellite Unit(s) Capacity	N/A	Current Satellite(s) Census	N/A
Total Capacity	896	Total Current Census	863

Inmates Assigned to Medical/Mental Health Grades

Medical Grade	*1*	*2*	*3*	*4*	*Impaired*	
	271	210	373	19	0	
Mental Health Grade (S-Grade)	*Mental Health Outpatient*			*MH Inpatient*		
	1	*2*	*3*	*4*	*5*	*Impaired*
	774	89	0	0	0	3

Inmates Assigned to Special Housing Status

Confinement/ Close Management	*DC*	*AC*	*PM*	*CM3*	*CM2*	*CM1*
	15	8	2	N/A	N/A	N/A

OVERVIEW

Gadsden Correctional Facility (GADCF) was the first privately owned facility in Florida to house state inmates under contract with the Department of Corrections. The facility, operated by Corrections Corporation of America under contract with the Correctional Privatization Commission, was established in 1995 to house adult female offenders. The facility houses minimum and medium custody, psychological grade 1 and 2, and all medical grade inmates. Academic, vocational, substance abuse, and self-betterment programs are offered at the facility.

Physical Health Summary
A thorough review of the physical health-related systems in place at the institution was conducted, including the physical plant, administrative processes, and the provision and documentation of care. The review revealed several areas of concern. Two of the chronic illness clinics needed improvement in both documentation and continuity of care. Other areas of concern included infection control, infirmary care, medication administration, quality management, mortality review, and preventative care.

Mental Health Summary
The current mental health program demonstrated many strengths. The clinical documentation provided by the mental health staff was thorough and substantive. The psychologist and psychological specialist were experienced and innovative and had developed relaxation groups as a supplement to group therapy activities. Inmates interviewed found the program very supportive and experienced no barriers to accessing services. Commendably, the mental health staff had adopted one uniform standard of care for suicidal and self-injurious inmates. In this regard, the practice of designated alternate housing had been discontinued, as had the use of 23-hour infirmary observation as an alternative to suicide observation status for self-injurious patients. Inmates on suicide observation status were observed constantly and observations documented at least every 15 minutes. Finally, clinical and correctional staff interviewed were well informed about the mental health program.

With the exception of the systems and documentation findings noted below, which require the attention of administrative, medical and mental health staff to correct, the overall mental health program demonstrated improvement in clinical management since the last survey of GADCF in October 1999.

Supplemental Report
There were no supplemental physical health or mental health findings requiring intervention by the department's Office of Health Services.

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			Numeric Score	
			Systems	Records
PHYSICAL HEALTH	Episodic Care	Episodic Care Systems	92	
		Emergency Care		100
		Follow-Up Care		100
		Infirmary Care		93
		Sick Call		98
	Chronic Care	Asthma Clinic		92
		Diabetes Clinic		99
		General Medicine Clinic		97
		Hypertension Clinic		98
		Immunity Clinic		91
		Seizure Clinic		94
		TB/INH Clinic		93
	Preventative Care		100	87
	Dental Care		94	97
	Mortality Review		100	76
	Other	Administrative	90	
		Consultation Requests	100	95
		Infection Control	91	
		Intake (Reception) Process		
		Intrasystem Transfers	100	86
		Medical Area and Inmate Housing	97	
		Medication Administration	94	87
		OBIS-Health Record Content	100	83
		Pharmacy		
		Quality Management	69	
MENTAL HEALTH		Access to Mental Health Services	89	98
		Inpatient Mental Health Services		
		Intellectual Functioning	100	100
		Psychiatric Restraints	100	
		Psychotropic Medication Practices		
		Outpatient Mental Health Services	92	89
	Self-Injury/Suicide Prevention	23-hour Observation	88	
		SOS Status		85
		Other Self-injury Prevention Status		
		Sexual Offender Services	83	
		Special Housing	100	90

PHYSICAL HEALTH FINDINGS

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

EPISODIC CARE

:	EPISODIC CARE SYSTEM REVIEW	Systems Score 92
Finding(s)	**Suggested Corrective Action(s)**	
PH-1: The sick Call Log was incomplete lacking entries for diagnosis and disposition.	Provide in-service training to health care staff regarding the importance of completing the Sick Call Log. Monitor log daily until closure is affirmed through the CMA Corrective Action Plan (CAP) assessment.	

Records Reviewed: 7	INFIRMARY CARE RECORD REVIEW	Records Score 93
Finding(s)	**Suggested Corrective Action(s)**	
PH-2: Four records lacked documentation of phone rounds on the weekends.	Provide in-service training to health care staff regarding importance of documenting rounds by phone on weekends. Monitor five infirmary records per month until closure is affirmed through the CMA CAP assessment.	

Records Reviewed: 6	IMMUNITY CLINIC RECORD REVIEW	Records Score 91
Finding(s)	**Suggested Corrective Action(s)**	
PH-3: Two records lacked evidence of confirmatory Western Blot testing.	Provide in-service training on patient care components required during immunity clinic encounters. Monitor five immunity records per month for confirmatory testing until closure is affirmed through the CMA CAP assessment.	

Records Reviewed: 6	IMMUNITY CLINIC RECORD REVIEW	Records Score 91

Finding(s)	Suggested Corrective Action(s)
PH-4: One record reviewed lacked evidence of pre- and post- counseling.	Provide in-service to health care staff regarding the requirement of pre- and post -counseling. Monitor five immunity clinic records monthly until closure is affirmed through the CMA CAP assessment.

Records Reviewed: 10	SEIZURE CLINIC RECORD REVIEW	Records Score 94

Finding(s)	Suggested Corrective Action(s)
PH-5: Six records lacked evidence of type of seizure, two records had conflicting type of seizure documented, and two records did not document last episode.	Provide in-service to clinical staff regarding documentation of frequency and type of seizure. Monitor five seizure clinic records monthly for documentation of type and frequency of seizure until closure is affirmed through the CMA CAP assessment.

Records Reviewed: 6	Tuberculosis (TB)/Isoniacid (INH) CLINIC RECORD REVIEW	Records Score 93

Finding(s)	Suggested Corrective Action(s)
PH-6: Three records reviewed lacked evidence that the physical examination conducted upon clinic enrollment focused on the upper respiratory tract.	Provide inservice for medical staff with reference to the focus of assessment of the upper respiratory tract during the enrollment into the clinic. Monitor five TB/INH records monthly until closure is affirmed through the CMA CAP assessment.
PH-7: Two record lacked evidence that pneumococcal vaccine was offered or a refusal obtained.	Provide in-service to health care staff regarding the importance of documentation of the pneumococcal vaccine being offered or obtaining a signed refusal. Monitor five TB/INH records monthly for documentation of the vaccine offered or a signed refusal until closure is affirmed through the CMA CAP assessment.

PREVENTATIVE CARE

Records Reviewed: 5	PREVENTATIVE CARE	Systems Score 100	Records Score 86

Finding(s)	Suggested Corrective Action(s)
PH-8: Four records lacked documentation of vital signs.	Provide in-service training to health care staff regarding documentation of vital signs. Monitor five annual appraisals per month for vital signs until closure is affirmed through the CMA CAP assessment.

DENTAL CARE

Records Reviewed: 10	DENTAL SERVICES	Systems Score 94	Records Score 97

Finding(s)	Suggested Corrective Action(s)
PH-9: No evidence that posters and/or plaques for preventative care displayed in the dental area.	Provide preventative care education through posters/plaques, or printed material in the dental clinic.

Discussion:
The routine treatment wait list showed an eleven-month waiting period. The dental staff consisted of one dentist and one dental hygienist. The dental hygienist functioned as a clerk and dental assistant. Staffing may need to be reviewed and revised to adequately serve the needs of this population. The typical staffing at a similar institutional dental clinic is: one dentist, two dental assistants and one clerk.

MORTALITY REVIEW

Records Reviewed: 10	MORTALITY REVIEW	Systems Score 100	Records Score 76

Finding(s)	Suggested Corrective Action(s)
PH-10: Three records revealed failure to recognize and address critical clues preceding each inmate's death. These situations included laboratory studies, emergency care assessments and follow-up referrals.	Provide in-service training to health care staff regarding appropriate assessment, treatment and follow-up especially as it relates to presenting conditions. Internally monitor and report results to the Quality Management Program regarding mortality events.
PH-11: Two records revealed that staff failed to enact timely and appropriate preventive measures in response to critical laboratory values and ER events. Care lacked adequate	Provide in-service training to health care staff regarding appropriate treatment and follow-up especially as it relates to presenting conditions. Internally monitor and report results to the

Records Reviewed: 10	MORTALITY REVIEW	Systems Score 100	Records Score 76

Finding(s)	Suggested Corrective Action(s)
treatment of the presenting problems.	Quality Management Program regarding mortality events.

Discussion:
One record reviewed revealed that the inmate was admitted to Lowell CI on November 9, 2000 and was diagnosed with Hyperthyroidism. The inmate was put on Inderal and placed on 60-day hold. However she was transferred to GADCF on November 29, 2000 where it was confirmed that she had Hyperthyroidism. Six weeks had elapsed without definitive treatment and the patient suddenly died in December. The team questions the transfer of the patient to GADCF without definitive treatment and plans for follow-up care after being diagnosed. .

OTHER

ADMINISTRATIVE	Systems Score 90

Finding(s)	Suggested Corrective Action(s)
PH-12: There was no policy available concerning inmates access to elective medical or surgical procedures unavailable through the facility.	Develop a policy addressing elective medical or surgical procedures and the protocol for the inmate to follow to access the procedures. Provide inservice to staff regarding the policy and procedure.
PH-13: There was no evidence of institutional statistics being gathered and evaluated quarterly for the improvement of the quality of care.	Provide in-service to pertinent staff to gather and review statistics quarterly for the purpose of improving care. Monitor the statistics monthly until closure is affirmed through the CMA CAP assessment.

INFECTION CONTROL	Systems Score 91

Finding(s)	Suggested Corrective Action(s)
PH-14: The infection control coordinator designated to oversee the infection control program had not received proper training to assist perform the responsibilities of the position.	Provide training through the Department of Health and/or educational programs to assist with the responsibilities of the infection control program.

Records Reviewed:	INTRASYSTEM TRANSFERS	Systems Score	Records Score
5		100	86

Finding(s)	Suggested Corrective Action(s)
PH-15: All five of the records lacked dates on the intrasystem transfer forms that were completed upon arrival of the inmate.	Provide in-service to staff regarding the importance of dating the intrasystem transfer form. Monitor five intrasystem transfer records monthly for date entries until closure is affirmed through the CMA CAP assessment.

Records Reviewed:	MEDICATION ADMINISTRATION	Systems Score	Records Score
5		94	87

Finding(s)	Suggested Corrective Action(s)
PH-16: Three records lacked date and signature for the medication orders.	Provide in-service to clinical staff regarding the importance of dating and signing the physician order. Monitor five records per month for dates and physician signatures (or medication orders) until closure is affirmed through the CMA CAP assessment.
PH-17: Four medication orders were not transcribed by the end of the shift in which they were written. One order was not written until two days after the clinic visit. Physician orders were written by the CHO on the progress notes. The nurse then had to transfer orders onto the physician order sheet. This brought delays in orders being transcribed and in delivery of medications.	Provide in-service to Chief Health Officer (CHO) regarding importance of writing physician orders on the physician order sheet. Monitor five records monthly for timely transcription of the physician orders until closure is affirmed through the CMA CAP assessment.

Discussion:
The physician wrote medication and follow-up orders on the progress note instead of the physician order sheet. The nurse had to transfer the order from the progress note onto the physician order sheet. That added another step to the process and created an opportunity for errors.

QUALITY MANAGEMENT	Systems Score
	69

Finding(s)	Suggested Corrective Action(s)
PH-18: Minutes for infection control, risk management, and mortality reports were not available.	Provide in-service to appropriate staff regarding the importance of recording infection control, risk management, and mortality reports. Monitor monthly reports from infection control, risk management, and mortality review until closure through is affirmed through the CMA CAP assessment.

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

System Reviews

- OBIS
- Chronic Illness Clinic
- Consultations
- Emergency
- Infirmary Care
- Intrasystem Transfer
- Mortality Review
- Preventative Care

Record Reviews

- Asthma Clinic
- Consultations
- Diabetes Clinic
- Emergency Care
- General Medicine Clinic
- Hypertension Clinic
- Sick Call

CONCLUSION

Both formal and informal staff interviews and observations were conducted. Staff was knowledgeable regarding the process of providing care. Observation of medical personnel, clinical staff, and security officers provided evidence of care being offered; however, documentation of the care and continuity of care was lacking in various records and logs. Staff indicated they would benefit from more classes on specific women's issues and diseases along with classes on IV therapy. Staff also indicated a need for more modern medical equipment like electronic thermometers and blood pressure devices.

Overall, due to the longevity of the clinical staff the level of care was adequate. Prior to September 6th it was difficult to obtain approval from the corporate office for overtime. The facility could not use agency nurses to fill insufficiently staffed shifts. This left the vacancies to be filled with nurses flexing their time, or the nursing supervisor and health service administrator covering the shifts. The corporate office sent out a memo on September 6th authorizing use of overtime, agency nurse coverage and/or use of a nursing pool. Hopefully, with these changes the clinical care will continue to improve.

MENTAL HEALTH FINDINGS

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

Records Reviewed: 10	ACCESS TO MENTAL HEALTH SERVICES	Systems Score 89	Records Score 98

Finding(s)	Suggested Corrective Action(s)
MH-1: There was no system in place to track whether inmate-declared psychological emergencies were responded to within one hour.	Provide in-service training to mental health and nursing on documentation of psychological emergencies. Monitor a minimum of five records per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
MH-2: The inmate handbook and mental health orientation materials were not available in Spanish.	Provide Spanish materials.

Records Reviewed: 10	OUTPATIENT MENTAL HEALTH SERVICES	Systems Score 92	Records Score 89

Finding(s)	Suggested Corrective Action(s)
MH-3: Mental health orientation was inconsistently documented: **a. Intake orientation by nursing staff did not document that orientation to mental health access was provided.** **b. Mental health staff did not consistently document that orientation to mental health services had been provided within eight days of arrival.**	Develop a system to ensure that documentation of orientation to mental health access is completed upon intake. This may be recorded as a note or as a stamp. Provide in-service training to mental health staff on the need to document inmate orientation within eight days of arrival. Monitor a minimum of five records per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
MH-4: An active *Consent for Mental Health Evaluation and Treatment* (DC4-663) was not consistently present in the records reviewed.	Provide in-service training to relevant staff members on the need to complete a consent form annually. Monitor a minimum of five records per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Discussion:
MH-3. Staff and inmate interview data indicated that orientation to mental health access was provided by a nurse within 24-hours as part of the initial intake process. Mental health staff then provided an in-depth orientation within eight days. However, the mental health component of the 24-hour intake process was not documented. The orientation provided by mental health staff was either not consistently documented or not timely.

MH-4. The records in question belonged to S2 inmates. S1 inmates evaluated for psychological emergencies, requests and confinement mental status evaluations also require current consents. One of the psychological emergency records reviewed did not have a current consent.

Records Reviewed:		SELF-INJURY/SUICIDE PREVENTION	Systems Score	Records Score
23-hr	N/A		88	N/A
SOS	8			85
Other	N/A			N/A

Finding(s)	Suggested Corrective Action(s)
MH-5: The physician's orders for suicide observation status (SOS) were not consistently renewed every 24 hours.	Provide in-service training on the requirement for daily renewal of orders by the physician. Monitor a minimum of five records per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
MH-6: The physician's orders for SOS did not consistently specify what items the patients were allowed in the infirmary isolation cells.	Provide in-service training on documentation requirements for physician orders. Monitor a minimum of five records per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
MH-7: The physician's daily rounds during the week to evaluate SOS patients were not consistently documented.	Provide in-service training on the requirement for daily rounds by the physician. Monitor a minimum of five records per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
MH-8: The two infirmary isolation cells and the confinement observation cell required maintenance. In each cell, the ceilings were breaking away from the sprinkler installations.	Repair the cells.
MH-9: There was no written policy for cleaning and fire retardation of security blankets, mattresses and shrouds.	Provide a written policy.

Discussion:
MH-6. Four of the eight orders reviewed specified items allowed and four did not. Clinical staff indicated that a non-specific admission order implied all items were allowed. However, to eliminate confusion and ensure patient safety, orders should specify mattresses, security blankets, shrouds and other applicable items as clinically appropriate for each patient. There should be a clinical rationale for items that are denied for safety purposes.

Records Reviewed:	SEX OFFENDER SERVICES	Systems Score	Records Score
N/A		83	N/A

Finding(s)	Suggested Corrective Action(s)
MH-10: Mental health staff reported that indicated sex offender screenings were not consistently provided within 30 days of arrival at the institution.	Provide in-service training to relevant staff on this requirement. Monitor a minimum of five records per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.

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

System Reviews

- Intellectual Functioning.
- Psychiatric Restraint
- Special Housing

Record Reviews

- Intellectual Functioning
- Access; Psychological Emergencies and Requests
- Special Housing

There had been no incidents of psychiatric restraint. There were no sex offenders eligible for treatment at the time of the survey and, therefore, no records were reviewed. The special housing record review resulted in a score of 90; in one of eight charts the confinement mental status evaluations were inconsistent regarding timeliness or completeness. This was not considered significant overall.

CONCLUSION

The current mental health program demonstrated many strengths. The clinical documentation provided by the mental health staff was thorough and substantive. The psychologist and psychological specialist were experienced and innovative and had developed relaxation groups as a supplement to group therapy activities. Inmates interviewed found the program very supportive and experienced no barriers to accessing services. Commendably, the mental health staff had adopted one uniform standard of care for suicidal and self-injurious inmates. The practice of designated alternate housing had been discontinued, as had the use of 23-hour infirmary observation as an alternative to SOS for self-injurious patients; both practices with which the CMA has had many concerns. Inmates on SOS were observed constantly and observations documented at least every 15 minutes, as is Corrections Corporation of America policy. Finally, clinical and correctional staff interviewed was well informed about the mental health program.

With the exception of systems and documentation findings noted above, which require the attention of administrative, medical and mental health staff to correct, the overall mental health program demonstrated improvement since the last survey of GADCF in October 1999.

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 require corrective action by institutional staff. Findings identified in a supplemental report require corrective action by regional or central office health services staff.