



# **CORRECTIONAL MEDICAL AUTHORITY**

## **PHYSICAL & MENTAL HEALTH SURVEY**

of

## **GAINESVILLE CORRECTIONAL INSTITUTION**

in

**Gainesville, Florida**

on

**November 18-20, 2003**

### **CMA Physical Health and Mental Health**

#### **Team Leader:**

Stephen Tomicich, RN

#### **Physical Health Team Members:**

Boyd Kellet, MD  
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#### **Mental Health Team Member:**

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## DEMOGRAPHICS

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

INSTITUTIONAL INFORMATION			
Population	Type	Custody Level	Medical Level
Male	Adult	Medium	1

### Institutional Potential/Actual Workload

<b>Main Unit Capacity</b>	<b>378</b>	<b>Current Main Unit Census</b>	<b>376</b>
<b>Annex Capacity</b>	<b>NA</b>	<b>Current Annex Census</b>	<b>NA</b>
<b>Satellite Unit(s) Capacity</b>	<b>378</b>	<b>Current Satellite(s) Census</b>	<b>368</b>
<b>Total Capacity</b>	<b>756</b>	<b>Total Current Census</b>	<b>744</b>

### Inmates Assigned to Medical/Mental Health Grades

<i>Medical Grade</i>	1	2	3	4	<i>Impaired</i>	
		703	64	6	0	0
<i>Mental Health Grade (S-Grade)</i>	<i>Mental Health Outpatient</i>				<i>MH Inpatient</i>	
	1	2	3	4	5	<i>Impaired</i>
	773	0	0	0	0	0

### Inmates Assigned to Special Housing Status

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



## OVERVIEW

The Correctional Medical Authority conducted a thorough review of the medical, mental health and dental systems at Gainesville Correctional Institution. 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.

### **Physical Health Findings**

Medical and dental systems at the institution were reviewed. Staff interviews indicated there were no obstacles to providing care that was considered acceptable in meeting professional community standards. However, staff resources are certainly taxed by also providing medical and dental services at Putman Correctional Institution. Staff is to be commended on the job being done with the resources available. Deficiencies and areas of concern are described in the physical health section of this report.

### **Mental Health Findings**

The mental health care provided to the S1 population at Gainesville Correctional Institution generally met all minimum standards of care. The mental health staff expressed a dedication to providing high quality care to the population served, and this was evident in their work. Minor documentation deficiencies were identified and are described in the mental health section of this report.

### **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.

### **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	77		
		Emergency Care		100	
		Episodic Care Follow-Up		100	
		Infirmatory Care		NA	
		Sick Call		100	
	<b>Chronic Care</b>	Asthma/Pulmonary Clinic		100	
		Diabetes Clinic		NA	
		General Medicine Clinic		86	
		Hypertension Clinic		98	
		Immunity Clinic		NA	
		Seizure Clinic		100	
	<b>Preventative Care</b>		100		94
	<b>Dental Services</b>		100		98
	<b>Mortality Review</b>		NA		NA
	<b>Other</b>	Administrative Processes	94		
		Consultation Requests	100		100
		Food Services	86		
		Infection Control	86		
		Intake Process (Reception)	NA		NA
		Intrasystem Transfers	100		100
Medical Area and Inmate Housing		95			
Medication Administration		100		75	
OBIS/Health Record Content		88		95	
Pharmacy Services		100			
Quality Management		82			
Area of Review			Area Score		
<b>MENTAL HEALTH</b>	Mental Health Systems		100		
	Access to Mental Health Services		98		
	Inpatient Mental Health Services		NA		
	Intellectual Functioning		100		
	Outpatient Mental Health Services		90		
	Psychiatric Restraint		NA		
	Psychotropic Medication Practices		NA		
	Reception/Intake Process		NA		
	<b>Self-Injury/Suicide Prevention</b>	23-hour MH Observation		NA	
		SOS Status		NA	
		Other Self-injury Prevention Status		NA	
	Sexual Offender Services		NA		
	Special Housing		NA		
	Use-of-Force		NA		

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

## PHYSICAL HEALTH FINDINGS

## SYSTEMS

<b>EPISODIC CARE</b>		<b>Systems Score</b> <b>77</b>
<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>	
<b>PH-1: (Sick Call) There was no weekly supervisory review of sick call encounters for accuracy, treatment modality, medication distribution, vital signs, documentation, education, completeness, and other clinically indicated actions.</b>	<p>Provide in-service training to staff on the importance of performing weekly supervisory reviews of the sick call records for complete and appropriate care.</p> <p>Provide documentation of ongoing reviews in the CAP closure file.</p>	
<b>PH-2: The emergency care log did not include the chief complaint/diagnosis.</b>	<p>Maintain an emergency care log that includes chief complaint/diagnosis.</p> <p>Include copies of the completed logs in the CAP closure file.</p>	
<b>PH-3: There was no weekly supervisory review of the emergency encounters for documentation of accuracy, treatment modality, medication distribution, documentation, education, completeness, and other clinically indicated actions.</b>	<p>Provide in-service training to staff on the importance of performing weekly supervisory reviews of the emergency care records for complete and appropriate care.</p> <p>Provide documentation of ongoing reviews in the CAP closure file.</p>	

<b>OBIS/HEALTH RECORD CONTENT</b>		<b>Systems Score</b> <b>88</b>
<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>	
<b>PH-4: The HSS-15 (showing past-due appointments) was not being run weekly as required by departmental policy.</b>	<p>Instruct staff on importance of running HSS-15 on a weekly basis.</p> <p>Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>	

<b>QUALITY MANAGEMENT</b>		<b>Systems Score</b> <b>82</b>
<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>	
<b>PH-5: The composition of the institutional QM committee does not adequately represent the institution's health disciplines, without including the Chief Health Officer/Medical Executive Director.</b>	<p>Instruct Chief Health Officer/Medical Executive Director on importance of being part of QM committee and attending meetings.</p> <p>Provide documentation of CHO inclusion in the QM committee and attendance at QM meetings.</p>	

<b>QUALITY MANAGEMENT</b>		<b>Systems Score</b> <b>82</b>
		<b>Suggested Corrective Action(s)</b>
		Continue monitoring until closure is affirmed through the CMA CAP assessment.
<b>PH-6: There was no evidence that the physician and dentist were provided annual peer/clinical reviews.</b>		Provide evidence of annual peer/clinical review for the physician and dentist.  Continue monitoring until closure is affirmed through the CMA CAP assessment.

<b>MEDICAL AREA AND INMATE HOUSING</b>		<b>Systems Score</b> <b>95</b>
<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>	
<b>PH-7: No safe-sharp supplies were used. The institution was waiting to use up the existing stock of approximately 19 syringes.</b>	Begin use of safe-sharp supplies as soon as current stock is used up and only reorder safe-sharps.  Routinely monitor medication administration with safe-sharps to ensure compliance.  Continue monitoring until closure is affirmed through the CMA CAP assessment.	
<b>PH-8: Medical confidentiality was compromised by posting mental health appointment call out lists in the dorms.</b>	Have call out lists posted in dorms that refer to medical only and route to mental health upon arriving at the medical unit.  Continue monitoring until closure is affirmed through the CMA CAP assessment.	

<b>INFECTION CONTROL</b>		<b>Systems Score</b> <b>86</b>
<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>	
<b>PH-9: There was no documentation that the Infection Control Coordinator had received formal training in the practices of infection control.</b>	Provide documentation that the Infection Control Coordinator has received formal training in the practices of infection control.	
<b>PH-10: The infection control coordinator did not receive or review monthly reports related to the overall sanitation of the facility and sanitation and cleanliness of the dining facility.</b>	<p>Provide in-service training to infection control coordinator on the importance of receiving and reviewing reports related to facility sanitation. Coordinate with applicable institutional staff to obtain the reports.</p> <p>Monitor for compliance and include documentation in the CAP closure file.</p> <p>Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>	

<b>FOOD SERVICE</b>		<b>Systems Score</b> <b>86</b>
<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>	
<b>PH-11: The swill room door was corroded and had a hole that would allow vermin to enter.</b>	<p>Replace swill door. (One had been requested).</p> <p>Monitor for compliance and include documentation in the CAP closure file.</p> <p>Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>	
<b>PH-12: A freezer floor was not clean. It was sticky with dried vegetables and trash on the floor.</b>	<p>Monitor freezers on weekly basis to ensure they are clean.</p> <p>Monitor for compliance and include documentation in the CAP closure file.</p>	
<b>PH-13: The food service manager was not able to produce documentation of a current state of Florida food certification.</b>	<p>Provide documentation of current state of Florida food certification for food service manager.</p> <p>Monitor for compliance and include documentation in the CAP closure file.</p>	



## CLINICAL

Records Reviewed <b>5</b>	<b>OBIS/HEALTH RECORD CONTENT</b>	Record Review Score <b>95</b>
Finding(s)	Suggested Corrective Action(s)	
<b>PH-14: Two of five records reviewed revealed the PULHESDXTI in the medical record did not match the PULHESDXTI in OBIS.</b>	<p>Instruct staff on importance of having PULHESDXTI in the medical record match the PULHESDXTI in OBIS.</p> <p>Monitor five records monthly to ensure that PULHESDXTI in the medical record matches OBIS.</p> <p>Monitor corrective action until closure is affirmed through the CMA CAP assessment.</p> <p>Provide copies of the monitoring log in the CAP closure file.</p>	

Records Reviewed <b>10</b>	<b>PREVENTATIVE CARE</b>	Record Review Score <b>94</b>
Finding(s)	Suggested Corrective Action(s)	
<b>PH-15: Three of 10 records reviewed did not have evidence or documentation of refusal of a hemocult, when a rectal exam was performed.</b>	<p>Monitor five records monthly to ensure hemocults are performed when rectal exams are done or provide documentation of refusal.</p> <p>Provide copies of the monitoring log in the CAP closure file.</p>	

Records Reviewed <b>10</b>	<b>GENERAL MEDICINE CLINIC</b>	Record Review Score <b>86</b>
Finding(s)	Suggested Corrective Action(s)	
<b>PH-16: Eight of ten records reviewed did not have baseline laboratory studies which included Alpha-fetoprotein for patients diagnosed with liver disease.</b>	<p>Instruct staff on the importance of ensuring patients with liver disease are receiving baseline laboratory studies which include Alpha-fetoprotein as well as follow-up AFP completed annually.</p> <p>Monitor five records monthly to ensure patients with liver disease are receiving baseline</p>	

Records Reviewed <b>10</b>	<b>GENERAL MEDICINE CLINIC</b>	Record Review Score <b>86</b>
Finding(s)	Suggested Corrective Action(s)	
	<p>laboratory studies which include Alpha-fetoprotein.</p> <p>Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>	
<b>PH-17: Three of ten records reviewed did not have evidence that laboratory studies were reviewed and any abnormalities addressed in a timely manner.</b>	<p>Monitor five records monthly to ensure laboratory studies are reviewed and any abnormalities addressed in a timely fashion.</p> <p>Provide copies of the monitoring log in the CAP closure file.</p>	
<b>PH-18: Two of ten records reviewed did not have appropriate medication regimens prescribed and monitored and re-evaluated at each clinic visit.</b>	<p>Monitor five records monthly to ensure appropriate medication regimens are prescribed and monitored and reevaluated at each clinic visit.</p> <p>Provide copies of the monitoring log in the CAP closure file.</p>	
<b>PH-19: Four of ten records reviewed did not have appropriate consultative referrals completed when indicated.</b>	<p>Stress importance of completing indicated consultative referrals to the attending physician.</p> <p>Monitor five general medicine clinic records monthly to ensure consultative referrals are completed when indicated.</p> <p>Provide copies of the monitoring log in the CAP closure file.</p>	
<b>PH-20: One individual who tested positive for syphilis had no documentation of treatment or refusal for treatment.</b>	<p>Stress importance of documenting treatment of syphilis or refusal of treatment.</p> <p>Monitor five records monthly to ensure individuals testing positive for STD's have documentation they are being treated or documentation of refusal.</p>	

Records Reviewed <b>3</b>	<b>MEDICATION ADMINISTRATION</b>	Record Review Score <b>75</b>
Finding(s)	Suggested Corrective Action(s)	
<b>PH-21: Two of three medication orders were not transcribed by the end of the shift during which they were written. Also, new</b>	<p>Monitor five records monthly to ensure medication orders are transcribed by the end of the shift during which they were written and</p>	

<b>Records Reviewed</b> <b>3</b>	<b>MEDICATION ADMINISTRATION</b>	<b>Record Review Score</b> <b>75</b>
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<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>
<b>medication order sets were not consistently used.</b>	current order set is being used.  Provide copies of the monitoring log in the CAP closure file.

<b>Records Reviewed</b> <b>20</b>	<b>DENTAL SERVICES</b>	<b>Record Review Score</b> <b>98</b>
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<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>
<b>PH-22: Four of twenty records reviewed indicated requests for routine treatment were not completed within six months of initiation or time frames between appointments were not within three months.</b>	Monitor five records monthly to ensure requests for routine treatment are completed within six months of initiation of treatment and time frames between appointments are within three months.  Provide copies of the monitoring log in the CAP closure file.

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

System Reviews

- Episodic Care Follow-up
- Consultation Requests
- Intra-system Transfers
- Medication Administration
- Dental Services
- Pharmacy Services
- Preventative Care

Record Reviews

- Sick Call
- Intra-system Transfers
- Asthma/Pulmonary Clinic
- Tuberculosis/INH Therapy Clinic
- Seizure Clinic
- Consultation Requests
- Emergency Care
- Episodic Care Follow-Up
- Hypertension Clinic

## **CONCLUSION**

Both formal and informal observations were conducted. Overall, staff was knowledgeable regarding the process of providing care. Many clerical errors likely would have been prevented with additional staffing. Currently, one Health Services Administrator (HSA) and one Director of Nursing are covering both Gainesville and Putnam Correctional Institutions. A new nurse for Gainesville CI was hired during the survey and should help to alleviate some of the work issues for the Director of Nursing.



## MENTAL HEALTH FINDINGS

### Description of Mental Health Department

- The mental health department at Gainesville CI was comprised of one psychological specialist. Outpatient mental health services were provided to individuals. No inpatient care was provided at this institution. The mental health staff member was competent and caring and interacted in a professional manner.

### Survey Results

Records Reviewed:	OUTPATIENT MENTAL HEALTH SERVICES	Area Score
<b>8</b>		<b>90</b>
Finding(s)	Suggested Corrective Action(s)	
<p><b>MH-1: Two of the eight records reviewed did not have proper documentation regarding receiving written and verbal orientation to mental health services.</b></p> <p style="margin-left: 20px;"><b>A) The stamp was not dated or signed.</b></p> <p style="margin-left: 20px;"><b>B) The stamp was not dated indicating mental health staff conducted an orientation to mental health services within 8 days of inmates arrival at the institution.</b></p> <p><b>This finding centers around entries not being dated, timed, signed, and stamped.</b></p>	<p>Instruct staff on importance of dating, timing, and signing of documents.</p> <p>Monitor five records monthly to ensure compliance and provide copies of documentation in the CAP closure file.</p>	

The following areas of review resulted in no significant problems.

- Intellectual Functioning
- Access to Mental Health Services
- Mental Health Services Systems

## CONCLUSION

Staff should be commended on the lack of findings noted in the review of mental health services. They are encouraged to maintain these successes and institute corrective action where needed.

## **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**

#### **ADMINISTRATIVE PROCESSES**

##### **Finding(s)**

**Dept-1: There was no evidence of a policy addressing elective medical or surgical procedures and how the inmate may pursue any elective medical or surgical procedure the department declines to provide.**

**Dept-2: 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.**

## **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.