



# CORRECTIONAL MEDICAL AUTHORITY

## PHYSICAL & MENTAL HEALTH SURVEY

of

## GLADES CORRECTIONAL INSTITUTION

in

Belle Glade, Florida

on

April 1 – 4, 2003

### CMA Physical & Mental Health Team Leader:

John W. Rainey, BS

### Physical Health Team Members:

Bernard Kimmel, MD  
Roberta Diehl, DDS  
Fidel Gonzalez, PA  
Kathy Kimmel, RN

### Mental Health Team Members:

Sherry Roth, PhD  
Jacquelyn Gallop, PHD, LCSW

## DEMOGRAPHICS

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

INSTITUTIONAL INFORMATION			
Population	Type	Custody Level	Medical Level
Male	Adult	Close	4

### Institutional Potential/Actual Workload

Main Unit Capacity	996	Current Main Unit Census	892
Annex Capacity	NA	Current Annex Census	NA
Satellite Unit(s) Capacity	524	Current Satellite(s) Census	524
Total Capacity	1520	Total Current Census	1394

### Inmates Assigned to Medical/Mental Health Grades

<i>Medical Grade</i>	1	2	3	4	<i>Impaired</i>	
		513	264	106	2	0
<i>Mental Health Grade</i> <i>(S-Grade)</i>	<i>Mental Health Outpatient</i>				<i>MH Inpatient</i>	
	1	2	3	4	5	<i>Impaired</i>
	884	0	0	0	0	0

### Inmates Assigned to Special Housing Status

<i>Confinement/ Close Management</i>	DC	AC	PM	CM3	CM2	CM1
		14	5	0	0	0

## OVERVIEW

Glades Correctional Institution (GLACI) is a close custody institution for adult males. It was originally constructed in 1932. Inmates with medical grades 1 through 4 and mental health grade 1 were housed at GLACI. Health care services were provided through a contract with Wexford Health Sources, Inc.

### **Physical Health Summary**

A thorough review of the institution's health care systems was completed including the physical plant, administrative processes, and the provision and documentation of care. The facility appeared clean and well organized and staff responded professionally. The area of greatest concern was record documentation as evidenced by untimely and or missing documentation of care in the infirmary records. Current records lacked initial baseline medical documentation. Findings of incomplete documentation on intrasystem transfers, incomplete or inaccurate medical documentation in OBIS and/or medical records, and various other inadequacies are reflected in this report. The Quality Management program also requires attention. Many areas of review resulted in no significant findings.

### **Mental Health Summary**

When last surveyed in April 2000, the mental health department consisted of one psychological specialist with oversight provided by a senior psychologist based at another institution. The psychological specialist is commended for continuing to provide the full range of mental health services required by the mental health grade I (S1) population. The mental health department remained consistent in the delivery of clinical services and the overall organization of the program. As in April 2000, there were no mental health survey findings requiring corrective action.

### **Supplemental Report**

In addition to the medical findings referenced above, a couple of other areas of concern were noted. These issues will require intervention by the department's Office of Health Services (OHS). These issues are identified and discussed in a supplemental report provided directly to the OHS.

### **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		
<b>PHYSICAL HEALTH</b>	<b>Episodic Care</b>	Episodic Care Systems	100		
		Emergency Care		86	
		Follow-Up Care		100	
		Infirmery Care		69	
		Sick Call		100	
	<b>Chronic Care</b>	Asthma Clinic		100	
		Diabetes Clinic		84	
		General Medicine Clinic		99	
		Hypertension Clinic		83	
		Immunity Clinic		88	
		Seizure Clinic		82	
	TB/INH Clinic		98		
	<b>Preventative Care</b>		100	80	
	<b>Dental Care</b>		94	85	
	<b>Mortality Review</b>		100	100	
	<b>Other</b>	Administrative	94		
		Consultation Requests	100	100	
		Infection Control	85		
		Intake (Reception) Process			
Intrasystem Transfers		100	79		
Medical Area and Inmate Housing		94			
Medication Administration		100	81		
OBIS-Health Record Content		88	66		
Pharmacy					
Quality Management	71				
<b>MENTAL HEALTH</b>	Access to Mental Health Services		100	100	
	Inpatient Mental Health Services				
	Intellectual Functioning		100	95	
	Psychiatric Restraints		100		
	Psychotropic Medication Practices				
	Outpatient Mental Health Services		100	96	
	<b>Self-Injury/Suicide Prevention</b>	23-hour Observation		100	
		SOS Status			
		Other Self-injury Prevention Status			
	Sexual Offender Services		100	100	
Special Housing		100	100		

# PHYSICAL HEALTH FINDINGS

## Survey Results

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

### EPISODIC CARE

Records Reviewed:	<b>EMERGENCY CARE RECORD REVIEW (Nursing Encounter)</b>	Records Score
8		86
Finding(s)	Suggested Corrective Action(s)	
<b>PH-1: Appropriate emergency care forms or nursing assessment forms were not always utilized and/or in SOAPE format.</b>	Provide in-service training to relevant staff on emergency room documentation requirements.  Review five records monthly for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.	

Records Reviewed:	<b>INFIRMARY CARE RECORD REVIEW</b>	Records Score
8		69
Finding(s)	Suggested Corrective Action(s)	
<b>PH-2: Documentation did not indicate that the physician/CA was always notified and orders obtained at the time of infirmary admission.</b>	Provide in-service training to relevant personnel on infirmary care protocol and documentation requirements.  Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.	
<b>PH-3: History and physicals were not always completed within 24 hours of admission.</b>	See PH-2 suggested corrective action.	
<b>PH-4: Documentation did not indicate daily rounds in person or by phone by a physician or clinical associate.</b>	Ensure rounds are completed and documented daily.  See PH-2 suggested corrective action.	

## CHRONIC CARE

Records Reviewed:	<b>DIABETES CLINIC RECORD REVIEW</b>	Records Score
8		84
Finding(s)	Suggested Corrective Action(s)	
<b>PH-5: Annual testing for the presence of microalbuminia when clinically indicated was not done.</b>	Provide in-service training to relevant staff on diabetes clinic protocols and documentation requirements.  Review five records monthly for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.	
<b>PH-6: The current volume of the medical record did not always contain the initial clinic visit documentation.</b>	See PH-5 suggested corrective action.	
<b>PH-7: Instruction in self-administration was not being documented.</b>	See PH-5 suggested corrective action	

Records Reviewed:	<b>HYPERTENSION CLINIC RECORD REVIEW</b>	Records Score
9		83
Finding(s)	Suggested Corrective Action(s)	
<b>PH-8: A diagnosis related to hypertension was not always listed on the problem list, and lab test results were not always recorded on the clinic flow sheet.</b>	Provide in-service training to relevant staff on hypertension clinic protocols and documentation requirements.  Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.	
<b>PH-9: The current volume of the medical record did not always contain the initial clinic visit documentation or a complete medical history related to the condition.</b>	See PH-8 suggested corrective action.	
<b>PH-10: Documentation did not always indicate that pneumococcal vaccine was offered or refused.</b>	See PH-8 suggested corrective action.	

Records Reviewed:	IMMUNITY CLINIC RECORD REVIEW	Records Score
1		88
Finding(s)	Suggested Corrective Action(s)	
PH-11: The medical history was insufficient regarding attention to risk factors, previous treatment and previous infections.	<p>Provide in-service training to relevant staff on immunity clinic protocols and documentation requirements.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>	

Records Reviewed:	SEIZURE CLINIC RECORD REVIEW	Records Score
8		82
Finding(s)	Suggested Corrective Action(s)	
PH-12: The current volume of the medical record did not always contain the initial clinic visit documentation. That made it impossible to determine if the physical examinations conducted upon clinic enrollment were complete.	<p>Provide in-service training to relevant staff on seizure clinic 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>	
PH-13: One record did not have a medical history related to the condition and most had insufficient medical histories.	See PH-12 suggested corrective action.	
PH-14: Types of seizures were not always documented. Also, most records had no documented evidence of a neurological consultation or a written explanation as to why one is not indicated.	See PH-12 suggested corrective action.	

Records Reviewed:	TB/INH CLINIC RECORD REVIEW	Records Score
10		98
Finding(s)	Suggested Corrective Action(s)	
PH-15: The problem list did not always include an appropriate diagnosis.	<p>Provide in-service training to relevant staff on TB/INH clinic documentation requirements.</p> <p>Review five records monthly for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.</p>	

## PREVENTATIVE CARE

Records Reviewed:	<b>PREVENTATIVE CARE</b>	Systems Score	Records Score
7		100	80
Finding(s)	Suggested Corrective Action(s)		
<p><b>PH-16: Annual PPD screening was not always completed. Documentation did not always include hemocult results when a rectal exam was to be performed. Minimum required diagnostic tests were not always performed.</b></p>	<p>Provide in-service training to relevant staff on preventative care protocol and documentation requirements.</p> <p>Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.</p>		

## DENTAL CARE

Records Reviewed:	<b>DENTAL SERVICES</b>	Systems Score	Records Score
10		94	85
Finding(s)	Suggested Corrective Action(s)		
<p><b>PH-17: Dental records did not always contain a DC4-734, Dental Health Questionnaire that was current within one year.</b></p>	<p>Provide in-service training to relevant staff on dental 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>		
<p><b>PH-18: Oral hygiene instructions were not documented as part of the dental treatment plan.</b></p>	<p>See PH-17 suggested corrective action.</p>		
<p><b>PH-19: Indicated records did not always have evidence of a periodontal screening and recorded results.</b></p>	<p>See PH-17 suggested corrective action.</p>		

## OTHER

	Systems Score
<b>ADMINISTRATIVE</b>	94
Finding(s)	Suggested Corrective Action(s)
<p><b>PH-20: There was no policy prohibiting the medical staff from participating in gathering forensic information and participating in body cavity searches for forensic purposes.</b></p>	<p>Develop a policy specifically addressing the standard and related finding.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>

<b>INFECTION CONTROL</b>		Systems Score
		<b>85</b>
Finding(s)	Suggested Corrective Action(s)	
<b>PH-21: Health care staff did not participate in or review the inspection process of the food service operation regarding sanitation and cleanliness.</b>	<p>Include dining facility inspections as part of the infection control program. At a minimum ensure that health services maintains copies of the inspection reports and addresses those issues that could have negative health implications.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>	
<b>PH-22: Submission of infection control data to the central office infection control coordinator was several months delinquent.</b>	<p>Provide in-service training to the institution infection control coordinator on infection control requirements. Provide counseling on timely submission of required reports. Require accountability of responsible party.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>	

Records Reviewed:	<b>INTRASYSTEM TRANSFERS</b>	Systems Score	Records Score
<b>8</b>		<b>100</b>	<b>79</b>
Finding(s)	Suggested Corrective Action(s)		
<b>PH-23: The DC4-760A did not always contain all necessary and/or correct information. Findings included: incomplete vital signs, current medication(s) not listed, and incorrect PPD data.</b>	<p>Provide in-service training to relevant staff on intrasystem transfer protocol 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>MEDICATION ADMINISTRATION</b>	Systems Score	Records Score
<b>10</b>		<b>100</b>	<b>81</b>
Finding(s)	Suggested Corrective Action(s)		
<b>PH- 24: Medication orders were consistently dated and signed but had no times indicated. Also the medical records did not always have corresponding notes from an advanced level provider regarding the medication order.</b>	<p>Provide in-service training to relevant staff on medication 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:	OFFENDER BASED INFORMATION SYSTEM (OBIS)	Systems Score	Records Score
7		88	66
Finding(s)	Suggested Corrective Action(s)		
PH-25: The most current PULHESDXTI found in the medical chart did not always match the latest entry in OBIS.	<p>Every intake record should be screened to ensure that it has up-to-date information in the current volume. A process should be established to ensure that all encounters are entered both in OBIS and the medical record. Staff should ensure that all annual and biennial requirements are within time frames that facilitate the event.</p> <p>Provide in-service training to relevant staff on medical record documentation and organization requirements.</p> <p>Review five records monthly for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.</p>		
PH-26: Passes, medical contacts, mental health contacts and laboratory tests were not always jointly reflected in both OBIS and the medical record.	See PH-28 suggested corrective action.		
PH-27: The next scheduled PPD was not always reflected on the appointment log in OBIS.	See PH-28 suggested corrective action.		

QUALITY MANAGEMENT (QM)		Systems Score
		71
Finding(s)	Suggested Corrective Action(s)	
PH-28: Required reports were not forwarded to OHS and there was no medical record committee that focused on QM issues.	<p>Provide in-service training to relevant staff on the requirements of the QM program. Formally remind staff of their responsibilities and take necessary action to bring the program into compliance in conjunction with compliance monitoring.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>	
PH-29: Meeting minutes following the CQR did not address efforts toward improvement for each standard scoring <80% and investigative studies were not initiated.	See PH-31 suggested corrective action.	

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

System Reviews

- Consultation Requests
- Episodic Care Systems
- Intrasystem Transfers
- Medication Administration
- Mortality Review
- Preventative Care

Record Reviews

- Asthma Clinic
- Consultation Requests
- Follow-Up Care
- General Medicine Clinic
- Mortality Review
- Sick Call

**CONCLUSION**

The CMA survey of Glades Correctional Institution revealed a number of clinical documentation and timeliness deficiencies especially in the area of infirmary care and intrasystem transfers. Many of these findings should be easily corrected. There was good cooperation and communication between the medical department and security personnel. Staff was complimented for their professionalism and cooperation during this survey.

# MENTAL HEALTH FINDINGS

## **Survey Results**

Glades Correctional Institution is a close custody facility which housed 884 psychological grade I (S1) adult males inmates at the time of the survey. The mental health staff consisted of one full-time psychological specialist who was a long-term employee of the institution. He is commended for continuing to provide the full range of mental health services required by the S1 population. .

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

### System Reviews

- Access to mental health services
- Intellectual functioning
- Outpatient mental health services
- Psychiatric restraint systems
- Self-Injury/suicide prevention
- Sex offender services
- Special housing systems

### Record Reviews

- Access to mental health services
- Intellectual functioning
- Sex offender services
- Special housing

## **CONCLUSION**

When last surveyed in April 2000, the mental health department consisted of one psychological specialist with oversight by a senior psychologist who was based at another institution. The mental health program remains consistent in the delivery of services to the S1 population. There were no survey findings requiring corrective action.

## 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.