



CORRECTIONAL MEDICAL AUTHORITY

PHYSICAL & MENTAL HEALTH SURVEY

of

HARDEE CORRECTIONAL INSTITUTION

in

Bowling Green, Florida

on

January 14-17, 2003

CMA Physical Health Team Leader:

John W. Rainey, BS

CMA Mental Health Team Leader:

Murdina Campbell, MSW

Physical Health Team Members:

Joe Gonzalez, MD
Roberta Diehl, DDS
Barbara Murphree, PA
Debbie Kings, RN

Mental Health Team Members:

Michael Clark, PhD
Lee Christenson, LCSW

DEMOGRAPHICS

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

INSTITUTIONAL INFORMATION			
Population	Type	Custody Level	Medical Level
1610	Male	Close	2

Institutional Potential/Actual Workload

Main Unit Capacity	1370	Current Main Unit Census	1314
Annex Capacity	N/A	Current Annex Census	N/A
Satellite Unit(s) Capacity	297	Current Satellite(s) Census	296
Total Capacity	1667	Total Current Census	1610

Inmates Assigned to Medical/Mental Health Grades

<i>Medical Grade</i>	1	2	3	4	<i>Impaired</i>	
		1025	593	0	0	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>
	1564	53	2	0	0	2

Inmates Assigned to Special Housing Status

<i>Confinement/ Close Management</i>	DC	AC	PM	CM3	CM2	CM1
		66	29	0	0	0

OVERVIEW

Physical Health Summary

Health services at this facility were provided through a contract with Wexford Health Sources. A thorough review of the medical health-related and dental systems at the institution, including the physical plant, administrative processes, and the provision and documentation of care was conducted. The staff was very professional and courteous. The facility appeared exceptionally clean. Nursing has an excellent process of triaging patients prior to their arrival for sick call. However, episodic care was deficient in several areas. The consultation logs were seamless, identifying all active consults on the most current month's log. Dental care is starting to suffer and could possibly have serious implications if prompt action is not taken to ensure continuity of care is maintained. The quality management program has been neglected and needs management's direction and support.

Mental Health Summary

A detailed review of the mental health department demonstrated a very organized program run by an experienced and qualified team, including a psychologist, two psychological specialists, and a clerk. The staff worked well as a team and demonstrated good working relationships with other departments. The clerk had excellent computer skills and provided organizational support to the clinicians. As a result of this teamwork mental health services were provided in a timely and appropriate manner. The two main areas of survey findings were incomplete documentation of the physician's orders and notes for suicide observation episodes and a lack of training for security and medical staff in the use of psychiatric restraints.

Supplemental Report

In addition to the medical and mental health findings referenced above, several other areas of concern were noted. These issues 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		
PHYSICAL HEALTH	Episodic Care	Episodic Care Systems	83		
		Emergency Care		61	
		Follow-Up Care		83	
		Infirmary Care		70	
		Sick Call		95	
	Chronic Care	Asthma Clinic		93	
		Diabetes Clinic		98	
		General Medicine Clinic		100	
		Hypertension Clinic		97	
		Immunity Clinic			
		Seizure Clinic		99	
	TB/INH Clinic		94		
	Preventative Care		80	95	
	Dental Care		95	84	
	Mortality Review		100	100	
	Other	Administrative	94		
		Consultation Requests	100	99	
		Infection Control	92		
		Intake (Reception) Process			
		Intrasystem Transfers	92	80	
Medical Area and Inmate Housing		94			
Medication Administration		88	80		
OBIS-Health Record Content		100	85		
Pharmacy					
Quality Management	67				
MENTAL HEALTH	Access to Mental Health Services		100	100	
	Inpatient Mental Health Services				
	Intellectual Functioning		100	80	
	Psychiatric Restraints		83		
	Psychotropic Medication Practices				
	Outpatient Mental Health Services		100	90	
	Self-Injury/Suicide Prevention	23-hour Observation		88	
		SOS Status			70
		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:	SICK CALL RECORD REVIEW	Records Score
7	(Nursing Encounter)	95

Finding(s)	Suggested Corrective Action(s)
PH-1: Referrals to higher-level providers were not always completed in a clinically timely manner.	Review records of five referrals per month for compliance. Continue until corrective action is confirmed through the CMA CAP assessment.

Records Reviewed:	EMERGENCY CARE RECORD REVIEW	Records Score
7	(Nursing Encounter)	61

Finding(s)	Suggested Corrective Action(s)
PH-2: Appropriate emergency care forms or nursing assessment forms were not utilized.	Provide in-service training to relevant staff on emergency room protocol and related documentation requirements. Review five records monthly for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.
PH-3: An assessment appropriate to the complaint was not always completed.	See PH-2 suggested corrective action.
PH-4: Follow-up evaluation/care was not always appropriate and consistent with the patient's subjective complaints and/or objective findings.	See PH-2 suggested corrective action.

Records Reviewed:	FOLLOW-UP CARE RECORD REVIEW	Records Score
6	(Physician-Clinical Associate Encounter)	83

Finding(s)	Suggested Corrective Action(s)
PH-5: Follow up visits by higher-level clinicians were not always completed in a clinically timely manner consistent with the presenting medical needs.	Provide in-service training to relevant staff on emergency room protocol and related documentation requirements. Review five records monthly for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.

Records Reviewed:		FOLLOW-UP CARE RECORD REVIEW (Physician-Clinical Associate Encounter)	Records Score
6			83
Finding(s)	Suggested Corrective Action(s)		
PH-6: Clinical orders from follow-up visits were not always appropriate and adequate for the presenting condition.	See PH-5 suggested corrective action.		
PH-7: Indicated diagnostic studies were not always ordered and scheduled in a timely manner.	See PH-5 suggested corrective action.		

Records Reviewed:		INFIRMARY CARE RECORD REVIEW	Records Score
10			70
Finding(s)	Suggested Corrective Action(s)		
PH-8: Physician/CA admission orders did not specify how often vital signs should be taken.	Provide in-service training to relevant personnel on infirmary care documentation requirements. Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.		
PH-9: Nursing admission notes lacked documentation of an orientation to the infirmary.	See PH-8 suggested corrective action.		
PH-10: Documentation did not indicate daily rounds in person or by phone by a physician or clinical associate.	Ensure rounds are completed and documented daily. Place documentation in the CMA CAP assessment closure file.		
PH-11: Discharge summaries were not always dated and timed by the physician.	See PH-8 suggested corrective action.		

CHRONIC CARE

Records Reviewed:		ASTHMA CLINIC RECORD REVIEW	Records Score
7			93
Finding(s)	Suggested Corrective Action(s)		
PH-12: Histories were insufficient for the indicated condition. It was also found that dates of attacks were not consistent with chart documentation.	Provide in-service training on documentation requirement for asthma clinic. Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.		

Records Reviewed:	DIABETES CLINIC RECORD REVIEW	Records Score
7		98
Finding(s)	Suggested Corrective Action(s)	
PH-13: Annual testing for the presence of microalbuminia when clinically indicated was not always completed.	Provide in-service training to relevant staff on testing protocols. Review five records monthly for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.	

Records Reviewed:	TB/INH CLINIC RECORD REVIEW	Records Score
10		94
Finding(s)	Suggested Corrective Action(s)	
PH-14: Medical histories were incomplete and some missing.	Provide in-service training to relevant staff on TB/INH clinic documentation requirements. Review five records monthly for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.	

DENTAL CARE

Records Reviewed:	DENTAL SERVICES	Systems Score	Records Score
10		95	84
Finding(s)	Suggested Corrective Action(s)		
PH-15: Administration, management and supervision of the dental program were inadequate and were not meeting institutional needs. This is evidenced by: <ol style="list-style-type: none"> a. A lack of continuity in care. b. Incomplete or inadequate charting of dental findings, diagnosis and appropriate treatment. c. Treatment not provided/completed within reasonable time frames. d. Timely and appropriate measures were not always taken to maintain optimal dental health and function. 	Review current staffing and if needed increase recruitment efforts employ needed staff. Establish a system of supervisory review to ensure the continuity and completeness of care. Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.		

OTHER

INFECTION CONTROL		Systems Score
		92
Finding(s)	Suggested Corrective Action(s)	
<p>PH-16: Medical staff do not participate in or review the inspection process of the food service operation for sanitation and cleanliness.</p>	<p>Include dining facility inspections as part of the infection control program. At a minimum ensure that medical maintains copies of the inspection reports and address those issues that could have negative health implications.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>	

Records Reviewed:	INTRASYSTEM TRANSFERS	Systems Score	Records Score
7		92	80
Finding(s)	Suggested Corrective Action(s)		
<p>PH-17: The most current DC4-760, Health Information Transfer Summary, is not being used. There was no evidence that a LPN or higher-level health care provider reviews the DC4-760 upon arrival of an inmate. The DC4-760A Arrival Summary did not always contain all necessary information.</p>	<p>Ensure that most current forms are in stock and utilized. Provide in-service training to relevant staff on intrasystem transfer documentation requirements and instruct them to document review of DC4-760 on the same form.</p> <p>Review five records per month for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.</p>		

MEDICAL AREA AND INMATE HOUSING		Systems Score
		94
Finding(s)	Suggested Corrective Action(s)	
<p>PH-18: OTC medications and contents of the first aid kits did not always match the inventory log.</p>	<p>Perform a physical inventory of all OTC medications and first aid kits to ensure that inventories are correct. Place documentation in the CMA CAP assessment closure file.</p>	
<p>PH-19: The food service facility did not have an adequate supply of paper towels or hand soap readily available. Also, ice scoops were being stored in the icemaker.</p>	<p>These issues need to be addressed to appropriate staff to correct these basic sanitary deficiencies. Medical needs to keep a close eye on these areas to ensure corrective action is taken and that proper sanitary measures are maintained in order to maintain good infection control.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>	

Records Reviewed:		Systems Score	Records Score
10		88	80
MEDICATION ADMINISTRATION			
Finding(s)	Suggested Corrective Action(s)		
PH-20: The medication administration area was located in a high traffic area allowing frequent interruptions and distractions.	<p>Restrict access to only those personnel required for medication administration of the pill line. Consider relocating items needed by staff for other areas such as the infirmary log.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>		
PH-21: Oral cavity checks were not completed during medication administration times, which compromised contraband control of medications.	<p>An oral cavity check should be completed for each inmate. The person doing the check must have a clear view.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>		
PH-22: Medication orders were not consistently timed.	<p>Provide in-service training to relevant staff on medical orders documentation requirements.</p> <p>Review five records monthly for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.</p>		

Records Reviewed:		Systems Score	Records Score
7		100	85
OFFENDER BASED INFORMATION SYSTEM (OBIS)			
Finding(s)	Suggested Corrective Action(s)		
PH-23: Chronic illness clinic forms were not filed consistently in one location. Some were filed among the chronological progress notes and others behind the brown divider on the left hand side in accordance with DC policy.	<p>Provide in-service training to relevant staff on record organization.</p> <p>All records should be reviewed for organization and completeness before being returned to file.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>		
PH-24: 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 the most up-to-date information in the current volume. Staff may want to look at the process in which medical profile changes are made to identify possible deficiencies. Provide in-service training to relevant staff.</p> <p>Review five records monthly for compliance. Continue until corrective action is affirmed through the CMA CAP assessment.</p>		

QUALITY MANAGEMENT		Systems Score
		67
Finding(s)	Suggested Corrective Action(s)	
PH-25: The quality management program has been inactive. Only one set of minutes was available for review. The annual clinical quality review had not been conducted and required reports had not been completed.	<p>Provide in-service training to relevant staff on the requirement of the quality management program. Compose a letter to committee members detailing them of their responsibilities. Take necessary action to establish bring into compliance the quality management program.</p> <p>Place documentation in the CMA CAP assessment closure file.</p>	

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

System Reviews

- Consultation Request
- Mortality Review
- OBIS Health Record

Record Reviews

- General Medicine Clinic
- Mortality Review

CONCLUSION

The CMA survey of Hardee Correctional Institution revealed clinical documentation and timeliness deficiencies primarily in the area of episodic care. The review of chronic care revealed a level of physical health care consistent with expected and required standards. Staff was complimented for their use of preprinted chronic illness forms. The quality management program was nearly inactive. Management and staff seemed dedicated and conscientious and had positive attitudes. There was good cooperation and communication between the medical department and security.

MENTAL HEALTH FINDINGS

Hardee Correctional Institution provides mental health services to an S1/S2 outpatient mental health population of adult male inmates. Of the 1,610 inmates served at the time of the survey, 53 were S2 inmates and the remaining inmates were S1s. Wexford Health Sources provided the mental health services at the institution.

Survey Results

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

Records Reviewed:	PSYCHIATRIC RESTRAINTS	Systems Score	Records Score
N/A		83	N/A
Finding(s)	Suggested Corrective Action(s)		
MH-1: Medical and security staff had not received training in the use of psychiatric restraints.	Provide appropriate training by April 2003. Include training as a component of the required annual training for all staff.		

Records Reviewed:	SELF-INJURY/SUICIDE PREVENTION	Systems Score	Records Score
23-hr N/A		88	N/A
SOS 7			70
Other N/A			N/A
Finding(s)	Suggested Corrective Action(s)		
MH-2: The physician's orders for suicide observation status (SOS) were incomplete in the cases reviewed: <ol style="list-style-type: none"> a. Orders were not consistently timed. b. Orders were not consistently dated. c. The frequency of suicide observation was not noted on the orders. d. SOS was not consistently reordered daily. e. Items allowed while on SOS such as mattress, blanket, privacy garment, etc., were not consistently specified in orders. 	Provide training to medical staff on requirements for physician's orders for SOS. Complete monthly reviews of five SOS records for compliance. Continue monitoring until completion of the initial CMA Corrective Action Plan (CAP) assessment visit.		

Records Reviewed:		SELF-INJURY/SUICIDE PREVENTION	Systems Score	Records Score
23-hr	N/A		88	N/A
SOS	7			70
Other	N/A			N/A
Finding(s)		Suggested Corrective Action(s)		
<p>MH-3: Documentation of the use of alternate medical cells for two SOS patients was incomplete:</p> <p>a. The physician's orders and infirmary progress notes did not document that the patients were managed in alternate medical cells. (See discussion below).</p> <p>b. The physician's orders did not specify continuous observation of the inmates as required.</p>		<p>Provide training to medical staff on requirements for physician's orders for SOS including identification of inmates managed in other than infirmary isolation cells.</p> <p>Complete monthly reviews of five SOS records for compliance. Continue monitoring until completion of the initial CMA Corrective Action Plan (CAP) assessment visit.</p>		
<p>MH-4: Notes of daily (weekday) rounds by the attending physician were not consistently present in the SOS records reviewed.</p>		<p>Provide training to medical staff on requirements for daily physician rounds and documentation of rounds.</p> <p>Complete monthly reviews of five SOS records for compliance. Continue monitoring until completion of the initial CMA Corrective Action Plan (CAP) assessment visit.</p>		

Discussion:

MH-3: Similar to other institutions, Hardee has two cells in confinement which have been identified as alternate medical beds. Staff reported that these beds are not used for SOS patients unless the certified infirmary isolation cells are occupied. Two such cases were identified during the survey. The alternate medical cells have not yet been retrofitted and certified for suicide isolation. Inmates placed in the alternate medical cells on SOS must be observed on a continuous basis. It is in the interest of patient safety to ensure that the use of these cells is clearly documented in the record, particularly the requirement for continuous observation.

OUTPATIENT MENTAL HEALTH SERVICES

There were no significant findings in this area of service delivery that required corrective action. There were three isolated issues including one case of incorrect documentation of S grade, one case where a mental health consent form was missing from the chart, and one case where an individualized service plan (ISP) review was late.

INTELLECTUAL FUNCTIONING

There were no significant findings in this area of service delivery that required corrective action. There was one record that lacked documentation of the initial psychological and intellectual screening. One inmate had been approved for work release although follow-up intellectual screening was pending (he was referred to the mental health staff at the time of the survey). Two inmates had multiple disciplinary reports indicating that cognitive dysfunction may be contributing to their behaviors. The staff had already identified the inmates as requiring further testing and assessment for clinical intervention.

Records Reviewed: OTHER ADMINISTRATIVE ISSUES	
N/A	
Finding(s)	Suggested Corrective Action(s)
MH-5: The construction of the sprinklers in the infirmary isolation cells was unsafe. Cloth or other material could be successfully tied to the sprinkler pipes resulting in a hanging (See discussion below).	<p>Address the construction problems to ensure a safe environment for SOS patients.</p> <p>Provide continuous monitoring of inmates placed in the infirmary isolation cells on SOS until the problem has been resolved.</p>

Discussion:

MH-5: The sprinklers in both cells could be reached by standing on the toilets. Communication with the regional mental health consultant (RMHC) on January 31, 2003 indicated that the sprinkler heads were designed to breakaway under 40 pounds of pressure, however, the pipes leading to the heads protruded from the cell walls. Cloth or other material could be successfully tied to the pipes and result in a completed hanging. Communication with the Assistant Warden for Operations on January 31, 2003 indicated that inmates placed in the infirmary on SOS currently receive 1:1 continuous monitoring. Continuous monitoring will be provided until the problem with the sprinklers has been resolved.

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
- Sexual Offender Services
- Special Housing

Record Reviews

- Access to Mental Health Services
- Sexual Offender Services
- Special Housing

CONCLUSION

The mental health staff provided all necessary services in a timely and effective manner. The primary area requiring corrective action related to the documentation of suicide observation status. The physician's orders for suicide observation status were often incomplete.

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.