



# **CORRECTIONAL MEDICAL AUTHORITY**

## **CLOSE MANAGEMENT MONITORING SURVEY**

of

## **LOWELL CORRECTIONAL INSTITUTION**

in

**Lowell, Florida**

on

**April 19 - 22, 2005**

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## SURVEY PURPOSE

In December 2001, the department entered into an agreement in a lawsuit entitled *Osterback v. Moore*. This lawsuit involved mentally ill inmates housed in a restricted setting called close management. Plaintiffs argued the placement of an inmate with a mental illness in a restricted housing unit exacerbated the symptoms of the mental illness. This claim was centered around the contention that placement in a close management unit, in which the majority of the inmates are housed in single-cells for 24 hours per day, is a form of sensory deprivation.

As a result of the agreement, the department committed to significant changes in the close management (CM) program. Prior to the lawsuit, close management units were located throughout the state in institutions that also housed general population inmates. The *Osterback* agreement required consolidation of all close management inmates into four facilities that house only close management inmates. The four specified institutions were Florida State Prison (FSP), Santa Rosa Correctional Institution (SARCI), Charlotte Correctional Institution (CHACI) and, for females, Dade Correctional Institution (DADCI). Subsequently, the department designated Lowell Correctional Institution (LOWCI) as the facility for close management females and added an additional institution for male inmates, Union Correctional Institution. In early December 2004, a 116-bed transitional care unit (TCU) was opened at Union Correctional Institution (UNICI) to house close management inmates requiring inpatient mental health services (referred to as “V” dorm).

A primary focus of the agreement included increased mental health assessment and treatment. Prior to placement in close management housing, mental health staff complete an assessment, recommending the level of programming needed for adequate adjustment. Then, a Behavioral Risk Assessment is completed. This document identifies areas, such as risk for suicidal behavior and violence, where programming and treatment should be focused.

Once the assessment is completed, the agreement calls for increased mental health treatment for those close management inmates in need of services. The 2001 General Appropriations Act provided additional mental health staffing to FSP and SARCI for this purpose. Increased group treatment as well as an expanded treatment team including security, classification, and program staff are significant changes enacted by the agreement.

In addition to mental health treatment, increased contact with program staff, to include education and religious services, increased phone calls and visitation, and increased outdoor recreation time are enhancements to the close management program.

The *Osterback* agreement also included a stipulation that the authority monitor the provisions of the agreement. In response to this requirement, the authority developed a monitoring instrument based on the *Osterback* agreement, Chapter 33-601.800, F.A.C., and Office of Health Services (OHS) policies and procedures. The authority provided the instrument to department staff and the plaintiffs’ attorneys for review and comment.

## DEMOGRAPHICS

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

Close Management Level	Current Census
Close Management Team Decision 1	9
Close Management Team Decision 2	11
Close Management Team Decision 3	19
Total Close Management Population	39

### Program Description

Close management inmates at Lowell Correctional Institution (LOWCI) were housed on one wing of one dorm in the Annex portion of the institution. The full range of outpatient mental health services was available including group and individual treatment, case management, psychiatric consultation, psychotropic medications and referral to inpatient care. Close management inmates were permitted reading materials, and the right to purchase a portable radio with headphones. Educational and literacy courses were available. Documentation reviewed and inmate interview data indicated exercise was provided as required. In progressive stages based on their individual classifications, inmates were permitted to make monitored telephone calls, receive canteen privileges, dayroom access, access to social television programs during dayroom periods, and non-contact visits.

According to documentation provided by the institution at the time of the survey, clinical staff dedicated to the CM program included one senior psychiatrist, one senior psychologist, one psychological specialist, and one registered nurse. The psychiatrist also provided reception and orientation services. The inmate population receiving outpatient mental health services in the combined main unit, annex, and satellite units was in excess of 1,100 inmates at the time of the survey: 909 psychological grade three (S3) and 203 psychological grade two (S2) inmates. Four senior psychiatrists were employed to provide psychiatric services to the combined S3/S2 population.

## OVERVIEW

### **Survey Summary**

The survey consisted of 33 individual inmate record reviews. These included seven close management mental health and classification record reviews, nine self-injury/suicide prevention record reviews, eight psychotropic medication practices record reviews, and nine post use-of-force record reviews. A comprehensive review was also completed of close management systems including policies, procedures, and practices. A tour was conducted of the close management housing wing including the dayroom and recreation yard. A sample of inmate daily record of segregation forms (DC6-229) was reviewed for mental health rounds, dayroom access including justification for the suspension of privileges, telephone privileges, canteen privileges, and exercise obtained. Finally, formal interviews were conducted with the senior psychologist, the classification supervisor, six correctional officers, and six inmates. The inmates interviewed represented various levels of close management. Five of the six inmates were S3s and one was an S2.

### **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 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.

# FINDINGS

## Survey Results

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

Records Reviewed:	<b>CLOSE MANAGEMENT RECORD REVIEWS</b>
7	
Finding(s)	Suggested Corrective Action(s)
<b>CM-1: Information on the Behavior Risk Assessment (BRA) item “A” was not consistently accurately rated (see discussion below).</b>	Review BRA requirements to ensure rating accuracy.  Monitor a minimum of ten records per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.
<b>CM-2: Institutional Classification Team (ICT) reviews were not consistently documented at the required intervals (see discussion below).</b>  <b>Note: <i>This was also a finding of the 2003 CM survey.</i></b>	Ensure that ICT reviews occur at specified intervals (once per week for the first 60 days in CM and every 30 days thereafter).  Provide training to relevant staff on the need to document reviews (Form DC6-229, <i>Daily Record of Segregation</i> ).  Monitor a minimum of ten classification records per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.

## Discussion:

### CM-1

BRA item A, *Major Axis I Disorder* was not consistently accurately rated given documented history and symptoms in two of the seven CM record review cases. In one case, item A was rated as “0” (no history) despite the inmate arriving at Lowell CI with a diagnosis of Depressive Disorder. She was prescribed Prozac and was symptomatic. Based on an individualized treatment plan (ITP) dated August 03, 2004, the inmate met the criteria for Major Depression. In March 2005, she was placed on suicide observation status (SOS) in one of the observation cells in the annex.

In one other case, the BRA dated March 17, 2005, rated item A as “0” despite moderate to mild symptoms of impairment in November through December 2004. Furthermore, the March 21, 2005, ISP documented the “inmate reports symptoms on a daily basis.” Details of both cases were passed on to the institution at the time of the survey.

### CM-2

The ICT reviews were not consistently documented in two of the seven CM cases reviewed. Also, five additional inmates were randomly selected and their DC6-229, *Daily Record of Segregation* forms reviewed. Four of these records also indicated inconsistent documentation of the required ICT reviews. Furthermore, in one case the indicated on-site interview by the State Classification Team (SCO) was not documented (form DC6-233 C, *Report of Close Management*). The DC #s and names of the seven inmates were provided to the institution at the time of the survey.

**Additional Discussion Items:**

1. A number of issues did not rise to the level of systemic findings requiring corrective action. However, during the survey individual cases were referred for review by staff to rule out potential problems. These included one inmate whose record indicated that problems in behavior and/or adjustment may not have been entirely adequately addressed. One inmate may benefit from review of the decision to downgrade to S1. One inmate may benefit from review for medical and/or psychiatric problems related to a possible eating disorder. During her interview, one inmate who had previously refused psychotropic medication indicated she was experiencing symptoms and may benefit from reassessment for medication. One inmate did not have a current consent for mental health treatment in her record. Another record lacked indicated end-of-sentence (EOS) planning, although there was time to accomplish this within required time frames. Finally, one record documented some inconsistency in the diagnosis which would benefit from further review.
  
2. In three of the seven CM cases reviewed, problems were identified with the inmate signatures on the ITPs (these signatures are intended to document the patient’s input in the treatment planning process). In one case, the ITP was signed by the inmate before it was completed. In another case, the inmate had signed consecutive scheduled ITP reviews before they had been completed. In one final case, the inmate’s signature on the ITP was not dated. This issue was addressed by the Assistant Director of Mental Health via e-mail dated April 21, 2005 (during the survey). This e-mail directed staff to document patient input into the treatment planning process as part of the patient encounter during which treatment goals, plans and reviews are discussed with the inmate. A draft ISP should be presented to the multidisciplinary treatment team (MDST) and finalized by having all members sign and date the ISP. If the patient is not present during the MDST meeting, she will be asked to sign and date the ISP during the next encounter.

<b>PSYCHOTROPIC MEDICATION PRACTICES</b>	
<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>
<b>CM-3: Psychotropic medications were not consistently continued as directed while the inmates were in close management housing status.</b>	<p>Ensure medications are administered as directed.</p> <p>Monitor a minimum of ten records per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.</p>

**Discussion:**

**CM-3**

The medication administration records (MARs) indicated doses of prescribed medications were missed in two of the seven close management record review cases. There were no documented reasons for this. The cases were passed on to the institution at the time of the survey.

Records Reviewed:	<b>SELF-INJURY/SUICIDE PREVENTION</b>
SOS	9

Finding(s)	Suggested Corrective Action(s)
<b>CM-4: Infirmiry records with required SOS documentation were not consistently opened for SOS inmates housed in J dorm observation cells (this applied to both CM and general population inmates).</b>	<p>This finding was addressed by the department at the time of the survey (see policy revision discussion below).</p> <p>Monitor a minimum of ten SOS cases per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.</p>
<b>CM-5: SOS patients were not consistently housed in the infirmary when an infirmary isolation management room (IMR) was available. Patients were instead housed in J dorm observation cells (this applied to both CM and general population inmates).</b>	<p>This finding was addressed by the department at the time of the survey (see policy revision discussion below).</p> <p>Monitor a minimum of ten SOS cases per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.</p>
<b>CM-6: SOS episodes were not consistently entered into the offender based information system (OBIS). This applied to both CM and general population inmates.</b>	<p>Ensure all SOS cases are entered into OBIS.</p> <p>Monitor a minimum of ten SOS cases per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.</p>
<b>CM-7: In five of nine records, the shift nursing assessments were not consistently documented (two inmates were CM and three were general population).</b>	<p>Ensure appropriate documentation occurs. Train staff as necessary.</p> <p>Monitor a minimum of ten SOS cases per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.</p>
<b>CM-8: In four of nine records, SOS patients were not consistently observed at the frequency ordered by the physician (two inmates were CM and two were general population).</b>	<p>Ensure appropriate documentation occurs. Train staff as necessary.</p> <p>Monitor a minimum of ten SOS cases per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.</p>
<b>CM-9: In four of nine records, entries in the records were not consistently timed, dated, signed, and stamped (three inmates were CM and one was general population).</b>	<p>Ensure appropriate documentation occurs. Train staff as necessary.</p> <p>Monitor a minimum of ten SOS cases per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.</p>
<b>CM-10: In three of nine records, post-discharge follow-up sessions were not consistently provided at the required frequency (one inmate was CM and two were general population).</b>	<p>Provide training to responsible staff.</p> <p>Monitor a minimum of ten SOS cases per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.</p>

Records Reviewed:		<b>SELF-INJURY/SUICIDE PREVENTION</b>	
SOS	9		

Finding(s)	Suggested Corrective Action(s)
population).  <i>Note: This was also a finding of the 2003 CM survey.</i>	closure is affirmed by the CMA CAP assessment.
<b>CM-11: In three of nine records, daily physician rounds were not consistently documented (all were general population inmates).</b>	Ensure appropriate documentation occurs. Train staff as necessary.  Monitor a minimum of ten SOS cases per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.
<b>CM-12: In two of nine records, SOS orders were not consistently dated and timed (both were CM inmates).</b>	Ensure appropriate documentation occurs. Train staff as necessary.  Monitor a minimum of ten SOS cases per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.
<b>CM-13: In two of nine records, the time frames for on-site management of SOS at an S3 institution were exceeded (one inmate was CM and one was general population).</b>	Ensure guidelines for on-site management of SOS at an S2/S3 institution are followed. Train staff as necessary.  Monitor a minimum of ten SOS cases per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.
<b>CM-14: In two of nine records, daily counseling by mental health staff was not consistently documented (both inmates were general population).</b>	Ensure appropriate documentation occurs. Train staff as necessary.  Monitor a minimum of ten SOS cases per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.

**Discussion:**

**Background**

Of the nine SOS patients reviewed, four were on CM status and five were general population inmates. Three of the five CM SOS patients were managed in J dorm observation cells; two were admitted to the infirmary then subsequently managed in J dorm observation cells. Three of the five general population SOS patients were managed in J dorm observation cells; two were admitted to the infirmary. The above findings clearly apply to the management of suicidal and self-injurious behaviors for both CM and general population inmates.

Lowell CI has four IMRs located in the infirmary. These cells are certified to SOS standards. Additionally, there are 12 observation cells located in the annex in J dorm that are certified to SOS standards. At the time of the survey, two of the J dorm observation cells were inspected by the survey team (J1106 & J1108). Unacceptably sharp edges were found on the bunk drawers (these could be used

for self-harm). During the survey, the sharp edges were removed from the two cells. The cells were subsequently inspected by the department and recertified to SOS standards. The institution inspected the remaining ten observation cells and determined they also needed the same repairs. The repairs were completed and the 10 remaining observation cells recertified by the department on Wednesday April 27, 2005. Documentation of the recertification was provided to the CMA on April 28, 2005. Notably, one of the CM records reviewed by the survey team indicated the inmate had threatened to cut herself on the sharp edges of her bunk drawer (this case was referred to the institution at the time of the survey).

### **Suicide and Self-Injury Policy Revision**

On July 21, 2004, the authority provided detailed written comments to the department regarding the then draft Procedure 404.001 *Suicide and Self-Injury Prevention*. The authority expressed concern that the use of an observation cell did not require admission to the infirmary with accompanying required documentation. This portion of the policy, which was finalized in December 2004, introduced a lesser standard of documentation of care for SOS patients housed in observation cells outside the infirmary. The authority was concerned that legal issues of disparate care could be raised for suicidal and self-injurious behavior occurring in observation cell housing if different levels of documentation of care and interventions were found. The authority recommended the policy be revised to require infirmary admission documentation for SOS patients temporarily housed in observation cell settings. While these policy changes were not forthcoming at the time, the department is nevertheless commended for directing these changes in response to the above noted findings of the Lowell CM survey. A summary of the revisions follows.

On Wednesday April 20, 2005, the department took immediate corrective action regarding Procedure 404.001 *Suicide and Self-Injury Prevention* when the department's Mental Health Director issued the following directives to the field via e-mail. The use of an observation cell for suicide and self-injury prevention was revised in policy to require admission to infirmary mental health care with all accompanying required documentation. In addition, observation cells are not to be used for SOS patients if an infirmary IMR is available. The use of an observation cell (when an IMR is not immediately available) is to occur only for the purposes of providing safe, temporary housing until the inmate can be evaluated by mental health staff. Such use of an observation cell is not to exceed 72 hours. Finally, an infirmary record must be opened when an inmate is housed in an observation cell.

### **Suicide and Self-Injury Prevention Findings**

For each of the findings, documentation of the cases was passed on to the institution at the time of the survey. Three additional issues did not rise to the level of findings. In one case, the physician did not specify the required interval of observation. In another case, the SOS order was not renewed every twenty-four hours. Finally, one inmate's discharge from SOS may have been premature. These cases were all passed on to the institution at the time of the survey.

### **General Discussion Item:**

In general, the medical records were in disarray. For example, the suicide and self-injury prevention documentation was scattered between the medical record and the infirmary record. It was difficult to locate many items needed to complete the survey. Some similar issues applied to the classification files. For example, the classification records did not contain the DC6-229, *Daily Record of Segregation* forms for 2005 (these were provided). The institution was given an opportunity to locate missing documentation and in many cases was able to find the items in question. However, reliable quality review, whether carried out by the department or the CMA, is potentially hampered by inconsistent and disorganized documentation.

## **CONCLUSION**

Overall, the close management program has continued to provide required services to the female close management population at Lowell CI. Corrective action is required in three areas including accurate rating of information on the Behavior Risk Assessments, consistent documentation of Institutional Classification Team reviews, and consistent administration of psychotropic medications for inmates in close management housing.

Finally, the documentation of suicide and self-injury prevention for both close management and general population inmates requires significant attention. Commendably, the department implemented immediate corrective action at the time of the survey to clarify documentation and management requirements for suicidal and self-injurious inmates at Lowell CI and system-wide. The CMA anticipates considerable change at the time of the corrective action plan assessment of this survey.