

**CORRECTIVE ACTION PLAN
ASSESSMENT**

Of

Lowell Correctional Institution

Held on

January 8, 2004

For the

Close Management Monitoring Survey
Conducted May 27-29, 2003

CMA Staff

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CAP Assessment of Lowell Correctional Institution

Overview

On May 29, 2003, the Correctional Medical Authority (CMA) concluded a close management monitoring survey of Lowell Correctional Institution (LOWCI). The survey report, detailing the findings of the survey team, was distributed on June 23, 2003. The CMA received the final corrective action plan (CAP) from the Department of Correction's Office of Health Services (OHS) on August 12, 2003. On January 8, 2004, CMA staff conducted an initial CAP assessment, the results of which are reported herein.

Assessment Summary

Ten mental health findings were reviewed during this CAP assessment. In the listing below, the remaining finding is described in detail.

Remaining Finding	Suggested Corrective Action
CM-7: Medication consent forms were not consistently present in the records reviewed.	<p>During the CAP assessment, a sample of five records was chosen to confirm corrective action. In all but one record, a current consent form was present. However, in the remaining four cases, the consent form was not completed in its entirety, often omitting indication of pertinent side effects. In one record, only the physician, and not the patient, had signed the form.</p> <p>Provide inservice training to psychiatrists on the proper completion of the medication consent form.</p> <p>Continue to monitor a minimum of five records each month until closure is affirmed through the CMA CAP assessment.</p>

Discussion of CM-3:

Finding CM-3 noted a lack of documentation of telephone calls, as well as mental health rounds, exercise, and dayroom access. A review of records conducted during the assessment continued to show a lack of documentation of telephone calls, as well as visitation. Several inmates were questioned regarding their access to phone calls and visits, and it was clear that these services were being provided as required. Therefore, the finding is considered closed. However, additional training should be provided to relevant staff members regarding the need to document this service on DC4-229.

Additional Discussion Item:

A review of records indicated that patients who are at risk for self-harm are being placed on 23-hour observation rather than Suicide Observation Status, as is required by policy. Regional staff had already identified this concern and implemented corrective action prior to this assessment.