# LOWELL C.I. SUPPLEMENTAL REPORT

**For CMA Survey Conducted January 22-25, 2002**

# PHYSICAL AND MENTAL HEALTH SURVEY FINDINGS REQUIRING OHS INTERVENTION

In addition to the physical and mental health findings of Lowell C.I. referenced in the main body of the survey report (which fall within the scope of the institutional staff to correct), several other areas of concern were noted. These findings may be based on standards adopted by the CMA, but not addressed in OHS policy, procedure, or directive, or on other issues beyond institutional control. Therefore, corrective actions at the institutional level can be initiated only by or with the authority or intervention of the OHS.

The items listed below identify the finding, the name of the audit instrument used by CMA surveyors and the specific screen number, if applicable, and what criteria were used to determine the standard was not met.

## PHYSICAL HEALTH

1. **Although staff stated that they conducted reviews of episodic care records; i.e., sick call and/or emergency care encounters, deficiencies in documentation and continuity of care revealed a need for a structured review process.** This standard is referenced in the CMA Administrative Audit Instrument, Screen 10 – "Is there a review of sick call and emergency charts by the senior nurse supervisor (SRN) and/or the chief health officer (CHO)? Charts should be reviewed by the SRN or CHO for appropriateness of care, medications, completeness of documentation, etc. If errors are found, are they addressed with the appropriate medical personnel?"

2. **No evidence was available demonstrating annual CHO and senior dentist peer review.** This standard is referenced in the CMA Administrative Audit Instrument, Screen 12 – "Is there at least an annual CHO and Senior Dentist peer review? These peer reviews should be conducted by another provider and be documented at the facility. Is there documentation of review of Physician Assistants and Advanced Registered Nurse Practitioners by the CHO, and dentists by the Senior Dentist?"

3. **The nursing staffing plan was heavily reliant upon agency nursing staff, averaging 350 staff hours weekly, according to administrative staff. Identified deficiencies in continuity of care and staff training were related to this problem.** This standard is found in the CMA Administrative Audit Instrument, Screen 6 – "Medical staffing should include a sufficient number of medical personnel to handle any medical situation that arises in accordance with the size and mission of the institution. Criteria should include, average number of sick call patients, number of chronically ill patients, number of inmates on pill call, infirmary status, number of inmates, mental health inmates, etc."

4. **Medication issues were identified in the following areas:**
    a) **Orders were not transcribed within four hours of being written, and**
    b) **Medications were not started within 24-hours.**

   This standard is referenced in the CMA Medication Administration Record and Chart Review Instrument, Screens 3 and 7 – “All orders were transcribed within four hours”; and “Any medication orders were started within twenty-four hours of the order. Exceptions can be made for non-formulary items.”

**MENTAL HEALTH**

1. **Physician’s orders did not specify observations at least every 15 minutes for inmates admitted to the infirmary for observation and prevention of self-injurious/suicidal behavior.** This standard is referenced in the CMA Self-Injury/Suicide Prevention Record Review Instrument, Screen 3 and is based upon national correctional healthcare standards and prevailing professional practices in the community at large.

2. **Twelve hours of clinical in-service was not provided to clinical staff annually.** This standard is referenced in the CMA Outpatient Mental Health Services Systems Screens Instrument, Screen 12 – “Treatment staff receive orientation, to include suicide prevention and restraints, and 12 hours of relevant in-service training annually.”

3. **Existing suicide/self-injury policy and procedures related to 23-hour Observation Status provides inadequate guidance to clinical staff at the institutional level. Resulting documentation was disjointed and failed to portray the event and interventions provided by staff. Policy direction given to staff required that they document in multiple subsections of the record despite the provision of care in a single setting. This process prevented a reviewer from chronologically tracking and evaluating care.** This standard is referenced in the CMA Self-Injury/Suicide Prevention Systems Screens Instrument, Screen 1 – “There is a written suicide/self-injury prevention policy/procedure that is detailed and clearly outlines policies and procedures for use with inmates considered to be at risk of suicide or self-harm, regardless of assessed motivation of the inmate (i.e. manipulative vs. mental health reasons).”