

CORRECTIONAL MEDICAL AUTHORITY (CMA)

PHYSICAL & MENTAL HEALTH SURVEY

OF

MAYO CORRECTIONAL INSTITUTION

in

Mayo, Florida

January 25 – 27, 2000

INSTITUTIONAL STATISTICS PROVIDED CMA ON January 11, 2000				
Population	Custody	Type	Maximum Capacity	Current Occupied Beds
Adult	Minimum through Close	Male	978	925

MEDICAL GRADES				
I	II	III	IV	Impaired
574	360	0	0	0

"S" GRADES				
I	II	III	IV	Impaired
0	14	0	0	0

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PHYSICAL HEALTH

Executive Summary

All conclusions were based on a sample review of medical records; interviews with offenders, health care providers and security staff; and a physical inspection of the institution.

Mayo Correctional Institution (MAYCI) is a close custody institution for minimum/close custody adult males. The institution was initially constructed in 1983 and reported a capacity of 978 beds. Their inmate census at the time of survey was 925. Both capacity and population had increased by approximately 250 offenders since the last survey in 1996. Health care staff had decreased from 13 to eight during that same period of time.

Health care consolidation had begun at MAYCI. The two primary clinical positions at the institution, the chief health officer and clinical associate, were half-time positions. Their other work location was Madison Correctional Institution (MADCI). The nurse supervisor was resigning the day after the survey's completion. Her replacement was to be the nurse supervisor also from MADCI, assigned on a half-time basis. There were concerns that using part-time clinicians and supervisors might compromise the overall quality of service. Some deficiencies in continuity of care and administrative functions were identified during the survey. It is too soon to tell what impact if any, these changes will have on clinical services and patient outcomes.

The survey findings produced four Level II citations, three concerning clinical management and one administrative deficiency. There was one additional issue identified.

Strengths

1. A review of Diabetes and TB/INH clinic records revealed timely care with no deficiencies.

Citations - Level I

There were no Level I citations noted during this survey.

Citations - Level II

CLINICAL MANAGEMENT / DOCUMENTATION

1. Assessment and/or treatment deficiencies were noted in all five (100%) infirmary records reviewed.
2. Deficiencies were identified in the following three chronic illness clinics:
 - a. Eight of nine (89%) COPD/asthma clinic records lacked elements of clinical documentation and/or inmate health education;
 - b. Three of nine (33%) hypertension clinic records evidenced treatment and/or health education deficiencies; and
 - c. A concern was identified in one of four (25%) seizure disorder records.

3. One of five records selected for a comprehensive review lacked evidence of a biennial physical examination. Two records demonstrated incomplete annual/biennial physical examinations. Offender health education was not documented as required in each of the five reviewed records.

Administrative

4. Minimum requirements for health care staff inservice training and mock code drills were not met.

Additional Issues Noted

5. Offenders complained that nursing staff failed to adequately announce confinement medical rounds. A review of two months of sign-in/out logs in confinement revealed that nurses spent an average of 16 minutes per visit performing confinement rounds, medication administration and documentation of their activities for the approximate 50 offenders housed there.

MENTAL HEALTH

Executive Summary

All conclusions were based on a sample review of medical records; interviews with inmates, health care providers and security staff; and a physical inspection of the institution.

Mayo Correctional Institution remains a close custody institution for adult males with a maximum capacity of 978 offenders. The pre-survey questionnaire indicated there were 925 occupied beds. Notably, the institution no longer houses close management inmates.

The structure and organization of the health care delivery system had changed since the 1996 CMA survey. According to documentation provided by the Department of Corrections, Office of Health Services, under phase three of the Department's Health Care Consolidation plan, Mayo Correctional Institution is classified as a Level 1 institution. Level 1 institutions, with some exceptions, essentially house medical grade 1 offenders with minimal or no health care problems. These institutions may not have 24-hour coverage or a full-time physician, and there may not be an operative infirmary (under these circumstances seriously ill offenders would be transferred to a covering institution). An advanced registered nurse practitioner will be assigned to most level 1 facilities.

According to the pre-survey questionnaire, there were 360 medical grade 2 offenders in addition to the 574 medical grade 1 offenders housed at Mayo Correctional Institution (compared to 209 and 448 respectively in 1996). There were 14 psychological grade 2 offenders (compared to 23 in 1996); the remainder of the offender population was psychological grade 1, as in 1996. There was 24-hour physician on-call coverage and 24-hour nursing coverage available. A part-time nurse practitioner was on staff and there was an operative infirmary.

In contrast to 1996, the senior psychologist position was allocated as a part-time position. This individual also had responsibility for mental health administration and service delivery functions at Madison Correctional Institution. Additionally, the psychological specialist allocations had been reduced from three positions in 1996 to two positions. At the time of the survey, the senior psychologist had been assigned to this institution two days a week for approximately seven weeks. The two remaining psychological specialists were long-term employees of the mental health department. It is too soon to tell what impact, if any, these changes will have on the mental health delivery system and patient outcomes.

The institution received two Level II citations regarding access and clinical management issues. One additional issue was noted.

- Indicated mental health assessment and follow-up was not consistently provided in the suicide observation cases reviewed.
- Daily physician reviews and appropriate orders were inconsistently documented in the suicide observation cases reviewed.
- There was no institutional operating procedure for the administration of involuntary psychotropic medication on an emergency basis.

Strengths

1. Three treatment groups were scheduled to start despite the reductions in mental health staff.
2. All offender requests (98) for mental health services in the six months prior to the survey had been responded to in a timely manner.

Citations - Level I

There were no Level I citations noted during this survey.

Citations - Level II

Access

1. Indicated mental health assessment and follow-up was not consistently provided in three of the six (50%) suicide observation cases reviewed.

Clinical Management/Documentation

2. Daily physician reviews and appropriate orders were inconsistently documented in the suicide observation cases reviewed.

Additional Issues Noted

3. In the event that an emergency treatment order might be indicated, there was no institutional operating procedure which addressed the issue.