CORRECTIONAL MEDICAL AUTHORITY

PHYSICAL & MENTAL HEALTH SURVEY

of

SOUTH FLORIDA RECEPTION CENTER

in

Miami, Florida

on

May 14 – 17, 2002

INSTITUTIONAL STATISTICS PROVIDED CMA on May 7, 2002		
Population	**Custody**	**Type**
Adult & Youthful	**Maximum**	**Male**

Main Unit Capacity	Current Main Unit Census	Current Number of Inmates Served
1509	1170	1170

CMA Physical Health Team Leader:
John W. Rainey, B.S.

Physical Health Team Members:
Stan Frankowitz, D.O.
William Haeck, D.O.
Roberta Diel, D.D.S
Fidel Gonzalez, P.A.
Teresa Wilhite, R.N.

CMA Mental Health Team Leader:
Kathy Pilkenton, M.S.W., M.Ed.

Mental Health Team Members:
Peter McGrath, M.D.
Victoria Urrutia, M.D.
Sherry Roth, Ph.D
Nancy Williams, Ph.D, L.C.S.W.
Sandra Bauman, Ph.D, A.R.N.P.
Pete Tyre, A.R.N.P.

OVERVIEW

On May 17, 2002, the Correctional Medical Authority concluded a physical and mental health survey of South Florida Reception Center (SFRC), located in Miami, Florida. At the time of the survey, SFRC served an adult and youthful offender male population of approximately 1170 inmates assigned to medical grades 1through 4 and psychological grades 1 through 5. SFRC was classified as a medical level 4 facility. Inmates requiring complex medical/dental care or psychotropic medication/inpatient mental health services were housed at this institution.

Medical Grade	***1***	***2***	***3***	***4***	***Impaired***	
	690	**127**	**282**	**4**	**13**	
Mental Health Grade (S-Grade)	***Mental Health Outpatient***			***MH Inpatient***		
	1	***2***	***3***	***4***	***5***	***Impaired***
	935	**36**	**84**	**0**	**29**	**6**
Confinement/ Close Management	***DC***	***AC***	***PM***	***CM3***	***CM2***	***CM1***
	37	**32**	**4**	**9**		

The goal of the survey was to determine if the physical/dental and mental health care systems in place at the institution were consistent with the 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.

A thorough review of the physical health-related systems in place at the institution, including the physical plant, administrative processes, and the provision and documentation of care was conducted. Survey findings suggest that episodic, chronic, preventative and dental care is being provided at a level appropriate to the inmate population. Most deficiencies were identified in other physical health program areas. One particular area of concern is the filing and record keeping of both physical and mental health documentation.

The numerous mental health findings reflect both the complexity of SFRC’s mental health mission (reception center, outpatient and inpatient services) and the transition of services from one private vendor to another that has occurred over the past year. Of primary concern were issues arising in the crisis stabilization unit (a lack of therapeutic activities, a lack of documentation regarding observed physical injuries, and insufficient psychiatric and mental health staff contacts with suicidal patients). Also of concern were psychotropic medication management issues that reflected the need for immediate correction in order to ensure safe and effective medication administration.

At the conclusion of the survey, an exit conference was held on site with department staff to discuss the preliminary findings of the team members. The physical health and mental health sections of this report reflect the findings and final conclusions drawn following an analysis of the information collected during the survey. Where recommended corrective actions are provided, these recommendations should not be construed as the only action required to demonstrate corrections, but should be viewed as guidance for development of a corrective action plan.

The following table lists the results from the systems and record review instruments used during the survey:

Findings Summary			Numeric Score*		
			Systems	Records	
PHYSICAL HEALTH	Episodic Care	Sick Call	100	94	
		Emergency Care	64	100	
		Physician/CA Follow-Up Care		100	
		Infirmary Care		100	
	Chronic Care	Chronic Illness Clinic Systems	100		
		Asthma		97	
		Diabetes		99	
		General Medicine		97	
		Hypertension		98	
		Immunity		100	
		Seizure		91	
		TB/INH		92	
	Preventative Care		100	100	
	Dental Care		100	99	
	Mortality			96	
	Other	Administrative Audit	77		
		Consultations	79		
		Infection Control	87		
		Intake Process	90	86	
		Intrasystem Transfers	80	67	
		Medication Administration		59	
		OBIS	75	69	
		Pharmacy			
		Quality Management	79		
MENTAL HEALTH		Inmate Access to Mental Health Services	75	75	
		Outpatient Mental Health Services	87	S1	86
				S2	100
				S3	80
		Intellectual Functioning	100	100	
		Sexual Offender Services	83	100	
		Special Housing	80	93	
		Psychotropic Medication	50	70	
		Self-Injury/Suicide Prevention	83	77	
		Psychiatric Restraints	100	100	
		Inpatient Mental Health Services	88	65	

* A score of 100 represents meeting all minimum care/systems standards. A score of less than 80% represents unacceptable level of care/systems standards.

PHYSICAL HEALTH FINDINGS

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

EPISODIC CARE

Records Reviewed: 7	SICK CALL (Nursing Encounter)	Systems Score 100	Records Score 94

Finding(s)	Suggested Corrective Action(s)
PH-1: One record had a MD referral but lacked any follow-up note.	• Until closure has been affirmed through the CMA CAP review, monitor five sick call records per month for the following criteria: 1) encounter forms are being completed accurately and appointments are promptly entered into OBIS-HS, 2) health records are reviewed for completeness after each encounter before being filed.

Records Reviewed: 6	EMERGENCY CARE (Nursing Encounter)	Systems Score 64	Records Score 100

Finding(s)	Suggested Corrective Action(s)
PH-2: The treatment area was somewhat cluttered and in need of cleaning, and equipment checks were only performed weekly.	• Organize supplies and equipment while replacing any outdated or unclear equipment labels. • Check medical equipment daily to ensure proper working order. • All outdated materials/ equipment should be updated immediately. • Clean and paint area as needed.
PH-3: There is no emergency care log or other suitable tracking mechanism.	• Develop a suitable method of tracking and reviewing emergency care services. The information maintained should be considered confidential and clearly identify emergency encounters.

Discussion: The Ambu bag is old and in need of replacement. Emergency room equipment should include a blood glucose monitor. Also, consideration should be given to placing an emergency bag at the inpatient mental health building.

CHRONIC CARE

Records Reviewed: 3	SEIZURE CLINIC RECORD REVIEW	Records Score 91

Finding(s)	Suggested Corrective Action(s)
PH-4: One record did not appropriately reflect a consideration for tapered medications.	• Provide in-service training on clinical management for seizure clinic care. • Review seizure clinic records to ensure that consideration for tapered seizure disorder medication, as indicated has been given. • Include documentation of these actions in the closure file.

Records Reviewed: 7	TB/INH CLINIC RECORD REVIEW	Records Score 92

Finding(s)	Suggested Corrective Action(s)
PH-5: No pneumococcal vaccine in any TB/INH charts and two influenza eligible inmates did not receive the vaccine.	• Provide in-service training on influenza and pneumococcal vaccine requirements. • Review TB/INH records and schedule any indicated vaccines that have not been offered. • Include documentation of corrective action in the closure file.

Discussion: A review of records from the Asthma, General Medicine,and Hypertension chronic illness clinics contained minor deficiencies as indicated in the following description:

- Asthma – Two of six records lacked a PEF expressed in percent.
- General Medicine – Two of four records lacked an appropriate diagnosis on the problem list.
- Hypertension – One of six records lacked a TSH baseline laboratory study.

Corrective action should include in-service training regarding the respective area of deficiency and documentation should be included in the closure file.

OTHER

ADMINISTRATIVE AUDIT	Systems Score 77
Finding(s)	**Suggested Corrective Action(s)**
PH-6: A manual of policies was not readily accessible to all healthcare workers 24 hours a day.	• Ensure that a manual of policies is placed in an area that is available to all personnel 24 hours a day. • Include documentation of corrective action in the closure file.
PH-7: There was no policy in place concerning notification of family members regarding inmates with serious illness or life threatening emergencies.	• Establish a policy on emergency notification. • Include documentation of corrective action in the closure file.
PH-8: Sick call and emergency care events were not routinely reviewed by the RNS and/or the CHO.	• Implement a process whereby the CHO, RNS, or designee tracks and monitors sick call and emergency care events on a regular basis. A sample of such records should be reviewed, at least monthly, for appropriateness and completion of assessment, care and referral, as indicated. • Documentation of the process should be maintained in the closure file until correction is affirmed through the CMA CAP assessment process.
PH-9: Specialized training was not documented for inmate workers responsible for disposing of bio-medical waste.	• Provide all inmates required to handle bio-medical waste with relevant specialized training. • Include documentation in the closure file.
PH-10: Communication between food service personnel and the medical section was inadequate.	• Coordinate with food service personnel to obtain needed reports for managing effective inmate diet programs.

Discussion: A discussion with food service revealed that a program was being initiated to inform medical of inmate compliance with medical diets.

During the administrative audit it was found that employee records were kept meticulously and were very organized.

Records Reviewed: 10	CONSULTATIONS	Systems Score: 80	Records Score: 79

Finding(s)	Suggested Corrective Action(s)
PH-11: In four of the ten records reviewed, deficiencies were noted in one or more of the following areas: • **One record contained a consultation form that was not completely filled out.** • **Two records did not have appropriate staff progress notes.** • **Three records contained completed consultations that were not signed/initialed and dated by the treating physician within required time frames.** • **Three records were missing required progress notes by the advanced level provider.** • **Three records were lacking related ongoing treatment plans.**	• Provide in-service training on protocols for consultations and documentation requirements. • Monitor five records per month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
PH-12: There was no documentation of the consultation log being reviewed at least monthly by responsible parties.	• Review the consultation log monthly and maintain documentation indicating the review. The responsible party should be the HSA, CHO, designated upper level provider or the RNS.

INFECTION CONTROL	Systems Score: 87

Finding(s)	Suggested Corrective Action(s)
PH-13: No one was designated in writing to oversee the infection control program	• A person should be designated in writing as the infection control coordinator. The coordinator should be trained in the practices of infection control and related monitoring/reporting requirements. • Documentation should be maintained in the closure file.

	INFECTION CONTROL	Systems Score 87
Finding(s)	**Suggested Corrective Action(s)**	
PH-14: There was no eye wash station available within the dental area.	• Place an eye washing station in the dental area.	
PH-15: No refrigerator log was maintained.	• Ensure that a daily log is maintained for all medical refrigerators.	
PH-16: There was no evidence that monthly sanitation inspections of the facility were conducted.	• Ensure that a monthly inspection of the facility for sanitation is being conducted or reviewed by the medical department. • Appropriate documentation should be in the closure file.	

Records Reviewed: 8	INTAKE PROCESS	Systems Score 90	Records Score 86
Finding(s)	**Suggested Corrective Action(s)**		
PH-17: The reception area was found to be somewhat cluttered and in need of cleaning and/or painting.	• Organize supplies and equipment while replacing any outdated or unclear equipment labels. • The area should be cleaned thoroughly and repainted if needed.		
PH-18: In the review of eight records the following deficiencies were noted: • **Three records did not reflect that inmates were offered HIV testing, and they lacked signed refusal forms.** • **Five records did not indicate that inmates had received necessary immunizations.** • **One record lacked an indicated problem list.**	• Provide in-service training to appropriate staff on intake protocols and documentation requirements. • Monitor five records per month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment		

Discussion: Observation of the intake process revealed it to be well organized and efficiently ran.

Records Reviewed:	INTRASYSTEM TRANSFERS	Systems Score	Records Score
5		80	67

Finding(s)	Suggested Corrective Action(s)
PH-19: Written instructions for accessing health services were not provided and necessary immunizations were not routinely scheduled.	• Each offender should be given written procedures for accessing sick call and other health services. • Provide in-service training on required immunizations and monitor five intrasystem transfer records per month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
PH-20: In the five records reviewed the following deficiencies were noted: • **One record lacked evidence of the Health Information Transfer Summary being reviewed.** • **Three records had incomplete Arrival Summaries.** • **All five records lacked evidence that vital signs were taken.** • **One record did not have required annual appointments scheduled.** • **All five records lacked signature stamps or were unsigned.**	• Provide in-service training on protocols for intrasystem transfers and documentation requirements. • Monitor five records per month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Records Reviewed:	MEDICATION ADMINISTRATION	Systems Score	Records Score
7		82	59

Finding(s)	Suggested Corrective Action(s)
PH-21: During the systems review the following deficiencies were found: • **Narcotic counts were not being done,** • **Personnel were unaware of any policy manual, and** • **Oral cavity checks were not done.**	• On each shift a narcotics count should be performed and documented. • Personnel administering medication should be given specific training on the process. They should know where the policy manual is located and be familiar with related policies.
PH-22: Each of the seven records reviewed had one or more of the following deficiencies: • **Medication orders were not signed, dated and timed,**	• Provide in-service training on documentation and procedure requirements for medication orders and protocols for medication administration.

Records Reviewed:	MEDICATION ADMINISTRATION	Systems Score	Records Score
7		82	59

Finding(s)	Suggested Corrective Action(s)
• **Nurses did not fill in all MAR coding boxes,** • **Counseling for non-compliance was not provided, and** • **Nurses administering medication did not sign and initial the MARs.**	• Monitor five medication orders and MARs per month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Records Reviewed:	OFFENDER BASED INFORMATION SYSTEM (OBIS)	Systems Score	Records Score
4		75	69

Finding(s)	Suggested Corrective Action(s)
PH-23: Responsible personnel were unfamiliar with the process for checking the OBIS-HS medical record for completeness upon arrival and prior to transfer. Deficiencies were noted in accuracy and timeliness of entries in OBIS records as evidenced by: • **The HSS-15 was not being printed and updated weekly,** • **Medical contacts, lab results and passes found in medical records were not reflected in OBIS, and** • **PULHESDXTI data in OBIS did not match the latest health record entries.**	• Provide in-service training on data entry requirements for OBIS records. • Monitor five records per month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.

Discussion: The medical records section was disorganized and records were not being updated timely. Medical records were found to contain medical documentation of other inmates. It appeared that medical appointments were being entered in a timely manner but entry of routine contacts was somewhat delayed. There appeared to be problems in providing data entry staff all the needed information to keep the various reports up-to-date.

QUALITY MANAGEMENT	Systems Score 79
Finding(s)	**Suggested Corrective Action(s)**
PH-24: No Clinical Quality Review Committee information was available.	• Review and implement protocols required by Office of Health Services Technical Instruction 15.09.01 or provide documentation of an acceptable alternative QM program.

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

System Reviews

- Chronic Illness Clinic Systems
- Preventative Care
- Dental Care
- Sick Call

Record Reviews

- Emergency Care
- Physician/NP/PA Follow-Up
- Infirmary Care
- Asthma Clinic
- Diabetes Clinic
- General Medicine Clinic
- Hypertension Clinic
- Immunity Clinic
- Preventative Care
- Dental Care
- Mortality

CONCLUSION

Physical health care services provided at SFRC appear to fall within accepted standards of care in most areas. Administrative and systems concerns constituted the major areas of deficiencies identified in the report findings. In order to avoid evolving major problems, it is critical that emphasis be placed upon medical documentation practices and medical record keeping, including OBIS-HS entries.

MENTAL HEALTH FINDINGS

Survey Results

Since the prior survey, Wexford Health Sources had assumed the contract for health and mental health services at this institution. Mental health services at SFRC consist of reception center psychological testing and classification, outpatient services to S2 and S3 inmates and inpatient services provided in the crisis stabilization unit (CSU). There had been no suicides since the prior CMA survey.

Corrective Action

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 specified monitoring should be included in the files for each finding. Monitoring by a clinician peer or supervisor must be documented, including 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.

Records Reviewed:	ACCESS	Systems Score	Records Score
3		75	75

Finding(s)	Suggested Corrective Action(s)
MH-1: There was not an effective system in place to track timely completion of responses to psychological emergencies.	• The current log is inadequate in that it does not record the time that staff responded. Develop a system (such as modifying the existing log) for tracking and ensuring that psychological emergencies are addressed within one hour. This system should be subject to regular supervisory review and sign-off to ensure timeframes are being met.

Records Reviewed:	ACCESS	Systems Score	Records Score
3		75	75

Finding(s)	Suggested Corrective Action(s)
	• The current log is inadequate in that it does not record the time that staff responded. • Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.
MH-2: Staff and inmate interviews suggested that significant delays occurred in notification of mental health staff when inmates in confinement declared psychological emergencies.	• Coordinate with security administrators to ensure the provision of in-service training to correctional staff posted to confinement regarding their responsibility to immediately notify mental health staff if an inmate declares a psychological emergency. • Conduct monthly reviews of the "Daily Record of Segregation" of all inmates declaring psychological emergencies to compare time declared and time mental health staff was notified. Delayed response events should be identified to security administrators. • Interview at least five confinement inmates per month regarding this issue. • Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.

Records Reviewed:	INPATIENT MENTAL HEALTH SERVICES	Systems Score	Records Score
13		88	65

Finding(s)	Suggested Corrective Action(s)
MH-3: Biopsychosocial assessments were not consistently completed or updated within five days of admission to the CSU.	• Provide in-service training on completion or updating, as appropriate, the biopsychosocial assessment within the required timeframe. • Review five new CSU admissions per month. Continue monitoring until closure of the finding is affirmed through the CMA CAP assessment.

Records Reviewed: 13	INPATIENT MENTAL HEALTH SERVICES	Systems Score 88	Records Score 65

Finding(s)	Suggested Corrective Action(s)
MH-4: Physical examinations were not consistently conducted within 72 hours of admission to the CSU.	• Provide in-service training on completion of physical examinations within the required timeframe. • Review five new CSU admissions per month. Continue monitoring until closure of the finding is affirmed through the CMA CAP assessment.
MH-5: Risk assessments for violence were not consistently completed within 72 hours of admission to the CSU.	• Provide in-service training on completion of risk assessments for violence within the required timeframe. • Review five new CSU admissions per month. Continue monitoring until closure of the finding is affirmed through the CMA CAP assessment.
MH-6: Therapeutic activities were not offered at the required level resulting in nearly constant in-cell confinement for many inmates in the CSU.	• Provide therapeutic activities as required per policy (12 hours/week in the CSU with at least two of the 12 hours available on weekends). • Ensure adequate nursing/psychology staffing to provide services at the required level. • Complete risk assessments for violence in a timely manner to enable out-of-cell activities for those inmates whose risk levels allow such activities to be conducted safely. • Coordinate with security administrative staff to ensure that security staffing coverage is adequate to provide services at the required level. • Include a copy of the revised milieu schedule and weekly attendance rosters in the CAP file. • Review five charts of CSU patients per month. Continue monitoring until closure of the finding is affirmed through the CMA CAP assessment.

Records Reviewed:	INPATIENT MENTAL HEALTH SERVICES	Systems Score	Records Score
13		88	65

Finding(s)	Suggested Corrective Action(s)
MH-7: Unexplained physical injuries were observed in two CSU patients.	• Provide in-service training to all nursing staff on all shifts regarding their responsibility to document any physical injuries, whether self-inflicted or inflicted during a use-of-force episode. Include in this training the importance of contacting the on-call physician for an Emergency Treatment Order in the case of self-inflicted injury or for contacting appropriate supervisory staff (e.g., the Chief Health Officer, the warden and/or institutional inspector) in the case of abuse allegations or evidence of inappropriate use of force. • Provide in-service training to all clinical staff regarding their responsibility to submit incident reports for any unexplained physical injuries they observe in CSU patients and/or any allegations of inmate abuse. • Coordinate with security administrative staff to ensure the provision of specialized training to security staff posted to the CSU. The training should emphasize mental health and behavioral management issues with a psychiatric population, particularly de-escalation strategies. • Compile a monthly listing of all physical injuries occurring in CSU patients and copy relevant portions of the medical records and use-of-force reports (if applicable) that document how the injuries occurred. Include copies of all incident reports related to unexplained injuries and/or abuse allegations that occur in the CSU in the CAP file. • Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.

MH-7 Discussion: While touring the CSU on 5/16/02, two inmates were observed by surveyors to have physical injuries for which there was no corresponding explanatory documentation in their medical records. One inmate alleged he was assaulted by correctional staff a number of nights prior. There was observed to be severe and extensive bruising of his right lateral rib cage, as well as some bruising on both arms. Psychology staff had observed these injuries as well and on 5/13/02 submitted an incident report to the warden, who indicated that the institutional inspector was investigating.

Another inmate was observed by surveyors on 5/16/02 to have reddening of his left eye accompanied by bruising around the left eye and eyelid. On 5/8/02 SFRC psychology staff noted that this inmate had two black eyes and staff submitted an incident report to the warden, which stated that they were unable to determine how the injury occurred. On 5/13/02 psychology staff observed additional injuries (a cut and reddening of the eye) in this inmate and submitted an incident report.

There was no explanatory documentation in the medical records of these inmates for the injuries. Also, the survey team was unable to confirm the existence of any use-of-force reports corresponding to the observed injuries. Of additional concern were staff comments during interviews indicating they had observed an increasing pattern of unexplained physical injuries and abuse allegations over the prior six to eight months.

Records Reviewed:	OUTPATIENT MENTAL HEALTH SERVICES	Systems Score	Records Score
15		87	S1: 86 S2: 100 S3: 80

Finding(s)	Suggested Corrective Action(s)
MH-8: Case managers were not consistently assigned to S-3 inmates within three days of arrival or assignment of S-grade 3.	• Provide appropriate in-service training on timeframes for case manager assignment. • Monitor five charts per month. Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.
MH-9: Diagnoses were not always consistent with presenting symptoms. Targeted problems and interventions did not always correspond with the diagnoses.	• Provide appropriate in-service training with clinical staff in the following areas: diagnostic practices, targeting interventions, continuity of care, medication practices. • Monitor five charts per month. Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.

MH-9 Discussion: Examples of this finding include a case where the patient was diagnosed with a psychotic disorder that was not addressed on the individualized service

plan (ISP). Another case was noted of a patient presenting with psychotic symptoms who was discharged from the CSU after refusing medication and there had been no outpatient follow-up to determine his mental status. A third example involved a patient presenting with hallucinations that were noted on the psychiatric evaluation and problem list but the patient was diagnosed only with depression and anxiety and treated only with Zoloft and Buspar. In another case an inmate presented with hallucinations but was diagnosed only with depressive disorder and treated with Sinequan. Clinical rationale and/or appropriate diagnostic changes were not documented in these cases.

Records Reviewed: 17	PSYCHOTROPIC MEDICATION PRACTICES	Systems Score 50	Records Score 70

Finding(s)	Suggested Corrective Action(s)
MH-10: Appropriate initial and on-going laboratory tests were not consistently ordered in the records reviewed. This was particularly noted when EKGs were indicated.	• Provide appropriate in-service training to psychiatric and nursing staff. • Monitor five charts per month. Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.
MH-11: Abnormal and/or missing laboratory findings were not consistently followed-up in the records reviewed.	• Provide appropriate in-service training to psychiatric and nursing staff. • Monitor five charts per month. Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.
MH-12: Physician orders were not consistently stamped with the legible, printed name of the psychiatrist writing the order.	• Ensure that either name stamps or printed labels are available for all psychiatrists and that they are consistently utilized. • Provide appropriate in-service training to psychiatric and nursing staff. • Monitor five charts per month. Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.

Records Reviewed: 17	PSYCHOTROPIC MEDICATION PRACTICES	Systems Score 50	Records Score 70

Finding(s)	Suggested Corrective Action(s)
MH-13: The medications ordered were not consistently appropriate for the symptoms and diagnosis in the records reviewed.	• Provide appropriate in-service training to psychiatric staff. • Monitor 10 (five outpatient and five inpatient) charts per month. Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.
MH-14: Appropriate follow-up by the psychiatrist after the initial prescription of medication did not consistently occur in the following areas: • **detailed progress notes clearly describing symptoms and response to medication;** • **clinically appropriate time intervals between contacts;** • **clinically appropriate rationales for any medication and/or dosage changes.**	• Provide appropriate in-service training to psychiatric staff. • Ensure adequate psychiatric staffing to implement and maintain correction. • Monitor five charts per month. Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.
MH-15: According to staff interviews, some psychotropic medications take three to four days to arrive. This time lag between when a medication is ordered and when it is available is unacceptable for the high acuity population of a CSU.	• A review should be conducted to determine which medications are not immediately available and ascertain the reasons. • Medications must be immediately available to meet the clinical needs indicated by patient conditions and clinician orders. • Conduct monthly monitoring of 10 charts (five outpatient and five inpatient). Include the medication order date and date of initial administration to the patient. • Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.
MH-16: The medication keys were kept in an unlocked nursing station desk.	• Provide appropriate in-service training to nursing staff on proper key control.

Records Reviewed:	PSYCHOTROPIC MEDICATION PRACTICES	Systems Score	Records Score
17		50	70

Finding(s)	Suggested Corrective Action(s)
MH-17: Regarding the night stock medication cabinet: • **Medications were counted only as used;** • **The cabinet was not labeled for each medication and the amount of each to be on hand;** • **An unlabeled bottle of various pills and capsules was found in the cabinet.**	• Provide appropriate in-service training to nursing staff on proper medication control procedures. • An appropriate system should be devised, to ensure that counts are done routinely. • Label appropriately and devise a medication replacement system. • The unlabeled bottle should be taken to the pharmacy for disposal.
MH-18: The narcotics lock box contained tape and other supplies but no narcotics. Ativan (a controlled substance) was stored in the unlocked medication refrigerator.	• The narcotics lock box should only contain narcotics. Provide appropriate in-service training to nursing staff.
MH-19: The unlocked medication refrigerator (with Ativan stored inside) contained IM, suppository and oral medications all stored together. Also, there was a great deal of frost build-up inside.	• Provide appropriate in-service training to nursing staff. • Keep refrigerator locked. • Defrost refrigerator regularly. • Separate medications by route administered.
MH-20: The IM syringes were not safety syringes.	• Replace with safety syringes. Ensure that only safety syringes are available and used by staff and provide evidence in the CAP file.
MH-21: Hour-of-sleep (H.S.) medications were routinely given at 6:00 p.m.	• Administer H.S. medications (outpatient and inpatient) at an appropriate time (e.g., 10:00 p.m. or near bedtime).

Records Reviewed:	RECEPTION/INTAKE PROCESS	Systems Score	Records Score
9		90	86

Finding(s)	Suggested Corrective Action(s)
MH-22: Consent for treatment forms were not consistently present in the records reviewed.	• Provide appropriate in-service training to reception/intake staff. • Monitor five charts per month. Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.
MH-23: There were no security staff routinely posted in the reception trailer where large groups of recently arrived inmates were present for psychological testing and orientation.	• Coordinate with security administrative staff to ensure adequate security staff for the reception trailer.

Records Reviewed:	SELF-INJURY/SUICIDE PREVENTION	Systems Score	Records Score
10		83	77

Finding(s)	Suggested Corrective Action(s)
MH-24: Physician orders for suicide observation status did not consistently specify the property to be allowed the patient (e.g., mattress, blanket, and privacy garment).	• Provide appropriate in-service training for psychiatrists on proper documentation. Clinical justification for denial of articles must be documented. • Monitor five charts per month of patients admitted to suicide observation status. Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.
MH-25: Daily rounds by the attending physician were not consistently documented for patients on suicide observation status.	• Provide appropriate in-service training for psychiatrists on the necessity of conducting and documenting daily rounds for SOS patients. • Ensure adequate psychiatric staffing to implement and maintain correction. • Monitor five charts per month of patients on suicide observation status. Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.

Records Reviewed:	SELF-INJURY/SUICIDE PREVENTION	Systems Score	Records Score
10		83	77

Finding(s)	Suggested Corrective Action(s)
MH-26: Daily contacts by mental health staff (e.g., case manager or psychologist) were not consistently documented for patients on suicide observation status.	• Provide appropriate in-service training with mental health staff on the necessity for conducting and documenting daily contacts. • Ensure adequate psychology staffing to implement and maintain correction. • Monitor five charts per month of patients on suicide observation status. Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.

Records Reviewed:	OTHER ADMINISTRATIVE FINDINGS	Systems Score	Records Score
N/A		N/A	N/A

Finding(s)	Suggested Corrective Action(s)
MH-27: There was inadequate documentation of monthly administrative review of mental health logs. Required information was not recorded on several logs (e.g., Psychotropic Medication Refusal Log, Admission to Isolation Management Room for Mental Health Reasons Log).	• Mental health logs should be reviewed on a monthly basis for completeness. The reviewer's signature and date on the log should document each review.
MH-28: Medical records were disorganized with several instances of missing documents and of loose papers placed in the front of the charts.	• Provide appropriate in-service training with medical records staff. • Ensure adequate staffing to implement and maintain correction. • Monitor five charts per month for proper chart organization. Continue monthly monitoring until closure of the finding is affirmed through the CMA CAP assessment.

No significant negative findings were noted in the following areas of review:

Systems
- Intellectual Functioning
- Sex Offender Services
- Special Housing
- Psychiatric Restraints

Records
- Intellectual Functioning
- Sex Offender Services
- Special Housing
- Psychiatric Restraints

CONCLUSION

Mental health services delivery at SFRC is complex due to the multi-faceted mission of the institution (reception center, outpatient mental health services and the crisis stabilization unit). An overlay to this complexity for the past year has been the change in vendor operating the health and mental health services at the institution. In all likelihood the findings in this report are at least a partial reflection of that transition. However, attention should be directed toward correcting deficiencies in both clinical care and documentation requirements. Staffing allocations were a concern and may have contributed to many of the reported findings.

SURVEY PROCESS

The goals of every survey performed by the CMA are (1) to determine if the physical, mental, and dental care provided to inmates in all state and privately operated correctional institutions is consistent with state and federal law and if that care conforms to 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 objectives are designed to evaluate inmate care and treatment in terms of effectiveness and fulfillment of statutory responsibility. 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 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, selected through purposeful sampling, 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

During the course of a three or four day evaluation, the survey team examines the institution's health-related administrative systems, tours inmate housing and health treatment areas, conducts staff and inmate interviews, and conducts a clinical review of health care records.

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 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 to result in the compromise of inmate health care. All findings identified in the body of the report will require a corrective action by institutional and/or regional/central office health services staff.