



CORRECTIONAL MEDICAL AUTHORITY

PHYSICAL & MENTAL HEALTH SURVEY

of

SOUTH BAY CORRECTIONAL FACILITY

in

South Bay, Florida

on

September 18 – 21, 2001

| FACILITY STATISTICS PROVIDED CMA on August 29, 2001 | | |
|---|---------|------|
| Population | Custody | Type |
| Adult | Close | Male |

| Main Unit Capacity | Current Main Unit Census | Satellite Unit(s) Capacity | Current Satellite Unit(s) Census | Current Number of Inmates Served |
|--------------------|--------------------------|----------------------------|----------------------------------|----------------------------------|
| 1400 | 1232 | N/A | N/A | 1232 |

CMA Physical Health Team Leader:

Diana Picolo, R.N., R.M.

CMA Mental Health Team Leader:

Deborah McNamara, L.C.S.W

Physical Health Team Members:

Bernard Kimmel, M.D.
 Robert Kast, M.D.
 Robert Weston, D.D.S.
 David Habel, P.A.
 Kathy Kimmel, R.N.

Mental Health Team Members:

Peter McGrath, M.D.
 Sherry Roth, Ph.D.
 Sandra Bauman, A.R.N.P.
 Larry Goble, L.C.S.W.

OVERVIEW

On September 21, 2001, the Correctional Medical Authority concluded a physical and mental health survey of South Bay Correctional Facility (SBCF), located in South Bay, Florida. Wackenhut Corrections Corporation operates this facility under contract with the Correctional Privatization Commission. At the time of the survey, SBCF served an adult male population of approximately 1232 inmates assigned to medical grades 1 through 4 and psychological grades 1 through 3. SBCF was classified as a medical level 3 facility. Inmates requiring complex medical/dental care and psychotropic medication were housed at this institution.

| <i>Medical Grade</i> | 1 | 2 | 3 | 4 | <i>Impaired</i> | |
|--|--|------------|------------|----------------------------|-----------------|-----------------|
| | 675 | 223 | 361 | 6 | 2 | |
| <i>Psychological Grade</i> | <u><i>Mental Health Outpatient</i></u> | | | <u><i>MH Inpatient</i></u> | | |
| <i>(S-Grade)</i> | 1 | 2 | 3 | 4 | 5 | <i>Impaired</i> |
| | 1172 | 69 | 24 | 0 | 0 | 4 |
| <i>Confinement/ Close Management</i> | <i>DC</i> | <i>AC</i> | <i>PM</i> | <i>CM1</i> | <i>CM2</i> | <i>CM3</i> |
| | 33 | 42 | 0 | 0 | 65 | 55 |

The above figures do not include satellite unit capacities.

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.

During the course of the four-day survey, the physical health survey team evaluated the facility's physical health systems and reviewed a total of 149 records. Review of the systems identified strengths involving infirmary and quality management. The infirmary logs for a period of six months were accurate and neatly typed. There was evidence of quality management meeting minutes with attached supplemental material for each quarter. The minutes reflected all required documentation listed in the survey tool used to evaluate that system. Additionally, there was evidence that committee members attended 100% of the quality management meetings.

A review of the physical health care systems identified some isolated issues, and the medical records reviewed identified a trend involving several chronic illness clinics. The issues identified under systems were; incomplete and/or inaccurate documentation regarding consultations, Offender Based Information System (OBIS) and sick call encounters. The trend identified under medical records was an overall lack of evidence of necessary diagnostic studies involving several chronic illness clinics. Additionally, the review of mortalities identified issues under both systems and record review. Under systems there were delays in time frames regarding submission of documentation, and

one mortality record reviewed indicated a delay in diagnosis and treatment. These and other findings are described in detail in the Physical Health Findings section of the report.

A review of the mental health care systems and documentation revealed that, overall, appropriate care was being given to the inmate population at SBCF. The mental health staff demonstrated a desire to provide good quality care tailored to the needs of their patients. Inmates interviewed expressed positive regard for the mental health staff. A review of the medical records did, however, reveal some deficiencies in documentation.

Progress notes did not consistently convey the interventions being provided, and the documentation entered into the OBIS was often inconsistent with the documentation in the records. There were some apparent delays in psychiatric interventions, although it was unclear at times, due to the poor organization of the record and the OBIS entries, if the patients were intended to be downgraded to S-2. Cells used for self-injury prevention in the special housing unit had not yet been certified and physician's orders for placement into these cells and the cell in the medical unit were not consistently completed every 24 hours. These and other findings are described in detail in the Mental Health Findings section of the report.

At the conclusion of the survey, an exit conference was held on site with the facility's 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 suggested corrective actions are provided, these suggestions 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 | 86 | 100 | |
| | | Emergency Care | 100 | 100 | |
| | | Physician/CA Follow-Up Care | 100 | 100 | |
| | | Infirmity Care | 100 | 100 | |
| | Chronic Care | Chronic Illness Clinic Systems | 100 | | |
| | | Asthma | | 99 | |
| | | Diabetes | | 96 | |
| | | General Medicine | | 97 | |
| | | Hypertension | | 93 | |
| | | Immunity | | 80 | |
| | | Seizure | | 100 | |
| | | TB/INH | | 95 | |
| | Preventative Care | | 100 | 100 | |
| | Dental Care | | 100 | 100 | |
| | Mortality | | 75 | 83 | |
| | Other | Administrative Audit | 100 | | |
| | | Consultations | 100 | 92 | |
| | | Infection Control | 100 | | |
| Intake Process (Reception) | | N/A | N/A | | |
| Intrasystem Transfers | | 100 | 96 | | |
| Medication Administration | | 100 | 100 | | |
| OBIS | | 100 | 98 | | |
| Pharmacy | | 100 | | | |
| Quality Management | 100 | | | | |
| MENTAL HEALTH | Inmate Access to Mental Health Services | 100 | 92 | | |
| | Outpatient Mental Health Services | 93 | S1 | 82 | |
| | | | S2 | 71 | |
| | | | S3 | 95 | |
| | Intellectual Functioning | 100 | 100 | | |
| | Sexual Offender Services | 83 | 84 | | |
| | Special Housing | 100 | 91 | | |
| | Psychotropic Medication | Omitted | 79 | | |
| Self-Injury/Suicide Prevention | 71 | 64 | | | |
| Psychiatric Restraints | 100 | Omitted | | | |
| A score of 100 represents meeting all minimum care/systems standards. A score of less than 80 represents an 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: | SICK CALL | Systems Score | Records Score |
|---|------------------|--|---------------|
| 9 | | 86 | 100 |
| Finding(s) | | Suggested Corrective Action(s) | |
| <p>PH-1: There was a tracking mechanism for sick call encounters called a medical contact log. Nine sick call encounters were selected from the medical contact log for review. Five of those encounters selected from the medical contact log indicated a one to four day delay in entry when compared with medical record entry. Additionally, it was difficult to identify inmates from the medical contact log who were housed in confinement and who might have accessed sick call.</p> | | <p>Monitor at least five sick call encounters per month for a period of time to ensure that the sick call encounter dates entered in the progress notes match the date entered on the medical contact log.</p> | |

Discussion:

The nursing supervisor immediately addressed the latter issue above. A decision was made to add an additional column to the medical contact log to capture inmate-housing area (i.e. confinement).

CHRONIC CARE

| Records Reviewed: | ASTHMA CLINIC RECORD REVIEW | Records Score |
|--|------------------------------------|--|
| 8 | | 99 |
| Finding(s) | | Suggested Corrective Action(s) |
| <p>PH-2: One of eight asthma records selected for review lacked a baseline chest x-ray.</p> | | <p>Provide inservice to clinicians regarding applicable elements of diagnostic studies as they relate to the asthma clinic</p> |

| Records Reviewed: | DIABETES CLINIC RECORD REVIEW | Records Score |
|--|--|---|
| 9 | | 96 |
| Finding(s) | | Suggested Corrective Action(s) |
| <p>PH-3: Four of nine diabetes records selected for review lacked evidence of applicable diagnostic studies. Additionally, abnormal test results were not addressed in a timely manner.</p> | | <p>Provide inservice to clinicians regarding applicable and complete diagnostic studies as it relates to the diabetes clinic. Monitor at least five diabetes records per month for three consecutive months to ensure that complete diagnostic studies are performed. Additionally, monitor records to ensure that results of diagnostic studies are reviewed and abnormalities addressed in a timely manner.</p> |

| Records Reviewed: | GENERAL MEDICINE CLINIC RECORD REVIEW | Records Score |
|--|--|--|
| 9 | | 97 |
| Finding(s) | | Suggested Corrective Action(s) |
| <p>PH-4: Two of nine general medicine records selected for review contained deficiencies. One record indicated that applicable follow-up laboratory tests were not performed. One record lacked evidence that the influenza vaccine was offered, and another record contained illegible clinical entries.</p> | | <p>Provide inservice to clinicians regarding follow-up laboratory tests as they relate to the general medicine clinic. Monitor at least five general medicine records per month for three consecutive months to ensure that follow-up laboratory tests are performed. Additionally, monitor records to ensure that influenza vaccine is offered and that clinical entries are legible.</p> |

| Records Reviewed: | HYPERTENSION CLINIC RECORD REVIEW | Records Score |
|--|--|---|
| 10 | | 93 |
| Finding(s) | | Suggested Corrective Action(s) |
| <p>PH-5: Four of ten hypertension records selected for review lacked some or all applicable diagnostic studies.</p> | | <p>Provide inservice to clinicians regarding the applicable elements of diagnostic studies as they relate to the hypertension clinic. Monitor at least five hypertension records per month for three consecutive months to ensure that applicable diagnostic studies are performed.</p> |

| Records Reviewed: | IMMUNITY CLINIC RECORD REVIEW | Records Score |
|--|---|------------------|
| 7 | | 80 |
| Finding(s) | Suggested Corrective Action(s) | |
| <p>PH-6: Six of seven immunity records selected for review lacked some or all applicable diagnostic studies. Additionally, the following deficiencies were noted:</p> <ul style="list-style-type: none"> • inadequate evaluation of two urinalyses that tested positive for glucose and two elevated blood sugars, • incomplete history (e.g. length of time infected and prior treatment), • lack of documentation regarding pre and post test counseling, and • medication (e.g. bactrim) not listed on inmate's last clinic visit. | <p>Provide inservice to clinicians regarding the applicable elements of diagnostic studies as they relate to the immunity clinic. Monitor at least five immunity records per month for three consecutive months to ensure that applicable diagnostic studies are performed. Additionally, monitor immunity records to ensure the following:</p> <ul style="list-style-type: none"> • adequate follow-up of abnormal test results, • complete histories, • documentation of pre and post test counseling, and • current medications listed on clinic visit form. | |

Discussion:

Recommendation was made to the facility's health services administrator to review the process involved in the maintenance and/or thinning of medical records to ensure that applicable documentation is carried forward.

| Records Reviewed: | TB/INH CLINIC RECORD REVIEW | Records Score |
|---|--|------------------|
| 6 | | 95 |
| Finding(s) | Suggested Corrective Action(s) | |
| <p>PH-7: Three of six TB/INH records selected for review contained deficiencies. One record lacked evidence that diagnostic studies were reviewed, and that abnormalities were addressed in a timely manner. One record lacked evidence of a monthly evaluation, and another contained incomplete clinical forms and illegible progress notes.</p> | <p>Provide inservice to clinicians regarding the applicable elements of diagnostic studies as they relate to the TB/INH clinic. Monitor at least five TB/INH records per month for three consecutive months to ensure the following:</p> <ul style="list-style-type: none"> • review of diagnostic studies and abnormalities addressed in a timely manner, • monthly evaluations, and • complete clinical forms and legible progress notes. | |

MORTALITY

| Records Reviewed: | MORTALITY | Systems Score | Records Score |
|---|---|---------------|---------------|
| 4 | | 75 | 83 |
| Finding(s) | Suggested Corrective Action(s) | | |
| <p>PH-8: A review of the mortality log indicated that the mortality review committee had not submitted its findings to the coordinator within three days of the death. Additionally, a review of the quality management log indicated that the committee's findings and the health care record were not submitted to central office within 14 days of the death.</p> | <p>The deficiency has since been corrected. See discussion on following page.</p> | | |
| <p>PH-9: One of four mortality records reviewed indicated a delay in diagnosis and treatment. A 40 year old morbidly obese male with chronic renal disease and uncontrolled hypertension presented to the medical clinic at 02:30 a.m. on January 21, 2000 with the following signs and symptoms:</p> <ul style="list-style-type: none"> • shortness of breath, • diaphoretic, • chest pain with expiratory wheezing noted in left lung, • numbness in both legs and left arm, • pain in both knees and back, • abnormal skin tone of both feet and cold to touch, and • left quadrant abdominal pain. <p>These signs and symptoms occurred over a 29-hour period with no apparent thought of a dissecting aortic aneurysm. While objective findings were minimal, the symptoms should have suggested the diagnosis. The inmate was transferred to a local hospital where he died at 11:30 a.m. on January 23, 2000. Unfortunately, even if diagnosed much earlier, it is probable that the outcome would have been the same.</p> | <p>Provide inservice to clinicians to recognize signs and symptoms that require immediate transfer in order to facilitate a timely diagnosis and the appropriate necessary treatment.</p> | | |

Discussion:

PH-8: The facility's health services administrator misunderstood the mortality policy. She has been instructed by the mortality review coordinator to send whatever documents are on hand in order to meet deadline times.

OTHER

| Records Reviewed: | CONSULTATIONS | Systems Score | Records Score |
|---|----------------------|--|---------------|
| 9 | | 100 | 92 |
| Finding(s) | | Suggested Corrective Action(s) | |
| PH-10: Two of nine consultations selected for review either lacked or contained a late physician's entry in the progress notes regarding findings and ongoing treatment. Additionally, one of the two consults indicated that the physician signed off two months later. | | Monitor at least five medical records' progress notes per month as they relate to consultation reports for three consecutive months to ensure physician's entry regarding applicable findings and ongoing treatment. Additionally, monitor to ensure that the physician signs off consultation reports in a timely manner. | |

| Records Reviewed: | INTRASYSTEM TRANSFERS | Systems Score | Records Score |
|---|------------------------------|---|---------------|
| 10 | | 100 | 96 |
| Finding(s) | | Suggested Corrective Action(s) | |
| PH-11: One of ten medical records reviewed for intrasystem transfer documentation lacked the DC4-760, Health Information Transfer Summary and the DC4-760A, Arrival Summary. | | Monitor at least five medical records per month for three consecutive months to ensure that the DC4-760 and the DC4-760A are completed or obtained. | |

| Records Reviewed: | OFFENDER BASED INFORMATION SYSTEM (OBIS) | Systems Score | Records Score |
|---|---|--|---------------|
| 6 | | 100 | 98 |
| Finding(s) | | Suggested Corrective Action(s) | |
| PH-12: The PULHESDXTI (dental grade) of one of six medical records reviewed did not match the dental grade entered on the OBIS PULHESDXTI. | | Monitor at least five medical records per month for three consecutive months to ensure that the PULHESDXTI in the record matches with the OBIS PULHESDXTI. | |

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

System Reviews

- Administration
- Ancillary Medical Services
- Chronic Illness Clinic
- Consultations
- Dental
- Emergency Care
- Follow-up Care
- Infirmery Care
- Infection Control
- Intrasystem Transfer
- OBIS
- Pharmacy
- Pill Line
- Preventive Care
- Quality Management
- Tour of Housing Areas

Record Reviews

- Dental
- Emergency Care
- Follow-up Care
- Infirmery Care
- Medication Administration
- Preventive Care
- Seizure
- Sick Call

CONCLUSION

Overall, the health care services provided at South Bay Correctional Facility meets the minimally accepted standards of care with exceptions as listed above.

Both formal and informal staff interview, as well as observation by surveyors, revealed no indications of interference with medical decisions. Overall, staff was very knowledgeable regarding the process of health care services. There were no indications that security staff failed to respect medical judgment in regard to housing, work assignments, diet, confinement or medical care.

Five inmates housed in general population and confinement areas were interviewed formally and their records reviewed, if indicted. Overall, inmates interviewed had no overt concerns or problems with the health care services provided at South Bay Correctional Facility.

MENTAL HEALTH FINDINGS

The mental health department at South Bay Correctional Facility was comprised of caring professionals eager to explore new treatment approaches to improve the care provided to the inmates housed at the institution. The use of group treatment was a strength at South Bay. Original groups tailored to the needs of the inmate population, such as Lifers, the Cognitively Impaired group, and a psychoeducational class for inmates nearing release, exemplified the desire present in the practitioners to excel in providing care. The senior psychologists recently received specialized training from the National Institute of Corrections in Sex Offender treatment.

A second strength of this facility was the services provided to close management inmates. The mental health department offered Anger/Stress Management and was scheduled to begin a Problem Solving group. In addition, other departments provided substance abuse education and Life Skills training.

Interviews with staff members and inmates suggested that the mental health care provided was appropriate. However, several findings were identified during the survey process, most relating to problems with documentation. They are detailed below.

Survey Results

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

| Records Reviewed: | | Systems Score | Records Score |
|---|--|--|----------------------------|
| 19 | OUTPATIENT MENTAL HEALTH SERVICES | 93 | S1: 82 S2: 71 S3: 95 |
| Finding(s) | | Suggested Corrective Action(s) | |
| MH-1: The Multidisciplinary Treatment Team did not have a regularly scheduled meeting time. | | Identify a regularly scheduled meeting time for the MDST that can accommodate all required members. Provide documentation in the closure file to indicate attendance. | |
| MH-2: Individualized Service Plan (ISP) documentation was insufficient: <ul style="list-style-type: none"> • reviews were not consistently completed at required intervals in several records reviewed, • all required signatures were not obtained, • ISPs were not completed for several patients reviewed who were identified as S-2s. | | Provide inservice training on ISP development and requirements. Monitor 10 or 10% of applicable records per month to ensure 90% compliance. Continue monitoring until a satisfactory Corrective Action Plan (CAP) assessment is achieved. | |

| | |
|---|---|
| <p>MH-3: Documentation was insufficient for many participants in group therapy:</p> <ul style="list-style-type: none"> • ISPs were not consistently completed, • Monthly group notes were vague and not individualized in many records reviewed, • Biopsychosocial Assessments (BPSAs) were often cursory. | <p>Provide inservice training on appropriate documentation for therapeutic groups.</p> <p>Monitor 10 applicable records per month to ensure 90% compliance. Continue monitoring until a satisfactory Corrective Action Plan (CAP) assessment is achieved.</p> |
|---|---|

| Records Reviewed: | PSYCHOTROPIC MEDICATION PRACTICES | Records Score |
|--|--|---------------|
| 5 | | 79 |
| Finding(s) | Suggested Corrective Action(s) | |
| <p>MH-4: Laboratory tests were not consistently completed at required intervals.</p> | <p>Provide inservice training on testing requirements.</p> <p>Monitor 10 applicable records per month to ensure 100% compliance. Continue monitoring until a satisfactory Corrective Action Plan (CAP) assessment is achieved.</p> | |
| <p>MH-5: Patients were not consistently seen by psychiatry at required intervals.</p> | <p>Devise a system to track all S-3 patients to ensure that a psychiatric appointment is scheduled as required.</p> <p>Monitor 10 applicable records per month to ensure 90% compliance. Continue monitoring until a satisfactory Corrective Action Plan (CAP) assessment is achieved.</p> | |

In one record reviewed, a patient's medication had been discontinued at another institution in May, 2000, but his S-grade was not lowered to S-2 at that time. He was transferred to South Bay in July, 2000, but was not seen by a psychiatrist at South Bay until September, 2001. Although this lapse did not have any undue consequences on this patient, the risk that a patient with a need for psychiatric services might be overlooked is of great concern. A tracking system to ensure that every S-3 patient is evaluated by psychiatry within 10 days of arrival, as required, is essential. The system should also ensure that the patient is seen at appropriate regular intervals as identified in the ISP.

| | |
|---|---|
| <p>MH-6: Required documentation, to include AIMS testing and medication consents, were not consistently completed within required time frames.</p> | <p>Provide inservice training on documentation requirements.</p> <p>Monitor 10 applicable records per month to ensure 90% compliance. Continue monitoring until a satisfactory Corrective Action Plan (CAP) assessment is achieved.</p> |
|---|---|

| | | | |
|---------------------------------------|--|------------------------------------|------------------------------------|
| <p>Records Reviewed: 5</p> | <p>SELF-INJURY/SUICIDE PREVENTION</p> | <p>Systems Score 71</p> | <p>Records Score 64</p> |
|---------------------------------------|--|------------------------------------|------------------------------------|

| Finding(s) | Suggested Corrective Action(s) |
|---|---|
| <p>MH-7: Retrofitted cells for self-injury prevention located in the special housing unit were not certified.</p> | <p>Obtain certification by regional Department of Corrections staff.</p> |
| <p>MH-8: Physician's orders were not consistently complete in the records reviewed:</p> <ul style="list-style-type: none"> • Orders did not specify items permitted in the cell, • Orders were not renewed every twenty-four hours, • Orders were not obtained for placement on all levels of suicide precaution used at the institution (SOS-I, SOS-II, SOS Alert). | <p>Provide inservice training on documentation requirements.</p> <p>Monitor all applicable records per month to ensure 90% compliance. Continue monitoring until a satisfactory Corrective Action Plan (CAP) assessment is achieved.</p> |
| <p>MH-9 (OHS): Physician's orders did not specify observations every 15 minutes.</p> | <p>Revise current policy to ensure compliance with the standards of the CMA and national corrections standards.</p> <p>Monitor all applicable records per month to ensure 90% compliance. Continue monitoring until a satisfactory Corrective Action Plan (CAP) assessment is achieved.</p> |

| | | | |
|-------------------|------------------------------|---------------|---------------|
| Records Reviewed: | SEX OFFENDER SERVICES | Systems Score | Records Score |
| 9 | | 83 | 84 |

| Finding(s) | Suggested Corrective Action(s) |
|--|--------------------------------|
| MH-10: No system was in place to ensure that sex offenders within 180 days of End of Sentence (EOS), regardless of S-grade, were assisted with arranging community-based treatment. | Develop an appropriate system. |

| | | | |
|-------------------|------------------------|---------------|---------------|
| Records Reviewed: | SPECIAL HOUSING | Systems Score | Records Score |
| 10 | | 100 | 91 |

| Finding(s) | Suggested Corrective Action(s) |
|---|--|
| MH-11: A Special Housing Health Appraisal (DC4-769) was not consistently completed on inmates being placed in Close Management. | Provide inservice training to relevant staff. Monitor 10 applicable records per month to ensure compliance. Continue monitoring until a satisfactory Corrective Action Plan (CAP) assessment is achieved. |
| MH-12 (OHS): Mental status exams were not consistently completed within twenty-four hours for inmates receiving mental health treatment. | Revise current policy to ensure compliance with the standards of the CMA and national corrections standards. |

| | | | |
|-------------------|------------------------------------|--|--|
| Records Reviewed: | OTHER ADMINISTRATIVE ISSUES | | |
| NA | | | |

| Finding(s) | Suggested Corrective Action(s) |
|---|--|
| MH-13: Information provided in the Offender Based Information System (OBIS) was not congruent with information in the medical records. Mental health staff did not have access to the OBIS system. | Develop a system to ensure that information is entered accurately into OBIS. Provide training when the system is developed. Provide OBIS access to all mental health staff. Monitor 10 records per month to ensure that all relevant information, to include S-grade, Sex Offender Treatment Status, and contacts with Mental Health, are congruent between OBIS and the medical record. Continue monitoring until a satisfactory Corrective Action Plan (CAP) assessment is achieved. |

| | |
|---|-------------------------------------|
| MH-14: Insufficient office space and group rooms were provided to the mental health staff. | Provide additional dedicated space. |
|---|-------------------------------------|

At the time of the survey, the mental health department consisted of two senior psychologists, two psychological specialists, and one part-time psychiatrist. Two offices were dedicated to this staff, one only recently acquired. An additional office, located in the special housing unit, was also used often by mental health staff.

| | |
|---|--|
| MH-15: Mental health staff did not have unlocking access to many essential doorways, often resulting in compromised safety due to confinement with inmates without the presence of security staff. | Ensure that all staff have unimpeded passage through essential doorways. |
|---|--|

During a tour of the institution, the surveyor, accompanied by mental health staff, was locked in a hallway with many inmates waiting for a doorway to be opened by remote access. The waiting time was lengthy and posed a safety risk. Interviews with institutional staff indicated that, previously, keys were available for these doorways but have since been removed.

| | |
|--|--|
| MH-16: Medical records were disorganized and active documents were not always filed in the active volume. | Monitor 10 records per month to ensure that the active record is organized by standard departmental chart order and that active documents remain in the active record. Continue monitoring until a satisfactory Corrective Action Plan (CAP) assessment is achieved. |
|--|--|

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

System Reviews

- Inmate Access to Mental Health Services
- Intellectual Functioning
- Psychiatric Restraints
- Special Housing

Record Reviews

- Inmate Access to Mental Health Services
- Intellectual Functioning
- Psychiatric Restraints
- Mortality

CONCLUSION

Overall, the mental health care provided at South Bay Correctional Facility was appropriate. Deficiencies in documentation comprised the majority of the findings. Staff and inmates interviewed voiced positive comments about the mental health department and the facility as a whole. A desire to provide interventions to ameliorate the symptoms of mental illness and provide increased coping abilities, for use both during and after incarceration, were evident in all staff involved in the survey process.

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.