



CORRECTIONAL MEDICAL AUTHORITY

PHYSICAL & MENTAL HEALTH SURVEY

of

TAYLOR CORRECTIONAL INSTITUTION

in

Perry, Florida

on

November 4- 7, 2008

CMA Physical Health Team Leader:

Paul R. Cornish

CMA Mental Health Team Leader:

Jane Holmes-Cain, LCSW

Physical Health Team Members:

Marjorie Kirsch, MD
Boyd Kellet, MD
Ashok Manocha, DDS
Steve Tomicich, ARNP
David Habel, PA-C
Sue Sims, RN
Judy Reinman, RN

Mental Health Team Members:

Carolyn Stimel, PhD
Lonny Meier, PhD
Jenene Case-Pease, LMHC, PhD
Mandy Petroski-Moore, LCSW
Ann Panzarino, RN
Cathy Morris, RN

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DEMOGRAPHICS

The institution provided the following information in the Pre-survey Questionnaire.

INSTITUTIONAL INFORMATION			
Population	Type	Custody Level	Medical Level
2,959	M	Close	4

Institutional Potential/Actual Workload

Main Unit Capacity	1,122	Current Main Unit Census	1,327
Annex Capacity	1,205	Current Annex Census	1,204
Satellite Unit(s) Capacity	432	Current Satellite(s) Census	428
Total Capacity	2,759	Total Current Census	2,959

Inmates Assigned to Medical/Mental Health Grades

	1	2	3	4	<i>Impaired</i>	
<i>Medical Grade</i>	1,863	543	443	9	32	
<i>Mental Health 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>
	2,894	64	N/A	N/A	N/A	0

Inmates Assigned to Special Housing Status

<i>Confinement/</i>						
<i>Close Management</i>	<i>DC</i>	<i>AC</i>	<i>PM</i>	<i>CM3</i>	<i>CM2</i>	<i>CM1</i>
	137	56	0	N/A	N/A	N/A

OVERVIEW

Taylor Correctional Institution (TAYCI) houses male inmates of minimum, medium and close custody levels and is designated as a medical grade 4 and psychological grade 2 facility. The Taylor complex is comprised of the Main Unit, the Annex, and a work camp.

The Correctional Medical Authority (CMA) conducted a thorough review of the medical, mental health and dental systems at TAYCI November 4 - 7, 2008. Record reviews evaluating the provision and documentation of care were also conducted. Additionally, a review of administrative processes and a tour of the physical plant were conducted.

Department Findings

In addition to the institutional findings contained in this report, other areas of concern were noted. These findings may be based on standards adopted by the CMA, and not addressed in OHS policy, procedure or directive. They may be based on issues beyond institutional control, requiring intervention at a higher level. The OHS should submit a separate corrective action plan for these findings. These findings are clearly identified as "Department Findings" and appear following the body of the Mental Health section of this report. Department findings from all institutional surveys, including those from the TAYCI survey will be routinely reviewed by the CMA QM Committee and reported in the CMA Annual Report.

Exit Conference and Final Report

At the conclusion of the survey, the survey team conducted an exit conference with institutional personnel to discuss preliminary survey results. The findings and final conclusions presented in this report are a result of further analysis of the information collected during the survey. The suggested corrective actions(s) included in this report should not be construed as the only action required to demonstrate correction, but should be viewed as a guide for developing a corrective action plan. 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 appropriate monthly monitoring should be included in the files for each finding. Unless otherwise specified, this monitoring should be conducted by an institutional clinician/peer and must be documented by a monthly compilation of the following:

- 1) The inmate names and DC numbers corresponding to the charts (medical records) reviewed;
- 2) The criteria/finding being reviewed;
- 3) An indication of whether the criteria/finding was met for each chart reviewed;
- 4) The percentage of charts reviewed each month complying with the criteria;
- 5) Back-up documentation consisting of copies of the relevant sections reviewed from the sampled charts.

PHYSICAL HEALTH FINDINGS

ADMINISTRATIVE SYSTEM REVIEWS

Medication Administration	
Finding(s)	Suggested Corrective Action(s)
<p>PH-1: An oral cavity check was not conducted on each inmate provided medication at the pill window.</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issue listed in the Finding(s) column.</p> <p>Create a monitoring instrument on which the issue is regularly examined to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through a CMA corrective action plan assessment.</p>

Discussion PH-1: During staff interviews, the surveyor was informed oral cavity checks are not routinely conducted, but are done only on those inmates for whom a note is written on the MAR that a check is needed.

CLINICAL RECORD REVIEWS

As the overall missions of both the Main Unit and Annex at TAYCI are similar and both areas are the responsibility of the same centralized medical management team, findings are considered relevant to the institution as a whole. Therefore unless the following findings are identified as unit-specific, they apply to both Units.

Episodic Care

Infirmary	
Finding(s)	Suggested Corrective Action(s)
<p>PH-2: Six records reviewed for the appropriate documentation of infirmary admissions revealed that:</p> <p>(a) Three records lacked evidence of a nursing admission note, nursing assessment, and/or patient education (orientation to infirmary).</p> <p>(b) All six records lacked sufficient</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which both issues are regularly examined by reviewing no less than five records weekly to evaluate the effectiveness of</p>

Infirmary	
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Finding(s)	Suggested Corrective Action(s)
<p>evidence a physician or clinical associate made daily infirmary rounds.</p>	<p>corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through a CMA corrective action plan assessment.</p>

Sick Call & Follow-Up	
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Finding(s)	Suggested Corrective Action(s)
<p>PH-3: Nine records reviewed for appropriate documentation of sick call encounters revealed that:</p> <p>(a) Two records contained documentation of a sick call encounter in which the health care provider's note was incomplete.</p> <p>(b) Based on the inmate's presenting complaint, three records reflected unacceptable wait times (13, six, and 15 days respectively) for follow-up appointments with a higher level provider following an initial sick call encounter.</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which both issues are regularly examined by reviewing no less than 10 records weekly to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through a CMA corrective action plan assessment.</p>

Discussion PH-3 (a) and (b): Documentation in one record contained an 8/13/08 note which reported "abscess, rule out MRSA". The inmate was prescribed an antibiotic, but a culture was not done to confirm the diagnosis. In addition, the antibiotic choice was not the best choice of empiric antibiotic for MRSA. A two-week follow-up was recommended, but was not completed.

In another example, an 8/6/08 note indicated an inmate presented with testicular pain and swelling. The assessment included a statement which indicated the inmate has a urinary tract infection and prostatitis; objective findings did not support the diagnosis of prostatitis. Follow-up was not well documented.

Chronic Clinics

Endocrine Clinic	
Finding(s)	Suggested Corrective Action(s)
<p>PH-4: A review of 16 records of inmates enrolled in the Endocrine Clinic revealed the following deficiencies:</p> <p>(a) Five records lacked evidence of an annual comprehensive dilated eye exam.</p> <p>(b) Nine records lacked evidence of an annual test for the presence of microalbuminuria. (see discussion)</p> <p>(c) Five records lacked evidence that appropriate medications such as anti-hypertension and lipid lowering agents, aspirin therapy, or other endocrine disorder drugs were prescribed or re-evaluated at each clinic visit.</p> <p>(d) Two records lacked evidence that a referral to a specialist was recommended even though objective findings suggested a referral was indicated.</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding all issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues are regularly examined by reviewing no less than 10 records weekly to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through a CMA corrective action plan assessment.</p>

Discussion PH-4 (b): Only one in nine patients was on an ACE inhibitor and had gross proteinuria that might exclude annual microalbumins.

General Comments: It was the opinion of the survey team that initial and follow-up physical exams consistently omitted peripheral vascular exams (pulses, capillary refill, edema), neurologic exams (standard is monofilament nylon light touch test for peripheral sensory neuropathy) and descriptions of skin integrity. There appeared to be a pattern of inadequate clinical response to worsening disease parameters. As a group, diabetics were poorly controlled despite stable weights and apparent adequate compliance.

In addition, although beyond the control of Taylor CI staff, it was noted the documentation of five dilated eye exams at RMC reflected appropriate left eye measurements of fundus vessels, but notes on the right eye were non-specific and indicated only, "OK, minimal changes". In each case, the right eye fundoscopic exam reports appeared to be almost identical.

Neurology Clinic

Finding(s)	Suggested Corrective Action(s)
<p>PH-5: A review of 16 records of inmates enrolled in the Neurology Clinic revealed that three records lacked evidence of documented seizure frequency and type, and/or cause of any acute complications. (see discussion)</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issue listed in the Finding(s) column.</p> <p>Create a monitoring instrument on which the issue is regularly examined by reviewing no less than five records weekly to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through a CMA corrective action plan assessment.</p>

Discussion PH-5: Seizure frequency (control) was not consistently addressed on chronic clinic forms "Chief Complaint" nor "Drug Adverse Affects". Sometimes nursing notes documented seizure frequency on DC4-770, but not always.

NOTE: As the concerns noted during reviews of chronic illness clinic records were revealed in all clinics to some degree, the findings noted in PH-7 - PH-10 below reflect issues which must be addressed through corrective actions in all chronic illness clinics.

Overall Chronic Clinic Reviews

Finding(s)	Suggested Corrective Action(s)
<p>A review of 96 chronic illness clinic records from both the Main Unit and the Annex revealed the following deficiencies:</p> <p>PH-6: Seventeen records reviewed for compliance with the documentation of baseline information such as diagnostic data, baseline lab results, and physical examinations inconsistently documented these components either upon clinic enrollment or during subsequent clinic visits. (see discussion)</p> <p>PH-7: Thirteen records inconsistently documented medical histories, either upon clinic enrollment or at subsequent clinic visits.</p>	<p>Provide in-service training to staff regarding the issues identified in the Finding(s) column.</p> <p>Create one monitoring instrument on which PH-6 - PH-9 are regularly examined by reviewing no less than 5 records weekly from each chronic illness clinic to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

Overall Chronic Clinic Reviews	
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Finding(s)	Suggested Corrective Action(s)
<p>PH-8: Twelve records inconsistently documented lab studies were ordered prior to clinic appointments and/or inconsistently documented steps taken to address abnormal lab results.</p> <p>PH-9: Thirty-two records inconsistently documented the provision of pneumococcal vaccine or signed inmate refusals.</p>	

Discussion PH-6: In only a few cases, clinic enrollment occurred at TAYCI; most other initial work-ups occurred at another institution such as a reception center. However, health care providers, including those at TAYCI must ensure records of chronically ill inmates reflect current and accurate diagnostic data upon which to make appropriate clinical treatment decisions.

Other Clinical Record Reviews

Medication Administration	
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Finding(s)	Suggested Corrective Action(s)
<p>PH-10: A review of 10 medication administration records (MAR) and the corresponding medical records revealed that in eight of 10 medical records and/or MARs at least one of the following discrepancies were noted:</p> <p>(a) Medication orders were not consistently legible or complete.</p> <p>(b) Medication orders were not consistently signed, dated, and timed.</p> <p>(c) Medication orders were not consistently transcribed by the end of the shift during which they were written.</p> <p>(d) Medication orders did not consistently have a corresponding note in the medical record.</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding all issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which all issues are regularly examined by reviewing no less than 15 medical records and corresponding MARs weekly to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through a CMA corrective action plan assessment.</p>

Medication Administration	
Finding(s)	Suggested Corrective Action(s)
<p>(e) MARs did not consistently note allergies.</p> <p>(f) All code boxes on the MARs were not consistently completed when the nurse administered medications.</p> <p>(g) MARs were not consistently reviewed for lapses in medication use or to ensure scheduled medications had been administered.</p>	

Offender Based Information System (OBIS)	
Finding(s)	Suggested Corrective Action(s)
<p>PH-11: A review consisting of comparisons between 18 individual medical records and corresponding OBIS information revealed the following discrepancies:</p> <p>(a) Fourteen of 18 records contained a DC4-730 (Problem List) that was either incomplete or inaccurate.</p> <p>(b) Seven examples were noted in which lab tests and results reflected in OBIS did not match documentation in the corresponding medical records.</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding both issues listed in the Finding(s) column.</p> <p>Create one monitoring instrument on which both issues are regularly examined by reviewing no less than 10 medical records and corresponding OBIS screens weekly to evaluate the effectiveness of corrections. Monitoring intervals may be modified to less often if results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through a CMA corrective action plan assessment.</p>

CONCLUSION

Physical health survey findings detail a number of areas requiring attention by institutional staff, particularly in the management of chronic illness clinics. These areas include the documentation of medical histories, baseline and follow-up lab results, and physical examination findings as an assessment tool. Also requiring attention is the provision of pneumovax vaccine to applicable chronic illness patients. These findings were noted in nearly all chronic illness clinics. Another area of particular concern identified during the survey was medication administration practices. Many examples of documentation practices requiring improvement were revealed during reviews of medication orders and medication administration records.

When these concerns were discussed in detail with institutional staff, they appeared motivated to improving the institutional health care delivery system. As each of the findings identified in this report fall well within the scope of institutional staff to correct, training and monitoring instruments developed to address these concerns should focus heavily on the documentation of chronic illness assessment and treatment and medication management. When developed, corrective action plans will provide the staff a useful blueprint to identify training opportunities and methods to ensure components of overall patient care are met in a timely manner.

MENTAL HEALTH FINDINGS

OVERVIEW

Taylor Correctional Institution provides outpatient mental health services only. The following are the mental health grades used by the department to classify inmate mental health needs that are provided at Taylor CI:

- S1 - Inmate requires routine care (sick call or emergency).
- S2 - Inmate requires ongoing services of outpatient psychology (intermittent or continuous).

As the overall missions of both the Main Unit and Annex at TAYCI are similar and both areas are the responsibility of the same centralized mental health team, findings are considered relevant to the institution as a whole. Therefore unless the following findings are identified as unit-specific, they apply to both Units.

CLINICAL

Outpatient Mental Health Services	
Finding(s)	Suggested Corrective Action(s)
<p>MH-1: A comprehensive review of 34 outpatient records (S1=14; S2=20) evaluating orientation and planning for newly arriving inmates revealed the following issues:</p> <p>(a) Nineteen of 31 applicable records did not contain evidence that mental health staff conducted orientation to mental health services within eight days of arrival at the institution.</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues in the Finding(s) column.</p> <p>Create one monitoring instrument on which issues identified in the findings column are examined on a regular basis.</p>

Outpatient Mental Health Services

Finding(s)	Suggested Corrective Action(s)
<p>(b) Thirteen of 31 applicable records did not contain evidence that mental health staff reviewed the record within fourteen days of the inmate's arrival. (see discussion)</p> <p>(c) In six of 18 applicable records service planning interviews were missing or late for newly arriving S2 inmates.</p> <p>(d) Six of 18 applicable S2 records did not contain evidence that a case manager was assigned within the required timeframe.</p>	<p>Monitor a minimum of ten records weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>
<p><i>Discussion: MH-1(b):</i> In some cases the preprinted incidental note indicated that the record was reviewed and gave a series of check boxes regarding future mental health plans; however it did not address the current diagnosis and mental health and substance abuse history. In the thirteen records listed above, there was no documentation that the record was reviewed.</p>	
<p>MH-2: Clinical reviews of Individualized Service Plans (ISP) revealed the following issues:</p> <p>(a) In seven of 18 records, ISP's were not completed within fourteen days.</p> <p>(b) Nine of 17 records inadequately documented timely reviews of the finalized ISP.</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues in the Finding(s) column.</p> <p>Create one monitoring instrument on which issues identified in the findings column are examined on a regular basis.</p> <p>Monitor a minimum of ten records weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

Outpatient Mental Health Services

Finding(s)	Suggested Corrective Action(s)
<p>MH-3: In eight of 19 records Bio-Psychosocial Assessments (BPSAs) or updates were missing or late.</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues in the Finding(s) column.</p> <p>Monitor a minimum of ten records weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>
<p>MH-4: In four of twenty records, inmates recommended for psychiatric consults were not referred in a timely manner. (see discussion)</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues in the Finding(s) column.</p> <p>Monitor a minimum of five records or all if less than five weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

Discussion: MH-4: Notes from psychological specialists indicate the inmates were voicing hallucinations and/or suicidal ideations. Requests for psychiatric consults were delayed by up to three months. Two of the inmates who received a psychiatric evaluation were prescribed medication, however in one of the records the order was scratched out by the physician at TAYCI. According to staff, inmates who have been prescribed psychotropic medication are transferred to an institution where psychiatric services are provided, however the transfer can take several days. Since these services are not provided at TAYCI, staff reported they were not giving the inmates awaiting transfer the medication. This issue was discussed with regional staff and it was determined that inmates should receive the medication at TAYCI while awaiting transfer to another institution.

Special Housing

Finding(s)	Suggested Corrective Action(s)
<p>MH-5: Four of ten records of inmates in special housing lacked evidence that initial mental status exams were completed within the required time frame. (see discussion)</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues in the Finding(s) column.</p> <p>Monitor a minimum of ten records weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

Discussion: MH-5: In two of the cases the initial mental status exams were over a month late. In one case, the inmate had been in confinement since August 2008 and had not yet been seen for the initial mental status exam. In addition notes written for inmates who refused evaluation were not individualized and often only the name and date were changed.

Self-Harm Observation Status (SHOS)

Finding(s)	Suggested Corrective Action(s)
<p>MH-6: A comprehensive clinical review of eight IMR (isolation management room) records revealed the following deficiencies:</p> <p>(a) Two of eight records lacked documentation that the inmate received a clinical assessment prior to placement in SHOS.</p> <p>(b) Two of eight records did not contain evidence of adequate post-discharge follow-up from SHOS. (see discussion)</p> <p>(c) Three of eight records contained orders that were not timed, dated and/or stamped.</p>	<p>Include documentation in the closure file that appropriate in-service training has been provided to staff regarding the issues in the Finding(s) column.</p> <p>Create one monitoring instrument on which issues identified in the findings column are examined on a regular basis.</p> <p>Monitor a minimum of five records or all if less than five weekly for compliance. Monitoring intervals may be modified to less often if the results indicate appropriate compliance or correction.</p> <p>Continue monitoring until closure is affirmed through the CMA corrective action plan assessment.</p>

Discussion: MH-6(b): In one case the inmate swallowed a razor blade prior to SHOS placement. Upon discharge his psychological grade remained S1 and he was seen only once for follow-up 16 days later. In the other case, the inmate attempted to flush his head down the toilet. He was seen by mental health in confinement 36 days after his release from SHOS.

During the review of the certification of the infirmary cells used for SHOS, it was noted that there were instructions to use “special precautions” when using cells 105 and 106. Upon inspection it was noted that these cells are equipped with handicapped toilets. These toilets have sharp edges and hardware that could potentially be used to tie cloth or other material to. These cells were subsequently decertified by regional staff.

CONCLUSION

The majority of the findings in the mental health area seem to be a reflection of the need for a stable mental health staff. According to staff there has been a high staff turnover over the past year. New people are hired however they only stay for a short period of time. There is currently only one mental health employee who has been with the institution for a significant period of time. Although staff from other institutions are brought in to provide assistance, there are issues with assessments and treatment being provided in a timely manner. In some cases there was up to a four month delay in newly arriving inmates receiving initial mental health services. In addition there was inconsistency in the documentation provided by mental health staff. In two cases, one provider documented the inmates were voicing hallucinations. Several days later another provider documented “no hallucinations in the past 90 days”. Staff report that one person has been hired and interviews are scheduled for another psychological specialist position. The Sr. Psychologist who previously worked at the institution is also slated to return. CMA staff is hopeful that a stable mental health staff can be maintained at TAYCI.

DEPARTMENT FINDINGS

In addition to the physical and mental health findings referenced previously in this report, there are several other areas of concern. These findings are beyond the scope of the institution to correct as they may be based on standards adopted by the CMA, but not addressed in department policy, procedure or directive. Or, they may be based on other issues beyond institutional control. Therefore, the department must initiate corrective action.

PHYSICAL HEALTH

Finding(s)
Dept-1: Special housing inmates were not offered one hour of exercise per day, five days per week outside the cell.
Dept-2: There was no evidence of a policy prohibiting the medical staff from participating in gathering forensic information and participating in body cavity searches for forensic purposes.

MENTAL HEALTH

There were no department findings for mental health

SURVEY PROCESS

The goals of every survey performed by the CMA are

- (1) to determine if the physical, dental and mental health care provided to inmates in all state public and privately operated correctional institutions is consistent with state and federal law, conforms to standards developed by the CMA, is consistent with 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 criteria designed to evaluate inmate care and treatment in terms of effectiveness and fulfillment of statutory responsibility are measured. 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 and public 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 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, /treatment plans, schedules, logs, administrative reports, physician orders, service 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

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 also 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 of compromising inmate health care. All findings identified in the body of the report under the physical or mental health sections require corrective action by institutional staff. Findings identified in the department section require corrective action by central office security or program area staff.