

# TAYLOR CORRECTIONAL INSTITUTION SUPPLEMENTAL REPORT

For CMA Survey Conducted January 14-17, 2003

## PHYSICAL AND MENTAL HEALTH SURVEY FINDINGS REQUIRING OHS INTERVENTION

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

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

### PHYSICAL HEALTH

1. **There is no participation in either weekly sanitation and cleanliness inspections of the dining facility and monthly sanitation inspections of the facility, nor is there evidence the inspection reports completed by others are forwarded to the medical department for review.** (Referenced in the CMA Infection Control System Review Instrument, Screens 12 and 13)

### MENTAL HEALTH

1. **Physician's orders (when present) did not specify observations at least every 15 minutes for inmates admitted to the infirmary for observation and prevention of self-injurious/suicidal behavior.** This standard is referenced in the CMA Self-Injury/Suicide Prevention Record Review Instrument, and is based upon national correctional healthcare standards and prevailing professional practices in the community at large.
2. **Delays of three to four months were occurring in obtaining appointments for psychiatric evaluations.** Waiting times of this length constitute an access barrier and unacceptable clinical practice. According to regional staff, the institution must utilize the North Florida Reception Center (NFRC) for psychiatric consultations and NFRC staff shortages were causing the delays in obtaining psychiatric evaluations. It should be noted that several inmates on the waiting list were demonstrating symptoms of serious mental illness requiring more expedient psychiatric/medication intervention. Action will be necessary by the Office of Health Services to correct this finding. Consideration should be given to a triage approach and to referring inmates to different institutions/regions in order to gain expedient psychiatric evaluations.