

# CORRECTIVE ACTION PLAN ASSESSMENT

of

Union Correctional Institution  
Close Management Program

held on

August 10, 2004

for the

Close Management Monitoring Survey  
Conducted November 04-07, 2003

## **CMA Staff**

Murdina Campbell, MSW, Government Analyst II  
Kaye Harris, RN, Surveyor

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## CAP Assessment of Union Correctional Institution Close Management Program

### **Overview**

On November 04-07, 2003, the Correctional Medical Authority (CMA) concluded a close management monitoring survey of Union Correctional Institution (UNICI). The survey report, detailing the findings of the survey team, was distributed on December 15, 2003. The CMA received the final corrective action plan (CAP) from the Department of Correction's Office of Health Services (OHS) on March 01, 2004. On August 10, 2004, CMA staff conducted a corrective action plan assessment, results of which are reported herein.

### **Summary**

Of the 28 findings reviewed, 20 were corrected, six were not corrected, and two remain open pending additional research by the Authority and discussion with the OHS.

#### **CM-1: CORRECTED**

*CM-1: Behavioral Risk Assessments (BRAs) were not consistently completed each time the Multidisciplinary Services Team (MDST) reviewed patient Individualized Services Plans (ISPs).*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

#### **CM-2: CORRECTED**

*CM-2: Categories receiving scores of two or higher on the BRAs were not consistently addressed on the ISPs.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

#### **CM-3: CORRECTED**

*CM-3: New BRAs were not completed within three working days if inmates were involved in a critical incident.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

#### **CM-4/Dept-1: CORRECTED**

*CM-4/Dept-1: State Classification Office Staff did not consistently conduct on-site interviews with inmates every six months.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-5: CORRECTED**

*CM-5: Inmates reported that, while group therapy was available, individual counseling was difficult to obtain.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-6: NOT CORRECTED**

*CM-6: Medication consent forms were not consistently signed for each class of medications prescribed and/or were not properly completed.*

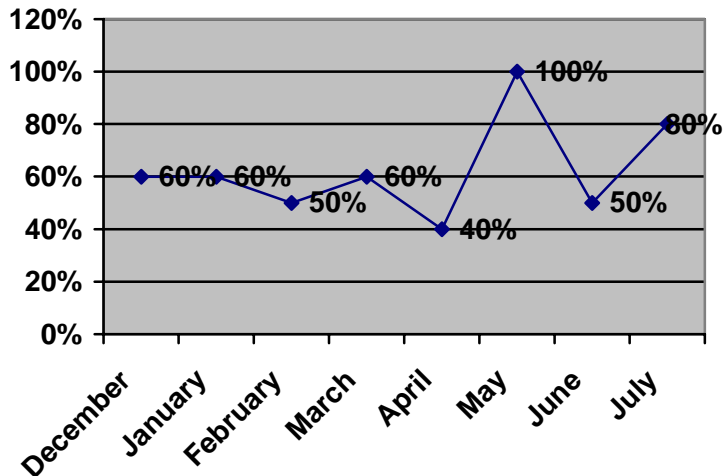
Documentation of in-service training on this finding was available in the closure file. Institutional monitoring demonstrated that appropriate medication consent forms were consistently used during the past four months. However, the forms were consistently complete for two months only.

*Recommended Corrective Action: Continue monitoring to ensure medication consent forms are properly complete. Continue monitoring a minimum of five records per month until closure is affirmed through the CMA CAP assessment.*

**CM-7: NOT CORRECTED**

*CM-7: Appropriate initial laboratory studies were not consistently completed at initiation of psychotropic medication.*

Institutional monitoring of this issue demonstrated a lack of sustained compliance (see the graph below). The overall compliance rate was 62.5 percent (29 records were reviewed over eight months from December 2003 through July 2004). This issue is particularly important when considered in conjunction with CM-8, 9, and 10 (these findings also related to medication practices are described below).



*Recommended Corrective Action: Review the requirements for initial laboratory studies when psychotropic medications are prescribed. Continue monitoring a minimum of five records per month to ensure compliance until closure is affirmed through the CMA CAP assessment.*

**CM-8: NOT CORRECTED**

*CM-8: Appropriate follow-up laboratory studies were not ordered and conducted as required.*

Documentation in the closure file indicated that 40 records were reviewed over eight months (December 2003 through July 2004). The overall compliance rate for this timeframe was 82.5 percent. However, inconsistencies were noted within the past four months with only 60% compliance in April and May 2004. Continued corrective action is recommended to demonstrate sustained compliance.

*Recommended Corrective Action: Review the requirements for follow-up laboratory studies for inmates prescribed psychotropic medication. Continue monitoring a minimum of five records per month to ensure compliance until closure is affirmed through the CMA CAP assessment.*

**CM-9/Dept: OPEN**

*CM-9: Annual physical health appraisals that included a face-to-face evaluation were not completed for patients receiving psychotropic medications.*

**Discussion**

This finding requires annual face-to-face physical assessments for inmates on psychotropic medications. The finding remains open but is deferred pending further consideration by the Authority and discussion with the OHS. Two issues need to be resolved. First, a consensus has not been reached by the Authority regarding whether or not an annual physical is required for inmates on psychotropic medication. It should be noted that inmates prescribed psychotropic medications are required to be provided psychiatric evaluations, on-going laboratory testing, assessment of involuntary movement, and medication education in addition to the physical exams/health assessments they may receive.

Second, the quality of physical assessments is also at issue. It is debatable whether an assessment by an LPN, even with referral as necessary to a higher level of care, meets the requirement for an adequate physical, or whether this should consist of a hands-on evaluation by a physician or clinical associate. Furthermore, the American Correctional Association standards (ACA) have been interpreted to require the latter. These issues require further discussion and clarification with the OHS.

Furthermore, this finding is significant given insufficient documentation to demonstrate corrective action in a number of medication practice areas reviewed during this assessment.

Resolution of this finding requires policy discussion with the OHS and is likely beyond the scope of the institution. CM-9 remains open and is referred for further discussion with the Authority and the OHS.

**CM-10: NOT CORRECTED**

*CM-10: Abnormal involuntary movement (AIMS) evaluations were not conducted as required for patients receiving antipsychotic medications.*

Institutional monitoring demonstrated the overall compliance rate during the past six months was 51.4 percent. Zero compliance was documented during January 2004 through March 2004. The compliance rate for April 2004 was 60 percent. Three months of 100% compliance was sustained during May 2004 through July 2004. The institution should be commended for significant movement towards correction on this finding. However, given the importance of appropriate AIMS evaluations and the need for further corrective action regarding CM-7 & 8 (above), continued monitoring is warranted to demonstrate sustained correction.

*Recommended Corrective Action: Continue monitoring a minimum of five records per month to ensure compliance until closure is affirmed through the CMA CAP assessment.*

**CM-11: CORRECTED**

*CM-11: Inpatient nursing staff administering medications did not properly observe patients swallowing their medications.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-12: CORRECTED**

*CM-12: At the outpatient medication line, Medication Administration Records (MARs) were initialed prior to actual administration of the medication; a different nurse administered the medications than the one who had pre-initialed the MARs; and dosages for the next morning's medication line were initialed on the day prior.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-13: CORRECTED**

*CM-13: Physician's orders did not consistently: Specify that observations occur at least every 15 minutes; or specify property allowed the inmate (e.g., mattress, blanket, privacy garment).*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-14: CORRECTED**

*CM-14: Seven of eight records reviewed reflected gaps in observations of suicidal patients ranging from 30 minutes to one hour.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-15: CORRECTED**

*CM-15: Suicide observation status (SOS) was not re-ordered every 24 hours and/or the time of the order was not documented.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-16: CORRECTED**

*CM-16: Nursing assessments of mood and affect were not consistently conducted once per shift.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-17: CORRECTED**

*CM-17: Daily physician rounds were not consistently conducted.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-18: CORRECTED**

*CM-18: Orientation to the inpatient unit was not documented as having occurred within four hours of admission.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-19: NOT CORRECTED**

*CM-19: Nursing assessments were not consistently conducted within four hours of admission and/or were incomplete.*

While movement towards correction was noted based on documentation in the closure file, CMA record review indicated that one of three charts reviewed was not compliant. In this case, an agency nurse was responsible for an incomplete assessment. Logistical difficulties in assuring training for all agency nurses are recognized. However, further monitoring is warranted to maintain compliance.

*Recommended Corrective Action: Continue monitoring a minimum of five records per month to ensure compliance until closure is affirmed through the CMA CAP assessment.*

**CM-20: CORRECTED**

*CM-20: Patients' weights were not recorded weekly by nursing staff as required.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-21: CORRECTED**

*CM-21: ISPs were not always initiated within required timeframes and goals were not always appropriate, realistic or measurable.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-22: CORRECTED**

*CM-22: The required hours of planned scheduled therapeutic activities were not consistently provided.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-23/Dept-2: CORRECTED**

*CM-23/Dept-2: Staffing the inpatient units exclusively with locum tenens psychiatrists impacted continuity and quality of care.*

At the time of the assessment visit, there were six full-time psychiatrists on staff at Union C.I. All were employees of the Department of Corrections.

**CM-24: NOT CORRECTED**

*CM-24: The least restrictive method (e.g., counseling, voluntary medication, emergency involuntary medication orders) was not documented as having been attempted prior to the application of psychiatric restraints.*

There had been nine cases of psychiatric restraints since December 2003. The institutional closure file documented compliance in only two of the nine cases. Furthermore, while training on this issue had been provided, the attendance rosters indicated only two physicians and none of the nurses had participated.

*Recommended Corrective Action: Train psychiatric and nursing staff in this requirement, including agency nurses. Continue monitoring all cases to ensure compliance until closure is affirmed through the CMA CAP assessment.*

**CM-25: CORRECTED**

*CM-25: Physician's orders were not obtained within 15 minutes of initiating restraints and/or the order was not signed.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-26: CORRECTED**

*CM-26: Assessment by the next working day following use of force did not consistently occur and appropriate mental health care was not provided prior to the use of force and/or subsequent to the incident in two of the four records reviewed.*

Only the use of chemical agents was assessed in this finding. With regard to the use of chemical agents, sufficient documentation was provided in the institutional closure file to demonstrate correction.

**CM-27/Dept-3: OPEN**

*CM-27: Inmates with seizure disorders were documented as having no risk factors that would contraindicate the use of electronic immobilization devices (EIDs).*

This finding is currently under consideration by the Authority.

**CM-28: CORRECTED**

*CM-28: Record reviews in general revealed the following administrative issues: Lack of consistency in use of a time recording format (e.g., 24-hour time v. a.m. /p.m. designations); numerous records with entries that were not timed, dated and/or included illegible signatures and were not stamped with name stamps (particularly for locum tenens and agency staff); and records, both outpatient and inpatient, were very disorganized with numerous missing and misfiled documents.*

Sufficient documentation was provided in the institutional closure file to demonstrate correction. Clearly, this issue will require continued attention to ensure maintenance of compliance.