



# **CORRECTIONAL MEDICAL AUTHORITY**

## **CLOSE MANAGEMENT MONITORING SURVEY**

of

## **UNION CORRECTIONAL INSTITUTION**

in

**Raiford, Florida**

on

**November 4-7, 2003**

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## SURVEY PURPOSE

In December 2001, the department entered into an offer of judgment in a lawsuit entitled *Osterback v. Moore*. This lawsuit involved mentally ill inmates housed in a restricted setting called close management. Plaintiffs argued the placement of an inmate with a mental illness in a restricted housing unit exacerbated the symptoms of the mental illness. This claim was centered around the contention that placement in a close management unit, in which the majority of the inmates are housed in single-cells for 24 hours per day, is a form of sensory deprivation.

As a result of the agreement, the department committed to significant changes in the close management program. Prior to the lawsuit, close management units were located throughout the state in institutions that also housed general population inmates. The *Osterback* agreement required consolidation of all close management inmates into four facilities that house only close management inmates. The four specified institutions are Florida State Prison (FSP), Santa Rosa Correctional Institution (SARCI), Charlotte Correctional Institution (CHACI) and, for females, Dade Correctional Institution (DADCI). Subsequently, the department designated Lowell Correctional Institution (LOWCI) as the facility for close management females. Since that time, a fifth close management unit was opened at Union Correctional Institution.

A primary focus of the agreement included increased mental health assessment and treatment. Prior to placement in close management housing, mental health staff complete an assessment, recommending the level of programming needed for adequate adjustment. Then, a Behavioral Risk Assessment is completed. This document identifies areas, such as risk for suicidal behavior and violence, where programming and treatment should be focused.

Once the assessment is completed, the agreement calls for increased mental health treatment for those close management inmates in need of services. The 2001 General Appropriations Act provided additional mental health staffing to FSP and SARCI for this purpose. Increased group treatment as well as an expanded treatment team including security, classification, and program staff are significant changes enacted by the agreement.

In addition to mental health treatment, increased contact with program staff, to include education and religious services, increased phone calls and visitation, and increased outdoor recreation time are enhancements to the close management program.

The *Osterback* agreement includes a stipulation that the authority monitors the provisions of the agreement. In response to this requirement, the authority developed a monitoring instrument based on the *Osterback* agreement, Chapter 33-601.800, F.A.C., and Office of Health Services (OHS) policies and procedures. The authority provided the instrument to department staff and the plaintiffs' attorneys for review and comment.



## DEMOGRAPHICS

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

Close Management Level	Current Census
Close Management Team Decision 1	115
Close Management Team Decision 2	70
Close Management Team Decision 3	48
Total Close Management Population	233

### Program Description

Close management (CM) inmates at Union Correctional Institution (UNICI) were housed in two separate dormitories with one of the two being designated for inmates with the greatest mental health needs (i.e., S3 inmates). Additionally, staff reported that expansion of the CM population is anticipated and new dormitories are under construction.

Close management inmates were permitted reading materials, and the right to purchase a portable radio with headphones. Educational and literacy courses were available. The required exercise time of two hours, three days per week had been implemented and outside exercise was provided in fenced areas behind the dormitories. In progressive stages based on their individual classifications, inmates were permitted to make monitored telephone calls, receive canteen privileges, dayroom access, access to social television programs during dayroom periods, and receive visits.

Both outpatient and inpatient mental health services were available at the institution, which functions as the department's primary inpatient treatment facility for CM inmates, particularly those inmates housed at nearby Florida State Prison. Outpatient mental health services available at the time of the survey included case management, group therapy, individual therapy, psychiatric care and psychotropic medications.

According to documentation provided by the institution at the time of the survey, clinical staff dedicated to the outpatient CM program included five psychological specialists and one senior psychologist. There were also six psychological specialists and one senior psychologist assigned to treat inpatient CM inmates. There were two full-time staff psychiatrists to serve both the open and CM outpatient inmate population and a series of rotating locum tenens psychiatrists served inpatient inmates. According to staff, a psychiatrist from Florida State Prison provides coordination and training for the locum tenens psychiatrists. Reportedly, at the time of the survey the institution was in the process of recruiting six additional psychological specialists, one psychiatrist and one senior psychologist. Of the 20 RN and 17 LPN positions allocated to UNICI, half were vacant. The institution relies heavily on agency nurses to staff vacant positions, particularly in the inpatient units.

## OVERVIEW

### Survey Summary

Reviews were conducted of the mental health and classification records of 20 CM inmates to confirm implementation of the CM program and assess adequacy of mental health services provision.

Additionally, the survey included eight self-injury/suicide prevention record reviews, ten inpatient record reviews, three restraint episode reviews, four use of force episode reviews and 21 psychotropic medication practices record reviews. A comprehensive review was also completed of close management systems including policies, procedures, and practices. A tour was conducted of the close management housing dormitories including dayrooms and exercise yards. A sample of inmate daily record of segregation forms (DC6-229) was reviewed for mental health rounds, dayroom access including justification for the suspension of privileges, telephone privileges, canteen privileges, and exercise. Formal and informal interviews were conducted with clinical staff, the classification supervisor, five correctional officers, and 10 inmates. The inmates interviewed represented various levels of close management.

### **Exit Conference and Final Report**

At the conclusion of the survey, an exit conference was held with institutional personnel to discuss preliminary survey results. The findings and final conclusions presented in the 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 of close management inmate records should be included in the files for each finding. Monitoring by a clinician peer must be documented by 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.

# FINDINGS

## Strengths

- The documentation systems required by the settlement agreement were in place.
- Close management inmates appeared to be receiving the out-of-cell exercise and self-betterment programming specified by the settlement agreement.
- An active group therapy program existed for CM inmates.
- Evidence was present that inmates were progressing through the CM level system.

## Survey Results

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

Records Reviewed: 20	<b>CLOSE MANAGEMENT RECORD REVIEWS</b>
Finding(s)	Suggested Corrective Action(s)
<b>CM-1: Behavioral Risk Assessments (BRAs) were not consistently completed each time the Multidisciplinary Services Team (MDST) reviewed patient Individualized Services Plans (ISPs).</b>	<p>Provide training to mental health staff regarding the requirement for completion of the risk assessment during the MDST meeting.</p> <p>Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<b>CM-2: Categories receiving scores of two or greater on the BRAs were not consistently addressed on the ISPs.</b>	<p>Provide training to mental health staff regarding the requirement for utilizing BRA results to assist in mental health treatment planning and the need for ISP modification when BRA categories receive a score of two or greater.</p> <p>Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<b>CM-3: New BRAs were not completed within three working days if inmates were involved in a critical incident.</b>	<p>Provide training to mental health staff regarding the requirement for completion of the risk assessment if the inmate was involved in a critical incident (e.g., use of force, psychiatric restraint, suicide attempt).</p> <p>Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<b>CM-4/Dept-1: State Classification Office staff did not consistently conduct on-site interviews with inmates every six months.</b>	<p>The department should ensure that the reviews are conducted as required by rule. Monitor a minimum of five records each month for</p>

Records Reviewed: <b>CLOSE MANAGEMENT</b>	
20 <b>RECORD REVIEWS</b>	
Finding(s)	Suggested Corrective Action(s)
	compliance. The sample should consist of inmates who have been in CM for at least six months. Continue monitoring until closure is affirmed through the CMA CAP assessment.
<b>CM-5: Inmates reported that, while group therapy was available, individual counseling was difficult to obtain.</b>	<p>Provide training to mental health staff regarding the need for documenting the setting (group or individual) in which the contact occurred. Additionally, if the contact occurred in a group, the contact note should reflect that inmates were informed individual sessions were available if needed or requested. Monitor a minimum of five CM inmate records each month for compliance.</p> <p>Interview a sample of five CM inmates receiving mental health services each month to determine if access to individual therapy is impeded and/or if there is a perception that individual counseling is unavailable. Take other corrective actions as needed to ensure adequate access to private and confidential individual therapy.</p> <p>Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>

**Discussion:** Inmates interviewed who were receiving mental health services indicated that, while group therapy was readily available, access to private, individual sessions was usually attainable only by declaring a psychological emergency, a step which they perceived results in unspecified punitive actions by staff and/or reflects poorly on their CM adjustment. It was noted in many records reviewed that routine case management contacts appeared to be held in group settings, as was occurring during the October 2002 CMA survey of open population inmates. The active group therapy program at UNICI is a positive development. However, there must also be unimpeded access to private, confidential mental health treatment. Staff interviews suggested that this was a resource issue, which should be alleviated by the anticipated hiring of additional clinical staff.

Records Reviewed: <b>PSYCHOTROPIC MEDICATION</b>	
21 <b>PRACTICES</b>	
Finding(s)	Suggested Corrective Action(s)
<b>CM-6: Medication consent forms were not consistently signed for each class of medications prescribed and/or were not properly completed.</b>	<p>Train relevant staff on the need to complete medication consent forms.</p> <p>Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<b>CM-7: Appropriate initial laboratory studies were not consistently completed at initiation of</b>	Train psychiatric and nursing staff, including agency and locum tenens staff, in this

Records Reviewed: <b>PSYCHOTROPIC MEDICATION PRACTICES</b>	
21	
Finding(s)	Suggested Corrective Action(s)
psychotropic medication.	<p>requirement.</p> <p>Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<b>CM-8: Appropriate follow-up laboratory studies were not ordered and conducted as required.</b>	<p>Train psychiatric and nursing staff in this requirement.</p> <p>Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<b>CM-9: Annual physical health appraisals that included a face-to-face evaluation were not completed for patients receiving psychotropic medications.</b>	<p>Provide annual physical health appraisals that include face-to-face evaluations, conducted by an ARNP, PA or MD, on all patients receiving psychotropic medications. Train medical, psychiatric and nursing staff in this requirement.</p> <p>Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<b>CM-10: Abnormal involuntary movement evaluations were not conducted as required for patients receiving antipsychotic medications.</b>	<p>Train psychiatric staff, including locum tenens staff, in this requirement.</p> <p>Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<b>CM-11: Inpatient nursing staff administering medications did not properly observe patients swallowing their medications.</b>	<p>Train nursing staff, including agency nurses, regarding proper observation technique (i.e., mouth checks) to ensure that medications are not checked for stockpiling or later contraband distribution.</p> <p>Observe a randomly selected inpatient medication pass at least twice monthly to ensure that proper procedures are followed. Include the results of these observations in the closure file. Continue monitoring until closure of the finding is affirmed through the CMA CAP assessment.</p>
<b>CM-12: At the outpatient medication line, Medication Administration Records (MARs) were initialed prior to actual administration of the medication; a different nurse administered</b>	<p>Train nursing staff, including agency nurses, in the requirement to initial MARs at the time the medication is actually administered.</p>

Records Reviewed: <b>PSYCHOTROPIC MEDICATION PRACTICES</b>	
21	
Finding(s)	Suggested Corrective Action(s)
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.	Observe a randomly selected medication administration line at least twice monthly to ensure that proper procedures are followed. Include the results of these observations in the closure file. Continue monitoring until closure of the finding is affirmed through the CMA CAP assessment.

Records Reviewed: <b>SUICIDE/SELF-INJURY PREVENTION</b>	
8	
Finding(s)	Suggested Corrective Action(s)
<b>CM-13: Physician's orders did not consistently:</b> <ul style="list-style-type: none"> <li>a) specify that observations occur at least every 15 minutes;</li> <li>b) specify property allowed the inmate (e.g., mattress, blanket, privacy garment).</li> </ul>	Train psychiatric and nursing staff, including locum tenens and agency staff, in the need to specify observation intervals on the order rather than to just write "SOS", "SOS P" or "SOS IP" and the need to specify allowable property. Also, train staff on the requirement that any property denied must be clinically justified.  Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
<b>CM-14: Seven of eight records reviewed reflected gaps in observations of suicidal patients ranging from 30 minutes to one hour.</b>	Train nursing, including agency nurses, and security staff in the requirement to observe patients admitted to suicide observation status as ordered by the physician (i.e., at intervals no greater than every 15 minutes) and to document those observations on the DC4-650.

**Discussion:** It was noted that observation sheets (DC4-650) specified that observations were to occur at least every 15 minutes. The gaps observed appeared to primarily occur around the approximate time of shift change.

<b>CM-15: Suicide observation status (SOS) was not re-ordered every 24 hours and/or the time of the order was not documented.</b>	Train psychiatric and nursing staff, including locum tenens and agency staff, in the need to re-order SOS every 24 hours and to document the time of the order.  Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
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Records Reviewed: <b>SUICIDE/SELF-INJURY PREVENTION</b>	
8	
Finding(s)	Suggested Corrective Action(s)
<b>CM-16: Nursing assessments of mood and affect were not consistently conducted once per shift.</b>	<p>Train nursing staff, including agency staff, in this requirement.</p> <p>Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<b>CM-17: Daily physician rounds were not consistently conducted.</b>	<p>Train psychiatric staff, including locum tenens staff, in this requirement.</p> <p>Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>

Records Reviewed: <b>INPATIENT MENTAL HEALTH SERVICES</b>	
10	
Finding(s)	Suggested Corrective Action(s)
<b>CM-18: Orientation to the inpatient unit was not documented as having occurred within four hours of admission.</b>	<p>Train nursing staff, including agency staff, in this requirement.</p> <p>Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<b>CM-19: Nursing assessments were not consistently conducted within four hours of admission and/or were incomplete.</b>	<p>Train nursing staff, including agency staff, in this requirement.</p> <p>Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<b>CM-20: Patient's weights were not recorded weekly by nursing staff as required.</b>	<p>Train nursing staff, including agency staff, in this requirement.</p> <p>Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<b>CM-21: ISPs were not always initiated within required timeframes and goals were not always appropriate, realistic or measurable.</b>	<p>Provide training to mental health staff regarding proper development and updating of the ISP to ensure that it is reflects individualization with appropriate goals addressing problems of current relevancy to the patient's functioning.</p>

<b>Records Reviewed: 10</b>		<b>INPATIENT MENTAL HEALTH SERVICES</b>	
<b>Finding(s)</b>	<b>Suggested Corrective Action(s)</b>		
	<p>Conduct monthly monitoring of five inpatient charts per month for presence of realistic and measurable goals. Continue monitoring until closure of the finding is affirmed through the CMA CAP assessment.</p>		
<p><b>CM-22: The required hours of planned scheduled therapeutic activities were not consistently provided.</b></p>	<p>Provide therapeutic activities as required per policy (12 hours/week in the CSU, 17 hours/week in the TCU, with at least two hours on the weekends).</p> <p>Ensure that clinical documentation reflects activities offered and activities actually provided each day, and that signed or witnessed refusal forms are completed.</p> <p>Ensure that adequate nursing/psychology staff are available to provide services at the required level.</p> <p>Ensure that security staff coverage is adequate to provide services at the required level.</p> <p>Include a copy of the revised therapeutic activities schedule and weekly attendance rosters for both the CSU and TCU in the CAP file.</p> <p>All instances where groups or activities are canceled due to staffing shortages should be recorded in the CAP file with the date and activity type noted as well as a notation regarding whether it was security, nursing, psychology and/or psychiatry staff that were insufficient.</p> <p>Review five charts of CSU patients and five of TCU patients per month for documentation of attendance at required number of hours of therapeutic activities or signed/witnessed refusals. Continue monitoring until closure of the finding is affirmed through the CMA CAP assessment.</p>		
<p><b>CM 23/Dept-2: Staffing the inpatient units exclusively with locum tenens psychiatrists impacted continuity and quality of care.</b></p>	<p>Expedite efforts to recruit and hire full-time staff psychiatrists for the inpatient units.</p> <p>The Office of Health Services (OHS) should re-visit psychiatric position allocations to the inpatient units.</p> <p>Include documentation of these efforts in the CAP file. Additionally, include in the file a</p>		

Records Reviewed: <b>10</b>	<b>INPATIENT MENTAL HEALTH SERVICES</b>
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Finding(s)	Suggested Corrective Action(s)
	monthly staffing profile displaying the psychiatric coverage, by provider name, for both inpatient units. Also, note whether the provider was a staff psychiatrist or a locum tenens psychiatrist.

**Discussion:** While a staff psychiatrist from Florida State Prison had been active in training and supervision, the large number and frequent rotations of the locum tenens psychiatrists precluded continuity of care. As an example, one inpatient may have had up to 15 different treating psychiatric physicians in the two-month period of August to October 2003, though it was difficult to determine due to illegible signatures and the lack of name stamps. Concerns regarding the care provided to this patient included an undated ISP review (appeared to be from October 2003) in which hallucinations were to be added as a problem. This was not done as of the survey date. Appropriate initial and on-going laboratory studies were not ordered. Proper informed consent forms for medications were not completed and/or updated. AIMS testing was not conducted as required. Physician orders were not signed and/or dated. When the patient was admitted to the CSU, a physician's inpatient admission note and physical examination were not completed in a timely manner. While the patient was on suicide observation status, a proper physician's order specifying observation intervals and items allowed was not completed, SOS was not re-ordered every 24 hours while the patient was retained in SOS and he was not observed consistently while in SOS. Additionally, he did not consistently receive daily counseling by mental health staff and daily physician rounds were not conducted on numerous occasions during his SOS inpatient stay.

<b>3</b>	<b>PSYCHIATRIC RESTRAINT</b>
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Finding(s)	Suggested Corrective Action(s)
<b>CM-24: The least restrictive method (e.g., counseling, voluntary medication, emergency involuntary medication orders) was not documented as having been attempted prior to application of psychiatric restraints.</b>	Train psychiatric and nursing staff, including locum tenens and agency staff, in this requirement.  Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.
<b>CM-25: Physician's orders were not obtained within 15 minutes of initiating restraints and/or the order was not signed.</b>	Train psychiatric and nursing staff, including locum tenens and agency staff, in this requirement.  Monitor a minimum of five records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.

## USE OF FORCE

Finding(s)	Suggested Corrective Action(s)
<p><b>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 four records reviewed.</b></p>	<p>Train mental health staff in the requirement to assess inmates by the next working day following a use of force incident. Also, train staff to proactively address mental health issues that may lead to the use of force and to specifically follow-up on those issues in a timely manner if a use of force incident occurs.</p> <p>Monitor for compliance a minimum of five records each month of inmates involved in use of force incidents. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<p><b>CM-27/Dept. 3: Inmates with seizure disorders were documented as having no risk factors that would contraindicate the use of electronic immobilization devices (EIDs).</b></p>	<p>Train staff that it is medically contraindicated to use EIDs on individuals having seizure disorders.</p> <p>The OHS should modify form DC4-650B (“Risk Assessment for the Use of Chemical Restraint Agents and Electronic Immobilization Devices”) to specifically include seizure disorder as a condition that may be exacerbated by the use of EIDs.</p>

**Discussion:** Though no incidents of EID use were noted as having occurred at Union CI, the potential for inappropriate use exists unless this finding is corrected.

## OTHER ADMINISTRATIVE ISSUES

Finding(s)	Suggested Corrective Action(s)
<p><b>CM-28: Record reviews in general revealed the following administrative issues:</b></p> <ul style="list-style-type: none"> <li>a) <b>Lack of consistency in use of a time recording format (e.g., 24-hour time versus a.m./p.m. designations).</b></li> <li>b) <b>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).</b></li> <li>c) <b>Records, both outpatient and inpatient, were very disorganized with numerous missing and misfiled documents.</b></li> </ul>	<p>Train medical, nursing, mental health and medical records regarding these issues.</p> <p>Ensure that medical records staffing is adequate given the recent increase in size and characteristics of the inmate population at UNICI.</p>

**Additional Discussion Item:**

The inmate Classification Files were very difficult to review as they are organized only in chronological order and documents were frequently misfiled. It is suggested the department consider implementing some form of record organization that includes content dividers, similar to the manner in which medical records are organized.

## CONCLUSION

The systems to bring Union CI into compliance with the offer of judgment appear to be in place and the institution had done an excellent job of implementing those systems within a very short time frame. This is particularly true given that the institution serves close management (CM) inmates having the highest acuity, in terms of mental health needs, of any in the state. However, performance was not yet within acceptable parameters in several areas.

Areas where improvement is needed included conducting and utilizing Behavioral Risk Assessments (BRAs) and several aspects of the mental health care provided to CM inmates. Regarding the BRAs, there was a lack of documentation that assessment results were used by the Multidisciplinary Services Teams to assist in mental health problem identification and to plan treatment. For example, services teams did not consistently complete BRAs each time individualized service plans were reviewed, new BRAs were not always completed if an inmate was involved in a critical incident, and BRA categories scoring two or greater were not always addressed on the ISP. Still, there was evidence of movement through the CM levels. Data provided by the institution reflected that of the 197 Union inmates who received a CM review from June 26, 2003 to October 26, 2003, 105 (53%) were moved to a less restrictive CM level or to open population.

Deficiencies in mental health care provided to CM inmates included numerous documentation issues. Additionally, there were findings needing expedient attention such as deficiencies in care of suicidal/self-injurious inmates, inadequate laboratory studies for inmates on psychotropic medications, medication administration that was not compliant with acceptable nursing practice and numerous findings in the inpatient area that may be related to extensive use of agency nurses and locum tenens psychiatrists not familiar with policies and procedures. In the outpatient area, while a strong group therapy approach exists, concerns surfaced regarding access to private and confidential individual therapy when needed. It should be noted that three of the findings (CM-4, CM-23 and CM-27) will require OHS and/or departmental level intervention to achieve full resolution.