



# CORRECTIONAL MEDICAL AUTHORITY

## PHYSICAL & MENTAL HEALTH SURVEY

of

## WAKULLA CORRECTIONAL INSTITUTION

in

Woodville, Florida

on

April 9 – 12, 2002

Institutional Statistics Provided to CMA on March 26, 2002		
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
1,525	1,353	100	100	1,453

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## OVERVIEW

On April 9, 2002, the Correctional Medical Authority (CMA) concluded a physical and mental health survey of Wakulla Correctional Institution (WAKCI), located in Woodville, Florida. At the time of the survey, WAKCI served a male, adult offender population of approximately 1,453 inmates assigned to medical classifications 1 through 4 and psychological grades 1 and 2. Inmates requiring complex medical/dental care and/or psychotropic medications as a part of mental health treatments were not housed at this institution.

<b>Medical Grade</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>Impaired</b>	
	<b>707</b>	<b>420</b>	<b>115</b>	<b>1</b>	<b>2</b>	
<b>Psychological Grade (S-Grade)</b>	<b><u>Mental Health Outpatient</u></b>			<b><u>MH Inpatient</u></b>		
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>Impaired</b>
	<b>1, 214</b>	<b>28</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>0</b>
<b>Confinement/ Close Management</b>	<b>DC</b>	<b>AC</b>	<b>PM</b>	<b>CM3</b>	<b>CM2</b>	<b>CM1</b>
	<b>61</b>	<b>28</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>

The above figures include satellite units.

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.

A thorough review of the physical health-related systems in place at the institution, including the physical plant, administrative processes, and the provision and documentation of care revealed only four relatively minor departures from CMA standards or with prevailing practice standards generally accepted in the community at large. One such finding relates to a lack of documentation of daily clinician rounds in the infirmary, another to incomplete documentation on DC4-760A forms (completed on each inmate upon their arrival at the institution), and the last two to a lack of consistency between information contained in medical records and the corresponding offender based information system (OBIS) screens.

Mental health staffing at Wakulla CI is inadequate to provide necessary clinical services to the inmate population. This was acutely demonstrated by deficiencies noted in the area of self-injury/suicide prevention as well as in the lack of a full-range of mental health services (e.g., therapy groups). There had been one apparent suicide at the institution since the prior CMA survey and, though the death was not clearly preventable, several areas of concern were noted. Complicating mental health services delivery to self-injurious/suicidal inmates at this institution has been the lack of an on-site physician for a significant length of time. While a physician had just been hired at the time of the survey, staff were unaware of any plans to increase the allocation of mental health staff at the institution.

In addition to the physical and mental health findings referenced above, which fall within the scope of the institutional staff to correct, several other areas of concern were noted that will require intervention by the department's Office of Health Services (OHS) to

address. These issues are clearly identified and discussed in detail in the Wakulla C.I. Supplemental Report (Physical and Mental Health Survey Findings Requiring OHS Intervention).

At the conclusion of the survey, an exit conference was held on site with department 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 regarding institutional issues 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:

Physical Health Findings Summary		Numeric Score*		
		Systems	Records	
	Episodic Care	Sick Call	100	100
		Emergency Care	100	98
		Physician/CA Follow-Up Care	N/A	98
		Infirmity Care	N/A	81
	Chronic Care	Chronic Illness Clinic Systems	100	
		Asthma		98
		Diabetes		100
		General Medicine		100
		Hypertension		100
		Immunity		N/A
		Seizure		100
		TB/INH		100
	Preventative Care	100	100	
	Dental Care	94	96	
	Mortality	N/A	98	
	Other	Administrative Audit	90	
		Consultations	100	100
		Infection Control	100	
Intake Process (Reception)		N/A	N/A	
Intra-system Transfers		100	82	
Medication Administration		94	98	
OBIS		100	78	
Pharmacy		N/A		
Quality Management	100			
<b>Mental Health Findings Summary</b>				
	Inmate Access to Mental Health Services	88	90	
	Outpatient Mental Health Services	73	S1	88
			S2	91
			S3	N/A
	Intellectual Functioning	100	100	
	Sexual Offender Services	83	81	
	Special Housing	60	88	
	Psychotropic Medication	N/A	N/A	
	Self-Injury/Suicide Prevention	86	39	
	Psychiatric Restraints	80	N/A	
Inpatient Mental Health Services	N/A	N/A		
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.

Records Reviewed:	<b>INFIRMARY</b>	Systems Score	Records Score
<b>8</b>		<b>N/A</b>	<b>81</b>
Finding(s)	Suggested Corrective Action(s)		
<p><b>PH-1: Five of eight records reviewed lacked documented evidence of daily clinician rounds, either in person during the normal duty week or by phone on weekends and holidays.</b></p>	<p>Provide in-service training to appropriate staff.</p> <p>Develop a call schedule to ensure weekend/holiday rounds are conducted, either by phone or in person.</p> <p>Monitor at least five infirmatory records monthly to ensure compliance. Continue monitoring until a 100% compliance rate is reached and maintained for three consecutive months.</p>		

Records Reviewed:	<b>INTRASYSTEM TRANSFERS</b>	Systems Score	Records Score
<b>10</b>		<b>100</b>	<b>82</b>
Finding(s)	Suggested Corrective Action(s)		
<p><b>PH-2: In five of 10 records reviewed, acute or chronic medical conditions, pending appointments (including consultations), laboratory tests, etc. were not fully annotated on the DC4-760A (Arrival Summary).</b></p>	<p>Provide in-service training to appropriate staff.</p> <p>Monitor five intra-system arrival summary forms (DC4-760A) monthly to ensure all required information is annotated. Continue monitoring until a 100% compliance rate is reached and maintained for three consecutive months.</p>		

Records Reviewed:	<b>OFFENDER BASED INFORMATION SYSTEM (OBIS)</b>	Systems Score	Records Score
<b>10</b>		<b>100</b>	<b>78</b>
Finding(s)	Suggested Corrective Action(s)		
<p><b>PH-3: In six of 10 records reviewed, medical contacts reflected in OBIS did not consistently match the medical contacts documented in the medical record.</b></p> <p><b>PH-4: In four of ten OBIS screens reviewed, the next scheduled PPD skin test date did not match the timeframe when it should occur.</b></p>	<p>Provide in-service training to appropriate staff.</p> <p>Monitor and compare five records against appropriate OBIS screens monthly to ensure all medical contacts and pending appointments are accurately reflected. Continue monitoring until a 100% compliance rate is reached and maintained for three consecutive months.</p>		

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

#### System Reviews

- Chronic Illness Systems
- Consultations
- Dental
- Emergency Care
- Infection Control
- Intra-system Transfers
- Medication Administration
- Offender Based Information System
- Preventative Care
- Quality Management
- Sick Call

#### Record Reviews

- Asthma Clinic
- Consultations
- Dental
- Diabetes
- Emergency Care
- General Medicine Clinic
- Hypertension Clinic
- Medication Administration
- Mortality
- Physician/CA Follow-Up
- Preventative Care
- Seizure Clinic
- Sick Call
- TB/INH Therapy Clinic

In addition to the findings identified in the body of this report, which fall within the scope of the institutional staff to correct, other areas of concern were noted that will require action/intervention by the department's Office of Health Services (OHS) to address. Refer to the Wakulla C.I. Supplemental Report (Physical and Mental Health Survey Findings Requiring OHS Intervention) for a description of the findings.

### **CONCLUSION**

The CMA survey of Wakulla C.I. revealed that, overall, staff provides a level of physical health care consistent with expected and required standards. Only four relatively minor findings were identified, each of which fall within the scope of the institutional staff to correct. Strengths identified during the survey include timely, competent, well documented, and appropriate clinical assessments and treatments by medical and nursing staff in both the episodic and chronic illness arenas and very well organized administrative documentation.



# MENTAL HEALTH FINDINGS

## Survey Results

There had been one apparent suicide since the prior CMA survey. This incident is discussed under the “Mortality” section. No episodes of psychiatric restraint use were reviewed, as psychiatric restraints had not been utilized in the year prior to the survey.

Where recommended corrective actions suggest in-service training, a copy of the curriculum should be included in the corrective action plan files. Additionally, evidence of appropriate monthly monitoring should be included in the files for each finding. Monitoring by a clinician peer should be documented by a monthly listing 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; and 4) back-up documentation consisting of copies of relevant sections from the sampled charts.

Records Reviewed:	<b>OUTPATIENT MENTAL HEALTH SERVICES</b>	Systems Score	Records Score
<b>13</b>		<b>73</b>	<b>S1: 88 S2: 91</b>
Finding(s)		Suggested Corrective Action(s)	
<p><b>MH-1: The full range of mental health services was not offered in that no therapy groups were available and only a sex offender group had been conducted in the prior year (see staffing issue discussion in “OHS Issues - Supplemental Report”).</b></p>		<ul style="list-style-type: none"> <li>• Develop a plan to offer group therapy groups such as anger and stress management and sex offender treatment as well as other groups. This plan should be developed in concert with OHS as resolving the staffing issue is integral to its successful implementation.</li> <li>• Include waiting lists for groups in the CAP file. The lists should specify the group title, inmate name, DC number, and date placed on the list.</li> </ul>	

**MH-1 Discussion:** Mental health clinical staff at Wakulla CI consisted of one senior psychologist with occasional “borrowing” of a psychological specialist from neighboring institutions. The main duty of the borrowed psychological specialist, who was on site one day per week, was to assist with confinement rounds (see “Special Housing” section below). Inmates interviewed who were on the mental health caseload of 25 S2 inmates were generally complimentary of the individual therapy services received but expressed dissatisfaction with the limited frequency and contact time of those services.

Records Reviewed: 10	SELF-INJURY/SUICIDE PREVENTION	Systems Score 86	Records Score 39
Finding(s)	Suggested Corrective Action(s)		
<p><b>MH-2: Inmates admitted to a self-injury/suicide prevention status did not always receive a thorough clinical evaluation prior to admission (or the next working day if after-hours).</b></p>	<ul style="list-style-type: none"> <li>• Provide appropriate in-service training for mental health staff. Include a copy of the training agenda/curriculum in the CAP file.</li> <li>• Review 5 charts per month of inmates admitted to SOS, alternative housing and 23-hour observation until 100% compliance is achieved for three consecutive months. Include copies of the relevant portion(s) of the sampled records in the CAP file.</li> </ul>		
<p><b>MH-3: Valid physician orders for infirmary admissions to suicide observation status (SOS) were not present in the records reviewed. Also, re-ordering of SOS by a physician was not conducted every 24 hours.</b></p>	<ul style="list-style-type: none"> <li>• Provide appropriate in-service training with physician staff. Include a copy of the training agenda/curriculum in the CAP file.</li> <li>• Provide in-service training reminding physicians and nursing staff that timed and dated physician orders are required that specify the frequency of observations as well as indicate what articles/property inmates are allowed to have in the cell.</li> <li>• Review 5 charts per month of inmates admitted to SOS until 100% compliance is achieved for three consecutive months. Include copies of the relevant portion(s) of the sampled records in the CAP file.</li> </ul>		
<p><b>MH-4: Daily rounds by an attending physician were not conducted with SOS patients.</b></p>	<ul style="list-style-type: none"> <li>• Review 5 charts per month until 100% compliance is maintained for three consecutive months. Include copies of the relevant portion(s) of the sampled records in the CAP file.</li> </ul>		
<p><b>MH-5: Daily face-to-face clinical evaluations by mental health staff were not completed on inmates admitted to alternative housing.</b></p>	<ul style="list-style-type: none"> <li>• Provide appropriate in-service training with mental health staff. Include a copy of the training agenda/curriculum in the CAP file.</li> <li>• Review 5 charts per month of inmates admitted to alternative housing until 100% compliance is achieved for three consecutive months. Include copies of the relevant portion(s) of the sampled records in the CAP file.</li> </ul>		

Records Reviewed:	<b>SELF-INJURY/SUICIDE PREVENTION</b>	Systems Score	Records Score
10		86	39

Finding(s)	Suggested Corrective Action(s)
<b>MH-6: Documentation of periodic observations of self-injurious/suicidal inmates was missing in the records of inmates admitted to alternative housing.</b>	<ul style="list-style-type: none"> <li>• Provide appropriate in-service training with nursing, correctional officer, and medical records staff regarding completion and filing of the DC4-650 form (observation checklist). Include a copy of the training agenda/curriculum in the CAP file.</li> <li>• Review 5 charts per month of inmates admitted to alternative housing until 100% compliance is achieved for three consecutive months. Include copies of the relevant portion(s) of the sampled records in the CAP file.</li> </ul>
<b>MH-7: Mental health staff did not provide adequate SOS or alternative housing post-discharge follow-up contacts in the records reviewed.</b>	<ul style="list-style-type: none"> <li>• Provide appropriate in-service training with mental health staff on the required frequency and content of post-discharge follow-up contacts for inmates discharged from SOS and alternative housing status. Include a copy of the training agenda/curriculum in the CAP file.</li> <li>• Review 5 charts per month of inmates admitted to IMR/SOS <b>and</b> 5 charts per month of inmates admitted to alternative housing until 100% compliance is achieved for three consecutive months. Include copies of the relevant portion(s) of the sampled records in the CAP file.</li> </ul>

**MH-2 through MH-7 Discussion:** The lack of an on-site physician for approximately eight months prior to the survey obviously contributed to the findings cited in MH-2 through MH-4 related to a lack of valid physician orders, daily rounds and re-ordering of SOS. While verbal orders were noted by nursing staff, they were almost never co-signed by a physician and the designated attending physician (usually from a neighboring institution or regional staff) never personally examined the patient in the records reviewed. Also, in at least one instance a notation was made by a psychologist no longer on staff, that the on-call physician could not be located therefore the psychologist signed the admission order. These serious findings should be remedied quickly by the fact that during the survey a full-time on-site physician began employment at Wakulla CI. However, the potential for repetition of the delay in filling a position as vital as a physician may exist at other institutions and is of continued concern.

Findings MH 5 through MH-7 relating to mental health staff responsibilities in providing care to self-injurious/suicidal inmates are serious deficiencies most likely reflective of a prioritization and staffing problem. While training and monitoring may assist in their resolution, additional on-site mental health clinical staff will be necessary for true correction to take hold and be maintained.

Records Reviewed:	SEX OFFENDER SERVICES	Systems Score	Records Score
6		83	81
Finding(s)		Suggested Corrective Action(s)	
<b>MH-8: Valid consent for treatment forms were not present in the records of inmates receiving sex offender treatment services.</b>		<ul style="list-style-type: none"> <li>• Provide appropriate in-service training with mental health staff. Include a copy of the training agenda/curriculum in the CAP file.</li> <li>• Review 5 charts per month of sex offenders until 100% compliance is achieved for three consecutive months. Include copies of the relevant portion(s) of the sampled records in the CAP file.</li> </ul>	

**MH-8 Discussion:** It was noted that, when the sex offender therapy group was offered, the documented treatment appeared to be thorough and appropriate.

Records Reviewed:	SPECIAL HOUSING	Systems Score	Records Score
5		60	88
Finding(s)		Suggested Corrective Action(s)	
<b>MH-9: There was not an effective system for tracking completion of confinement evaluations.</b>		<ul style="list-style-type: none"> <li>• Develop an effective system (i.e., a log) in compliance with TI 15.05.18 for tracking the completion of required confinement evaluations. It is suggested that this system should record inmate name, DC number, date entered confinement, date evaluations are due, date completed, and date of inmate release from confinement.</li> <li>• Provide a copy of the log in the closure file.</li> </ul>	

**MH-9 Discussion:** Due to the lack of a system for tracking completion of confinement evaluations it was not possible to effectively review performance in this area. The limited records reviewed suggested that there may be a problem in timely completion of evaluations as one record reflected a late evaluation. A pattern, however, could not be established due to the aforementioned lack of a tracking system.

Records Reviewed:	PSYCHIATRIC RESTRAINTS	Systems Score	Records Score
0		80	N/A
Finding(s)		Suggested Corrective Action(s)	
<b>MH-10: Staff were unable to locate the key to the room where the psychiatric restraints are kept for a significant length of time. When the room key was located the key to unlock the restraints could not be located.</b>		<ul style="list-style-type: none"> <li>Develop a plan for ensuring that the access to the psychiatric restraints and the restraint key is readily available (i.e., within 2-3 minutes) and train all medical and mental health staff regarding the procedure. Provide a copy of the plan, training curriculum and training attendance roster in the CAP file.</li> </ul>	

No significant negative findings were noted in the following areas of review:

**Systems**

- Access
- Intellectual Functioning
- Sex Offender Services

**Records**

- Access
- Intellectual Functioning
- Outpatient Mental Health Services

**MORTALITY REVIEW**

There had been one suicide at Wakulla CI since the prior CMA survey. This death was of an inmate who apparently hung himself while in disciplinary confinement. Documents reviewed were limited to the medical record and the inmate classification file. Review of this documentation revealed several areas of concern. While it is impossible to say if any death is preventable, the following issues were noted:

- 1) **The vegetative symptoms of depression and degree of helplessness and hopelessness should be more completely assessed and documented, including documentation of the absence of symptoms.** The medical record and classification file of this inmate reflected numerous contacts where medical and security staff noted the inmate was crying and exhibiting agitation. Mental health staff characterized the inmate as manipulative.
- 2) **In future cases of this type the inmate should be more comprehensively assessed for the presence of a thought disorder and the assessment should be more thoroughly documented, including documentation of the absence of symptoms.** This recommendation is made given the inmate's documented risk factors and given the inmate's statements and documented writings (noted in the classification file) that suggest the possibility of increasingly disordered and bizarre thought processes in the final month of his life.
- 3) **Inmates discharged from infirmary mental health observation status should be routinely followed up with a documented face-to-face clinical evaluation at least within seven days of discharge to confirm initial impressions.** This inmate was discharged from 23-hour infirmary observation status on 12/12/01 and was not seen again by mental health staff until the inmate declared a psychological emergency on 12/20/01.

- 4) **Collateral information within the medical record should be utilized and addressed in a mental health clinical assessment.** Information from nursing assessments and actions (e.g., the inmate was given a 10 m.g. dose of valium i.m. for agitation per a telephoned physician's order) and from the DC4-650 form (observation sheet) regarding the inmate's behavior while in the infirmary were not addressed in the documentation of the 12/12/01 clinical encounter with mental health staff.
- 5) **Collateral information from security and classification staff should be utilized and addressed in a clinical mental health assessment.** This is particularly important with an inmate who is pending entry into close management status, such as this inmate.
- 6) **Formal avenues should be explicitly outlined by policy for medical and mental health staff to report allegations of inmate abuse and such reporting should be clearly documented and staff should be trained in the policy.** This inmate made numerous allegations that officers were abusing him in confinement. Assuming these allegations were not the product of a thought disorder, they should have been reported to appropriate staff (e.g., the institutional inspector and the warden). It is unclear whether or not that occurred other than a notation in the medical record by mental health staff that the OIC (officer in charge) was contacted regarding the interview of 12/12/01. The content of that contact is not detailed.
- 7) **Policy clarity is needed for guiding medical staff in providing "clearance" prior to the use of chemical agents (e.g., OC pepper gas) on inmates.** Policy should address the specific purpose and criteria for medical clearance as well as ethical issues when staff are asked to repeatedly clear an inmate for use of the agents within a short period of time. Also, the issue of how recent the inmate's last physical examination was should be explored in developing such a policy. Additionally, it is suggested that the policy address consultation with mental health staff in situations of repeated and numerous applications of chemical agents with no apparent change in inmate behavior. Chemical agents were documented as having been used on this inmate five times from 12/16/01 to 12/18/01 and four times from 1/6/02 to 1/9/02. Chemical agents were used on this inmate for the last time at approximately 11:20 p.m. on 1/9/02. He was found dead from an apparent suicide by hanging at approximately 6:07 a.m. on 1/10/02. Though it is not possible to establish a direct connection between the use of chemical agents and the inmate's suicide, the repeated use of chemical agents in a 24-hour period may significantly exacerbate any underlying psychopathology.
- 8) **Documentation in the medical record regarding the actions taken in performing cardiopulmonary resuscitation should be specific and clear.** It is unclear whether or not an AMBU bag was utilized with this inmate or if O2 was applied by nasal cannula only, nor is it clear if a true pulse or a compression pulse was present during the CPR procedure conducted by nursing staff.

## **CONCLUSION**

Mental health staffing at Wakulla CI is inadequate to provide necessary clinical services to the inmate population. This was acutely demonstrated by deficiencies noted in the area of self-injury/suicide prevention as well as in the lack of a full-range of mental health services (e.g, therapy groups). Complicating mental health services delivery at this institution has been the lack of an on-site physician for a significant length of time. While a physician had just been hired at the time of the survey, staff were unaware of any plans to increase the allocation of mental health staff at the institution.



## 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.