



# **CORRECTIONAL MEDICAL AUTHORITY**

## **PHYSICAL & MENTAL HEALTH SURVEY**

of

### **ZEPHYRHILLS CORRECTIONAL INSTITUTION And CORRECTIONS MENTAL HEALTH INSTITUTION**

in

**Zephyrhills, Florida**

on

**July 24-26, 2001**

<b>INSTITUTIONAL STATISTICS PROVIDED CMA on July 17, 2001</b>				
<b>Population</b>	<b>Custody</b>	<b>Type</b>	<b>Maximum Capacity</b>	<b>Current Occupied Beds</b>
<b>Adult</b>	<b>Close</b>	<b>Male</b>	<b>693</b>	<b>534</b>

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## OVERVIEW

On July 25, 2001, the Correctional Medical Authority concluded a physical and mental health survey of Zephyrhills Correctional Institution (ZEPCI) and Corrections Mental Health Institution (CMHI), located in Zephyrhills, Florida. At the time of the survey, ZEPCI/CMHI served an adult, male population of approximately 693 inmates assigned to medical grades 1 through 4 and psychological grades 1, 2, 3, and 5. ZEPCI/CMHI was classified as a medical level 4 facility. Inmates requiring complex medical/dental care and psychotropic medication/inpatient mental health services were housed at this institution.

<i>Medical Grade</i>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<i>Impaired</i>	
	<b>234</b>	<b>200</b>	<b>86</b>	<b>16</b>	<b>1</b>	
<i>Psychological Grade</i>	<u><i>Mental Health Outpatient</i></u>			<u><i>MH Inpatient</i></u>		
<i>(S-Grade)</i>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<i>Impaired</i>
	<b>118</b>	<b>53</b>	<b>320</b>	<b>0</b>	<b>38</b>	<b>44</b>
<i>Confinement/ Close Management</i>	<i>DC</i>	<i>AC</i>	<i>PM</i>	<i>CM3</i>	<i>CM2</i>	<i>CM1</i>
	<b>21</b>	<b>28</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

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 was conducted, including the physical plant, administrative processes, and the provision and documentation of care. The review revealed several areas of concern with need for improvement including a failure to document narcotic count at each shift change, an incomplete sick call log, inmates' medical complaints being filled in on the sick call log by officers, and medical records and logs not having dates or times documented. Both records and logs were difficult to read. Incomplete histories were noted in chronic illness clinics.

With regard to the mental health program, the inmate population required the full range of mental health services including inpatient hospitalization at the Corrections Mental Health Institution, psychotropic medication management, and outpatient treatment services for a caseload of over 300 S3 and 50 S2 inmates. Significant areas of concern included inadequate mental health staffing and related deficiencies in outpatient treatment and significant lapses in the quality of medication management for inpatient inmates.

At the conclusion of the survey, an exit conference was held with on site 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 drawn following an analysis of the information collected during the survey. Where recommended corrective actions are provided, these recommendations 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:

Findings Summary		Numeric Score*		
		Systems	Records	
<b>PHYSICAL HEALTH</b>	<b>Episodic Care</b>	Sick Call	71	76
		Emergency Care	100	91
		Physician/CA Follow-Up Care	100	95
		Infirmity Care	91	93
	<b>Chronic Care</b>	Chronic Illness Clinic Systems	100	
		Asthma		90
		Diabetes		97
		General Medicine		94
		Hypertension		83
		Immunity		93
		Seizure		60
		TB/INH		100
	<b>Preventative Care</b>	100	100	
	<b>Dental Care</b>	100	100	
	<b>Mortality</b>	100	76	
	<b>Other</b>	Administrative Audit	93	
		Consultations	100	89
		Infection Control	91	
		Intake Control	na	na
		Intake Process	na	na
Intrasystem Transfers		100	86	
MAR and Chart Review			98	
OBIS		100	100	
Pill Line		88		
Pharmacy		100		
Quality Management	86			
<b>MENTAL HEALTH</b>	Inmate Access to Mental Health Services		100	100
	Outpatient Mental Health Services	86	S1	35
			S2	75
			S3	75
	Intellectual Functioning	83	N/A	
	Sexual Offender Services	100	91	
	Special Housing	100	90	
	Psychotropic Medication	100	65	
	Self-Injury/Suicide Prevention	100	84	
	Psychiatric Restraints	33	74	
Inpatient Mental Health Services	86	94		
<p>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.</p>				

## PHYSICAL HEALTH FINDINGS

### Survey Results

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

- Consultations
- Dental
- Asthma Clinic
- Diabetes Clinic
- Emergency Care
- Intra-system Transfers
- OBIS
- Pill Call
- Preventative Care
- TB/INH Prophylaxis Clinic

### EPISODIC CARE

Records Reviewed:	<b>SICK CALL</b> (Nursing Encounter)	Systems Score	Records Score
<b>7</b>		<b>71</b>	<b>76</b>
Finding(s)	Recommended Corrective Action(s)		
<p><b>PH-1 Sick call log was not filled in by clinical staff. It was reported that officers documented the inmate medical complaints on the log thereby compromising confidentiality.</b></p>	<p>Review sick call log daily for completeness and completion by clinical staff.</p> <p>Provide ongoing in-service to health care staff regarding confidentiality.</p>		
<p><b>PH-2 An inmate presenting with chest pain was treated for hyperventilation and was not referred to an advanced level provider. An EKG was ordered by a psychiatrist on a different date with no documentation to support order or outcome.</b></p>	<p>Provide in-service to clinical staff regarding referral protocol.</p> <p>Review with medical staff the importance of documentation of care.</p> <p>Monitor ten sick call records monthly for appropriate documentation until attaining three consecutive months of 100% compliance.</p>		

Records Reviewed:	<b>HYPERTENSION CLINIC</b> <b>RECORD REVIEW</b>	Records Score
<b>8</b>		<b>83</b>
Finding(s)	Recommended Corrective Action(s)	
<p><b>PH-3 Four of the eight records lacked complete medical histories.</b></p>	<p>Provide in-service training for medical staff on the requirements for complete medical histories in hypertension clinic.</p> <p>Monitor ten records per month until 100% compliance is maintained for three consecutive months.</p>	

Records Reviewed:	<b>SEIZURE CLINIC RECORD REVIEW</b>		Records Score
5			60
Finding(s)		Recommended Corrective Action(s)	
PH- 4 Five out of five records reviewed had incomplete medical histories. Four records out of five had no documentation of type of seizure and four records lacked neurological consults.		<p>In-service training should be provided for clinicians and supporting clinical staff regarding ongoing seizure care through chronic illness clinics.</p> <p>Monitor five seizure clinic records per month until 100% compliance is achieved for three consecutive months.</p>	

### MORTALITY

Records Reviewed:	<b>MORTALITY</b>		Systems Score	Records Score
3			100	76
Finding(s)		Recommended Corrective Action(s)		
PH- 5 Three records were reviewed. One record lacked a complete final physician death summary, three records had no death certificate, and all three records had poor legibility.		<p>Institute a system to audit mortality records for required documentation.</p> <p>Provide in-service training for medical staff regarding legibility of documentation.</p> <p>Have physician(s) review TI 15.09.09, Mortality Review Program with specific attention to death summary form, and TI 15.12.03, Health Records.</p>		

### OTHER

Records Reviewed	<b>ADMINISTRATIVE AUDIT</b>		Systems Score
NA			93
Finding(s)		Recommended Corrective Action(s)	
PH- 6/OHS- 1 No evidence was provided of an annual peer review of the chief health officer (CHO) apart from the annual performance evaluation.		Institute a system by which annual peer review of the CHO is conducted. This system should be coordinated through regional health services.	

## **CONCLUSION**

Both formal and informal staff interviews and observations revealed no indications of interference with medical decisions. Overall, staff was very knowledgeable regarding the process of providing care. According to the health care staff there is a nursing shortage resulting in a need for ongoing overtime coverage. Agency nurses are not used at this institution for back up coverage. Staff expressed need for cross training between mental and physical health, and medication administration, due to the frequent shifting of assignments to provide coverage. This institution has not had a nursing supervisor recently. The mental health supervisor has acted as a resource person for the nursing department with the CHO overseeing daily routines. The vacant nursing supervisor position had not been advertised at the time of the survey. It was reported that the nursing supervisor would oversee both the physical and mental health care services at ZEPCI/CMHI, and Hillsborough CI. Considering the complexity of CMHI's mission this may prove to be a difficult position to fill, or keep filled. Many issues surfacing during the survey could no doubt be addressed with strong leadership within the nursing department. This could contribute to a more cohesive work effort between administration and health services.



# MENTAL HEALTH FINDINGS

## Survey Results

There was one death requiring review from a mental health perspective since the last survey of Zephyrhills Correctional Institution (ZEPCI) and the Corrections Mental Health Institution (CMHI).

Records Reviewed:	INPATIENT MENTAL HEALTH SERVICES	Systems Score	Records Score
9		86	94
Finding(s)	Recommended Corrective Action(s)		
<p><b>MH-1</b> The inmates had not signed one third of the inpatient ISPs reviewed, and there was no indication that the inmates had refused to sign their ISPs.</p>	<p>Ensure inpatient inmates are present as required at the treatment plan reviews and that patient signatures or refusals are documented.</p> <p>Monitor ten charts per month until 90% compliance is achieved for three consecutive months.</p>		

## Discussion

There were a number of strengths in the inpatient program. The staff worked well together and had good rapport with the inmates. Treatment was clearly goal oriented towards the highest level of inmate functioning. Medication was administered at the appropriate time for the desired effect (i.e., hour of sleep (hs) medications were given at 8 pm). There was also evidence of good pre-release planning. There were sufficient and appropriate group activities for inmates progressing through the level system to higher levels of functioning. Finally, the security staff was observant and reported concerns to the mental health staff.

Records Reviewed:	OUTPATIENT MENTAL HEALTH SERVICES	Systems Score	Records Score
16		86	S1 35 S2 75 S3 75
Finding(s)	Recommended Corrective Action(s)		
<p><b>MH-2</b> Initial intake record screenings were not completed within 24 hours in the outpatient records reviewed.</p>	<p>Provide training on intake processing. Enter an individual note into the medical record on the date the record was screened.</p> <p>Monitor 10% of new intakes or a minimum of ten charts per month until 100% compliance is achieved for three consecutive months.</p>		
<p><b>MH-3/OHS-1</b> Written and verbal orientation to mental health services was not completed within 24 hours in the outpatient records reviewed. (See discussion below).</p>	<p>Develop a mechanism to ensure mental health orientation is provided within 24 hours.</p> <p>Monitor 10% of new gains or a minimum of ten charts per month until at least 90% compliance is achieved for three consecutive months.</p>		
<p><b>MH-4</b> ISPs were not consistently developed within 14 days in the S3 records reviewed.</p>	<p>Provide training on ISP completion.</p> <p>Monitor 10% of applicable S3 charts or a</p>		

Records Reviewed:		OUTPATIENT MENTAL HEALTH SERVICES	Systems Score	Records Score
16				86
Finding(s)		Recommended Corrective Action(s)		
		minimum of ten charts per month until at least 90% compliance is achieved for three consecutive months.		
<b>MH-5</b> Treatment goals were generally vague and non-measurable in the outpatient records reviewed.		Provide training on the development and implementation of measurable treatment goals.  Monitor 10% of applicable charts or a minimum of ten charts per month until 90% compliance is achieved for three consecutive months.		
<b>MH-6</b> Treatment interventions other than medication monitoring were rarely documented as indicated in the outpatient records reviewed.		Provide training on the provision of therapeutic interventions including frequency of therapeutic contact recommended for outpatient inmates (suggest refer to Technical Instruction on Outpatient Services).  Monitor 10% of applicable charts or a minimum of ten charts per month until 100% compliance is achieved for three consecutive months.		
<b>MH7</b> The consent for evaluation and treatment was inconsistently documented in the S1 records reviewed.		Monitor 10% of applicable charts or a minimum of ten charts per month until 100% compliance is achieved for three consecutive months.		
<b>MH8</b> Biospsychosocial assessments (BPSAs) were not consistently completed prior to the initiation of group treatment in the S2 records reviewed.		Provide training on the requirements for BPSAs.  Monitor 10% of applicable charts or a minimum of ten charts per month until 100% compliance is achieved for three consecutive months.		
<b>MH-9</b> The diagnosis was not consistently appropriate in the outpatient records reviewed given the inmates' symptoms and history.		Provide training on documentation of clinical symptoms and on the development of clinically supported diagnoses.  Monitor 10% of applicable charts or a minimum of ten charts per month until 100% compliance is achieved for three consecutive months.		
<b>MH-10</b> Case management was not consistently timely in the S3 records reviewed.		Review case management requirements with mental health staff to ensure timely provision of this service.  Monitor 10% of applicable S3 charts or a minimum of ten charts per month until 100% compliance is achieved for three consecutive months.		

Records Reviewed:	OUTPATIENT MENTAL HEALTH SERVICES	Systems Score	Records Score
16		86	S1 35 S2 75 S3 75
Finding(s)		Recommended Corrective Action(s)	
<b>MH-11</b> The outpatient records were generally disorganized and notes were often illegible.		Review legibility requirements with mental health staff.  Monitor 10% of applicable charts or a minimum of ten charts per month until 90% compliance is achieved for three consecutive months.	

**Discussion**

**MH-3/OHS-1** Although the current system meets the requirement within the OHS policy, it is not consistent with the standards of the CMA or with national corrections standards. The CMA recommends a revision of current policy.

Records Reviewed:	PSYCHIATRIC RESTRAINTS	Systems Score	Record Score
3		33	74
Finding(s)		Recommended Corrective Action(s)	
<b>MH-12</b> Three areas of concern were noted in the psychiatric restraint cases reviewed: <ul style="list-style-type: none"> <li>a. There was no documentation in any of the records indicating that the warden or designee was informed of the event.</li> <li>b. There was no documentation in any of the records indicating that the patient was offered the use of a urinal as required every two hours.</li> <li>c. In one case, the restraints were not removed after the patient had been calm for 30 minutes.</li> </ul>		Provide training on documentation and clinical requirements regarding the management of patients in psychiatric restraints.  Monitor all applicable charts until ten cases have demonstrated 100% compliance in the areas noted (a – c).	

Records Reviewed:	PSYCHOTROPIC MEDICATION PRACTICES	Systems Score	Records Score
15		100	65
Finding(s)		Recommended Corrective Action(s)	
<b>MH-13</b> There were significant findings regarding medication practices in the mortality (suicide) which occurred at CMHI: <ul style="list-style-type: none"> <li>a. Documented severe medication side effects were not adequately addressed;</li> <li>b. There was no consideration given to returning to a medication plan with less severe side effects that had been</li> </ul>		Organize and provide training on the management of psychotropic medication side effects including review of patients' previous history of side effects, consideration of the use of atypical antipsychotics for patients not responding to current treatment, the need to address all treatment recommendations, the recognition and treatment of affective symptoms in the inpatient population, and the involvement of patients in their treatment.	

Records Reviewed:	PSYCHOTROPIC MEDICATION PRACTICES	Systems Score	Records Score
15		100	65
Finding(s)		Recommended Corrective Action(s)	
<p>documented as previously effective with this patient, and that the patient had requested;</p> <p>c. There was no consideration given to the use of an atypical antipsychotic for a patient not responding to current treatment;</p> <p>d. A recommendation by a staff psychiatrist to pharmacologically address well-documented affective symptoms was not addressed.</p> <p>e. There was no evidence that an attempt had been made to explain his treatment options to the inmate.</p> <p>(See discussion below).</p>		<p>Monitor 10% of inpatient charts or a minimum of ten charts per month regarding safe and effective medication practices until 100% compliance is achieved for three consecutive months.</p>	
<p><b>MH-14</b> In the inpatient records reviewed, long-acting neuroleptics were consistently used without first trying the shorter acting forms of the medications. (See discussion below).</p>		<p>Organize and provide training on safe and effective medication practices including the appropriate use of long-acting neuroleptics with the inpatient population.</p> <p>Monitor 10% of the applicable inpatient charts or a minimum of ten records per month regarding safe and effective use of long-acting neuroleptics until 100% compliance is achieved for three consecutive months.</p>	
<p><b>MH-15</b> In the inpatient and outpatient records reviewed, baseline and follow-up assessments of abnormal involuntary movements (AIMS), EKGs, and thyroid function testing were not consistently completed when indicated.</p>		<p>Provide training on requirements for baseline and follow-up assessments.</p> <p>Monitor 10% of the inpatient charts or a minimum of ten records per month until 100% compliance is achieved for three consecutive months.</p>	

**Discussion**

**MH-13** This chronic paranoid schizophrenic patient's history of non-compliance with oral medications likely complicated treatment. However, several interventions were omitted that may have influenced the outcome in this case. First, consistently documented medication side effects (akathisia with severe psychomotor agitation) were not adequately treated. At the time of his death, the patient continued to receive the long-acting neuroleptic Haldol Decanoate. Second, return to a previously effective medication plan (that the patient had requested) was not considered. Third, use of an atypical antipsychotic such as Zyprexa or Clozaril was not considered for a patient refractory to current treatment. Fourth, the recommendation of one psychiatrist to pharmacologically address well-documented affective symptoms was not addressed. Finally, there was no documentation that an attempt had been made to explain treatment options to the patient.

**MH-14** Most psychotropic medications have the potential for serious side effects with medical complications. Therefore, it is good practice to initiate treatment with the shorter-acting form of a medication prior to considering the longer-acting form.

Records Reviewed:	<b>SELF-INJURY/SUICIDE PREVENTION</b>	Systems Score	Records Score
<b>9</b>		<b>100</b>	<b>84</b>
Finding(s)		Recommended Corrective Action(s)	
<b>MH-16</b> In the outpatient infirmary records reviewed, the physicians' orders for Suicide Observation Status (SOS), were not consistently dated or timed, or documented on physician order forms.		Provide training on the requirements for physician orders for SOS.  Monitor all outpatient SOS cases until 100% compliance is achieved for three consecutive months.	
<b>MH-17</b> In the inpatient records reviewed, the attending physician did not consistently reorder SOS every 24 hours.		Provide training on the requirements for physician orders for SOS.  Monitor all inpatient SOS cases until 100% compliance is achieved for three consecutive months.	
<b>MH-18</b> In the inpatient records reviewed, the SOS patients were not consistently observed at the frequency ordered by the physician.		Provide training on the requirements for observation of SOS patients.  Monitor all inpatient SOS cases until 100% compliance is achieved for three consecutive months.	

Records Reviewed:	<b>SPECIAL HOUSING</b>	Systems Score	Records Score
<b>5</b>		<b>100</b>	<b>90</b>
Finding(s)		Recommended Corrective Action(s)	
<b>MH-19</b> Mental health staff did not consistently interview inmates on the mental health caseload within 24 hours of admission to confinement.		Ensure that interviews are conducted within 24 hours of admission to confinement.  Monitor all applicable cases until 100% compliance is achieved for three consecutive months.	

Records Reviewed:	<b>OTHER ADMINISTRATIVE ISSUES</b>	Systems Score	Records Score
		<b>na</b>	<b>na</b>
Finding(s)		Recommended Corrective Action(s)	
<b>MH-20/OHS-2</b> The outpatient psychological specialist positions are inadequate to provide the required mental health services in a timely and appropriate manner. Current staffing patterns in this area do not meet the guidelines of the 1996 DC Mental Health Services Plan. This situation is aggravated by clerical vacancies and the part-		Ensure allocated and filled positions are sufficient to provide the full range of required mental health services.  Continue to recruit and fill vacant positions.  Minimize the assignment of staff to other	

Records Reviewed:	<b>OTHER ADMINISTRATIVE ISSUES</b>	Systems Score	Records Score
[REDACTED]		na	na
Finding(s)	Recommended Corrective Action(s)		
time assignment of mental health staff to another institution in addition to their responsibilities at ZEPHCI. (See discussion below).	institutions, either on a full-time or temporary basis, in addition to their duties at ZEPH/CMHI.		
<b>MH-21</b> Record review and staff interview data indicated that the response of security and health care staff to inmates engaging in self-injurious behavior is at times delayed in both the outpatient and inpatient programs. (See discussion below).	<p>Review security and health care staff response to suicide/self-injury episodes and identify any reasons for delay. Address any identified delays.</p> <p>Minimize any delays resulting from requirements to film use of force incidents. Develop a mechanism to document response times.</p> <p>Ensure number and location of security cameras is sufficient for ZEPHCI and CMHI.</p>		
<b>MH-22</b> The documentation indicating that the suicide observation cells had been certified could not be located on-site (copies of the inspections were obtained from the regional office during the survey).	Ensure current copies of cell inspection and certification by the region are kept on-site.		
<b>MH-23</b> Staff interviews reported a delay of two to five days before outpatient inmate requests for mental health services were delivered to the mental health department.	<p>Recommend that all departments including administration, security and health/mental health meet to resolve the delay and ensure requests are received by mental health at least by the next working day.</p> <p>Monitor 10% or ten requests for mental health services per month until 100% compliance is achieved for three consecutive months. (Note the date written and date received on the monitoring sheet).</p>		
<b>MH-24</b> Training was not provided for mental health, medical, or security staff in the use of psychiatric restraint.	Provide training.		
<b>MH-25</b> Key mental health, medical, and security staff did not know where the restraint equipment was kept for use in the infirmary.	Provide training.		

**Discussion**

**MH-20/OHS-2** One of the two outpatient psychiatrist positions and both outpatient clerical positions were vacant. The number of psychological specialist positions allocated did not meet the guidelines of the 1996 DC Mental Health Services Plan. One of the two outpatient senior psychologists and two outpatient psychological specialists had been assigned to another institution at least one day per week in addition to their duties at ZEPHCI. Furthermore, one of the six outpatient psychological specialists was on extended sick leave, and average caseloads were 75 S3/S2 inmates per psychological specialist. Outpatient staff interview data indicated that it was difficult to provide needed coverage for annual leave. The outpatient staffing problems were reflected in the lack of timely development of ISPs and BPSAs, lack of timely case management, and generally disorganized documentation in the medical records.

In contrast to the outpatient program, the current inpatient-staffing pattern is adequate to provide the full range of required mental health services. However, the inpatient unit has only been at one-third to one-half capacity for some time and there were no females and only one youthful offender on the unit at the time of the survey. If the unit were to reach its capacity of 97 beds, psychological specialist and psychiatrist positions would not be adequate according to the guidelines of the 1996 DC Mental Health Services Plan. Furthermore, two of the seven allocated inpatient psychological specialist positions are permanently assigned to another institution and one position was permanently deleted last year. Mental health staff from the inpatient program is also subject to temporary assignment to other institutions in addition to their duties at CMHI.

Finally, the process of updating mental health staff credentials and privileges has left psychological specialists in both programs temporarily without privileges for a range of required mental health services (in particular, groups, suicide assessment, and crisis intervention). Training has been conducted in the area of crisis intervention and suicide assessment in order to address some of the gaps in privileges.

**MH-21** The department requires that all use of force must be filmed including physical intervention to prevent self-injurious behavior or apply psychiatric restraints. This necessitates ensuring that a video camera is present to film the use of force as it takes place. While the medical executive director and colonel reported that an inmate would be prevented from harming himself/herself regardless of whether a video camera had been secured to film the intervention, nursing and psychiatric staff indicated that interventions were delayed while waiting for the video camera to arrive. These concerns were also raised regarding one of the inpatient suicide/self-injury cases reviewed and in one further case mentioned by psychiatric staff. No significant injuries were reported in either of these cases.

During a telephone conversation of July 30, 2001, the HSA reported that there was only one working video camera at the institution (located at CMHI) and that four cameras were on order. He stated that three other cameras normally located in confinement and the control room were broken.

## **CONCLUSION**

The inmate population at Zephyrhills/CMHI required the full range of mental health services including inpatient hospitalization, psychotropic medication management, and outpatient treatment services. Significant areas of concern included inadequate mental health staffing and related deficiencies in outpatient treatment and documentation. There were also lapses in the quality of psychotropic medication management, particularly in the inpatient unit. These included inconsistent provision of baseline and follow-up laboratory testing and assessment of involuntary movement. There was also a failure to adequately treat severe medication side effects in the one mortality (suicide) case.



## 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.