ON-SITE ACCESS TO CARE REVIEW
FOLLOW-UP ASSESSMENT
of

TOMOKA CORRECTIONAL INSTITUTION

for the

Physical and Mental Health Review
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CMA STAFF
Jane Holmes-Cain, LCSW
Lynne Babchuck, LCSW

CMA CLINICAL SURVEYOR
Rosemary Bates, APRN

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I. Overview

In May 2021, the Correctional Medical Authority (CMA) conducted an on-site Access to Care Review of Tomoka Correctional Institution (TOMCI) to determine whether inmates had adequate access to timely physical, dental, and mental health essential health care services during the COVID-19 pandemic. The survey report was distributed on June 8, 2021. Unlike the traditional survey process, the Access to Care Review does not require a corrective action plan or subsequent monitoring. However, a follow-up review may be warranted if access to care issues are identified that if left unaddressed could impact patient health outcomes. A written plan was submitted by TOMCI in June 2021 which outlined how the deficiencies identified in the report would be addressed. On November 3, 2021, patient records were reviewed to assess the adequacy of the improvements.

II. Assessment Summary of Deficiencies Requiring Institutional Action

Area of Concern – Chronic Illness Clinics	**Assessment**
• Ensure that all abnormal labs are reviewed and addressed in a timely manner	Chronic illness clinics were evaluated to be consistent with Department standards and abnormal labs were reviewed timely.
Conclusion: No further action is required.	

Area of Concern – Medication Administration	**Assessment**
• Ensure that all MARS are completed appropriately, and inmates receive medications as prescribed	A review of records indicated that inmates did not consistently receive medications as prescribed, as evidenced by multiple blanks on the MARs.
Conclusion: This area of concern should continue to be addressed.	

Area of Concern – Sick Call Services	Assessment
• Ensure that sick call requests are triaged and assessed appropriately, and inmates are treated in a timely manner	Documentation of sick call visits continued to demonstrate incomplete assessments and delays in treatment.
Conclusion: This area of concern should continue to be addressed.	

Area of Concern - Consultations	Assessment
• Ensure that consultations and follow-up diagnostic testing are completed in a timely manner	Consultation services were markedly improved. Documentation indicated patients were evaluated and treated in a timely manner.
Conclusion: No further action is required.	

Area of Concern – Psychological Emergencies	Assessment
• Ensure that emergency evaluations are completed for inmates in a mental health crisis	A review of psychological emergencies demonstrated compliance with Department policy.
Conclusion: No further action is required.	

Area of Concern – Self-harm Observation Status	Assessment
• Ensure that inmates on SHOS are assessed by the seventh day after discharge to evaluate mental status and institutional adjustment • Ensure that all discharges from SHOS are clinically appropriate • Ensure that inmates on SHOS are observed at the frequency ordered by the clinician	Multiple deficiencies were noted in the review of services provided to inmates in SHOS; these included a lack of follow-up mental health care and inadequate safety observations.
Conclusion: These areas of concern should continue to be addressed.	

Area of Concern – Use of Force	Assessment
• Ensure that applicable inmates are interviewed by mental health staff within the required time frame following a use of force episode	There was no evidence that all applicable inmates were evaluated following a use of force episode.
Conclusion: This area of concern should continue to be addressed.	

Area of Concern – Special Housing	Assessment
• Ensure inmates receive a physical evaluation prior to placement in confinement • Ensure mental status exams are completed within the appropriate time frame for inmates held in confinement	Several deficiencies continued to be noted in the review of services provided to inmates held in confinement. Physical evaluations contained inaccurate information or were missing pertinent information. Additionally, mental status examinations were not completed within required time frames.
Conclusion: This area of concern should continue to be addressed.	

Area of Concern – Mental Health Services	Assessment
• Ensure inmates receive counseling and case management as indicated on their ISP	A review of mental health services indicated non-compliance with Department policy. Individualized Service Plans were not located for a majority of inmates and there was no evidence that all services were completed at the required intervals.
Conclusion: This area of concern should continue to be addressed.	

Area of Concern – Psychotropic Medication Practices	Assessment
• Ensure that all MARS are completed appropriately, and inmates receive medications as prescribed	A review of records indicated that inmates did not consistently receive medications as prescribed, as evidenced by multiple blanks on the MARs. This occurred for inmates held in confinement, as well as inmates in the general population.
Conclusion: This area of concern should continue to be addressed.	

Area of Concern – Inmate Requests	Assessment
• Ensure that mental health inmate requests are received and responded to timely and appropriately	A review of mental health inmate requests demonstrated compliance with Department policy.
Conclusion: No additional follow-up is required.	

Area of Concern – Medical Records	Assessment
• Ensure that documents are filed timely and organized according to Department standards	Medical records appeared to be maintained according to Department standards.
Conclusion: No additional follow-up is required.	

III. Conclusion

Further action is required for several of the concerns noted above. TOMCI should continue to implement their improvement plans. Follow-up by the CMA will take place within 90 days.